NATIONAL RURAL HEALTH ALLIANCE INC.

Submission

to the

Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years

conducted by the House of Representatives Standing Committee on Ageing

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Working to improve health in rural and remote Australia
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"We have choices, we can use our ageing population as an opportunity that allows our society to blossom. Alternatively, it can be an enormous burden which eventually becomes our downfall"[1]

EXECUTIVE SUMMARY

Without effective steps to make Australia's rural, regional and remote communities sustainable into the future, other strategies to address the consequences of an ageing population in rural and remote areas have a limited chance of success. As a nation we need to devote serious attention and resources to ways in which greater numbers of places in non-metropolitan areas can be sustainable, can grow and can offer a high level of health and well-being - including for older people.

Future action to plan for the ageing population must take into account the needs of all age groups, not simply the elderly. It would be unfortunate if deserved attention to the needs of our elderly alienated other groups or had unnecessary or unintended negative consequences for people in those other groups.

Planning for Australia's elderly should be based on sophisticated approaches to forecasting future population profiles so that national, local and regional planning can occur effectively and be based on needs. This would result in the most desirable situation in which the distribution of health and aged care resources, and effort overall, was determined to a greater extent than is currently the case by relative need.

Rural, regional and remote areas are extremely diverse. Nevertheless some generalisations are possible about what it is that defines the circumstances of older people in non-metropolitan areas and therefore distinguishes them from their capital city peers. It is these rural aspects of ageing on which this submission focuses.

In a consideration of the well-being of older people, these defining general rural characteristics include the following risks:

- the adverse effects of distance on access to services (most significantly the poor supply of local aged care places and service);
- the more common absence of growth and, as a consequence, the more common existence of poor physical infrastructure;
- poor communications (including transport);
- small numbers, which impacts on the unit costs of services and the relative shortage of support staff;
- the greater incidence of some health risk factors such as smoking, obesity, and avoidable injury and accidents; and
- stigma, caused by the greater visibility of circumstances.

These risks to well-being are counter-balanced by some of the positive factors for older rural people, such as having peace and quiet and fresh air, lower housing costs, the relative absence of community violence and the greater visibility of aberrant behaviours and, for those who can grow old where they were brought up, a great sense of comfort from being in known surroundings.

Although remote centres have a youthful population, Australia's s trend towards an ageing population is more pronounced in rural and remote areas overall than in the cities. In 1996 a greater proportion of those Australians who were 60 years old or more lived in rural, regional and remote Australia than had been the case ten years earlier. 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 aged profile of rural areas 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") regarded as beneficial for retirement

Three rural 'regions of contrast' are briefly examined: declining communities with ageing populations; developing and thriving communities, many of them serving as regional centres and others of them on Australia's coastline; and remote Indigenous communities.

The remainder of the submission is structured around the principles of the *National Strategy for an Ageing Australia.* It does this despite the fact that correspondents of the Alliance who contributed to the submission were not at all familiar with that Strategy or its content. This is of concern; if the National Strategy is to be meaningful, and to have meaningful results, it must be better promoted and contain more of direct relevance to people in rural, regional and remote areas.

Overall the major limitations in the health and aged care systems for country Australians, including for older people, relate to problems of access, and an inequitable resource allocation.

The outstanding areas of under-resourcing are in the areas of capital resources for the development and upgrading of aged care places; training, support and remuneration of workers in the health and aged care sector; oral and dental health; income and/or capital support for people in rural and remote areas whose financial means have been adversely affected by developments beyond their control; and some special consideration for ageing Indigenous people (from a realistic age for their particular circumstances).

In the submission we have listed a number of key strategies (in the spirit of the National Strategy), and under each of them, one or more Priority Actions (which are in the nature of specific recommendations to the Inquiry). The Strategies are as follows:

Strategy 1
Future actions to meet the challenges and opportunities for Australia flowing from its ageing population must take into account the implications of an ageing society, and of policies put in place because of it, for all groups.

Strategy 2
Future approaches to Australia's ageing population must include new processes and structures to monitor trends in key aspects of Australian society and to ensure that the implications of these trends are reflected in updated versions of the *National Strategy for an Ageing Australia.*

Strategy 3
Future policy approaches to rural and remote areas must include governments, businesses and communities working together in regional areas in ways envisaged in the 1999 Regional Summit to ensure that, wherever possible, rural and remote communities become sustainable.

Strategy 4
Future approaches to issues in rural and remote areas must ensure that where sustainability in the longer term is unlikely for particular communities for whatever reason, governments, businesses and communities work together to find ways to ensure that people remaining in those communities have the best quality of life possible and have access to a full range of services appropriate to their needs.

Strategy 5
Future action for remote Indigenous communities must include groups representing Indigenous people and governments working together to develop a specific plan for the ageing of the Indigenous population which recognises the early ageing of this group which perhaps commences from age 35 years.

Strategy 6
Future action to plan for the ageing population must take into account the needs of all age groups, not simply the elderly, and be based on sophisticated approaches to forecasting future population profiles so that local and regional needs-based planning can occur effectively.

Strategy 7
Future approaches by the Government must ensure that the National Strategy for an Ageing Australia appropriately reflects the needs of rural and remote communities; and that it is well publicised and used as a guide to underpin policy and program development for rural and remote areas.

Strategy 8
Future approaches to the old age pension must reflect increases in costs of living, including particular market effects in rural and remote areas, and the erosion of capital values in some rural areas, to ensure that retired Australians in those areas

have a standard of living comparable with city retirees and consistent with maintaining health.

Strategy 9
Future approaches to health in rural and remote communities must involve Governments closely monitoring the socio-economic status of residents in rural and remote areas on a small area basis, and responding when it is clear that the health of people in certain areas is seriously impacted by their socio-economic status.

Strategy 10
Governments, business and community leaders must work to put in place a set of policies, programs and public attitudes that will underpin a transition to a culture of investment in the older workforce, development of new skills for older workers, and employment systems that accommodate their needs.

Strategy 11
Future approaches to accommodation must enable rural and remote communities to develop a plan for their current and future accommodation requirements to meet the accommodation needs of all their members and taking into account projections for their future population profiles.

Strategy 12
Future approaches to transport and communications in rural and remote areas must involve Governments, businesses and communities working together to ensure integration of transport and communications systems to provide a mix of these services which is affordable and effective, enabling all community members to access services and information which are important in their lives and which take into account the changing needs arising from an ageing population.

Strategy 13
Future approaches to the prevention of falls must identify best practice approaches suited to rural and remote areas and extend programs based on these to older people in rural and remote areas.

Strategy 14
Future health policies and planning must give population health approaches an increased priority in rural and remote areas, with dedicated long-term funding available to support population health programs.

Strategy 15
Future approaches to assisting older people in rural and remote communities to maintain health and reverse trends to reduced physical capacity must include action by State and local governments and businesses to preserving and enhancing aspects of community life and local facilities which contribute to this.

Strategy 16
Future approaches to initiatives related to an ageing population in rural and remote areas must have initiatives to enhance older members' opportunities to contribute meaningfully to their communities' well-being as a central facet.

Strategy 17
Future approaches to public funding for health and aged care must ensure that health and aged care resources are distributed equitably, taking into account health needs and the realistic costs of providing services, with a special emphasis on increasing resources to rural and remote communities with relatively poor health.

Strategy 18
Innovative service models must be the basis of future approaches by funders and providers to improving the access in rural and remote areas to a range of specialised services needed by the elderly.

Strategy 19
Future approaches to ensuring world class care in rural and remote communities must recognise that the availability of a readily accessible, appropriately skilled and educated, and properly supported health and community services workforce is crucial.

Strategy 20
Future approaches to the provision of health and aged care in rural and remote areas must encourage facilities to identify and adopt relevant evidence based practices in their services.

Case-studies at the end of the submission provide anecdotal insights into some of these issues.

We would like to thank all of those who provided input to this submission. The level of interest among the Alliance's constituents was at an unprecedented level. This proves to the members of the Standing Committee what they must already know: that the topic of Australia's ageing population is a matter of great concern to very many individuals and interest groups.

We thank the Committee for allowing the Alliance the time to make a submission, and we commend it to your attention.

INTRODUCTION

The National Rural Health Alliance (NRHA) is the peak national multi-professional non-government body working to improve health in rural, regional and remote Australia. There are currently 24 Member organisations (see Attachment A), including those representing consumers, health and aged care services, doctors, allied health professionals, nurses, pharmacists, health managers, Aboriginal health organisations and health science students.

The work of the NRHA is based on the principles of social justice and the right of all Australians, wherever they live, to a comprehensive health service for themselves and their families. The Alliance is committed to promoting the provision of high quality, accessible and appropriate health care services to people of all ages in the diverse communities of rural and remote Australia.

NRHA's approach to its submission

This submission uses the *National Strategy for an Ageing Australia*[2] as its framework. That Strategy has four key themes:

- independence and self provision;
- attitude, lifestyle and community support;
- healthy ageing; and
- world class care.

In addition, the submission emphasises the fundamental issue of sustainability for rural and remote communities into the future. Without effective steps to make Australia's rural, regional and remote communities sustainable into the future, other strategies to address the consequences of an ageing population in rural and remote areas have a limited chance of success.

There are also some case studies which illustrate the problems and challenges country Australia is already facing in the context of its ageing populations.

The submission focuses specifically on strategies that are appropriate for the health and well-being of rural and remote communities, the NRHA's core business. 'Country Australia' is extremely diverse but there are some general differences compared with 'metropolitan Australia'. The submission identifies a range of strategies designed to ensure that older people in rural and remote areas benefit from policies and programs to address issues arising from the ageing of the Australian population in general.

Many of the issues discussed in the *National Strategy for an Ageing Australia*[2] are just as relevant to the rural, regional and remote population as they are to older Australians more generally. It is important to ensure that strategies and actions put in place are appropriate for rural and remote communities as well as for metropolitan areas. The general issues include:

- economic security;
- good health and freedom from disability as long as possible, but with access to health and aged care services when needed;

- attitudinal and structural changes in workplaces to remove barriers to workforce participation by older people;
- increased support and resources for older people wishing to remain in or re-enter the workforce;
- continuing participation in society and quality of life including access to services such as education, health and welfare, recreation and leisure and contributing to their own communities;
- the importance of positive community attitudes to older people;
- freedom from abuse and discrimination;
- comfortable and appropriate housing;
- mobility;
- access to and ability to use new and emerging home and service industry technologies (eg internet, ATM banking, home entertainment systems);
- a sense of security in and out of the home (safety is a big issue and deserves serious consideration);
- convenient location of services used by older people; and
- ready access to information about services and activities of interest to older Australians.

The rapid ageing of the Australian population has implications for all Australians, whatever their age and wherever they live – for instance through the level and targeting of taxation and government outlays. It is therefore important that all policies, strategies and actions associated with Australia's ageing population take into account the needs of all Australians and that we do not focus so much on older Australians that other groups in society become neglected and potentially alienated. What this means for the health and ageing sector, among other things, is the need to adopt a 'whole of life' approach to policies and programs, allowing a seamless transition between age cohorts for need groups if possible, while still accommodating the specific needs of individuals and groups within a variety of contexts.

Strategy 1
Future actions to meet the challenges and opportunities for Australia flowing from its ageing population must take into account the implications of an ageing society for all groups.

The NRHA notes that the Inquiry's terms of reference call for long-term strategies (ie for the next 40 years). There will obviously be major changes over that period which substantially affect Australia's political, economic, social, technological, cultural, environmental, population and health characteristics. Notwithstanding the great difficulty of looking forward 40 years, we have focussed in this submission on strategies which appear to have long-term significance and have also suggested some priority short-term actions consistent with those strategies.

Policies and strategies for ageing obviously have to be flexible to accommodate inevitable but unpredicted changes. We therefore suggest that one of the key recommendations for the Standing Committee be the establishment of an ongoing process to monitor trends in key aspects of Australian society so that the National Strategy can be amended as appropriate.

Strategy 2
Future approaches to Australia's ageing population must include new processes and structures to monitor trends in key aspects of Australian society and to ensure that the implications of these trends are reflected in updated versions of the *National Strategy for an Ageing Australia.*

In preparing this submission the NRHA invited input from its Member Bodies and from members of *friends* of the Alliance. There was a huge response, both from organisations and individuals, indicating a major interest in and concerns about issues related to ageing in rural, regional and remote communities. This high level of response no doubt reflects the fact that the NRHA's contacts are facing the consequences of ageing populations on a daily basis in their communities. Many rural and remote communities already have 18 per cent of their population aged 65 years or older, a figure not anticipated to be reached in Australia overall until 2021.

This submission draws heavily on those responses. Many issues appeared repeatedly in comments received. As a consequence, authorship is not generally acknowledged except in the cases of direct quotes and specific examples of innovative approaches to service provision or where material is obtained from a publication.

Some Member Bodies of the NRHA have made separate submissions to this Inquiry. These organisations have also contributed in varying degrees to the preparation of this submission, which has the general endorsement of all of the NRHA's Member Bodies. This endorsement indicates general support for the Alliance's position, but it does *not* mean that every Member Body necessarily supports every word in this submission. Consequently the submissions from the Alliance's individual Member Bodies may differ in emphasis or detail, including in their recommendations. These differences reflect the specific concerns of each group and their perceived solutions and should help the Committee to understand the issues from a wide range of perspectives.

Sustainability of Rural and Remote Australian Communities

While the NRHA is an organisation focusing primarily on health, it has a major interest in rural development, itself a health issue. Without rural development to ensure sustainable rural and remote communities in future, there will be a greater number of declining communities with ageing population and infrastructure, perhaps with little sense of direction, an uncertain future and poorly motivated leaders.

A low level of rural development contributes directly to poor health through inferior services and infrastructure, and the stress, frustration and alienation that people feel. It also results in poor health indirectly through the difficulty governments and the private sector experience in providing health services to areas that have small, sparse or declining populations.

The National Rural Health Alliance therefore believes that meeting the challenges of an ageing population will not be possible in isolation from a broader, strategic long-term approach to sustaining regional, rural and rural communities. Such an approach would involve all facets of government, industry and communities in, for example:

- creating an economic climate to rejuvenate regional Australia;

- changes in taxation;
- a major emphasis on land care and other natural resource management issues; and
- major investments in infrastructure and social and human resource capital development.[3 4]

The 1999 Regional Summit recognised that regional Australia must embrace new approaches if it is to sustain itself and thrive by meeting the opportunities and challenges of the twenty-first century:

> *".....new partnerships now need to be formed among governments, businesses and communities, all of whom have to play their part. .....Community development will not happen without governments, business and community stakeholders each making their contributions towards locally developed plans within a regional context. Communities that have reinvented themselves have identified and capitalised on their natural strengths, resources and self-interests to enhance their environmental assets and generate economic and social development."*[5]

The NRHA also believes that all health policies, including those related to the ageing population, must be based on a social model of health which addresses the broad determinants of health and is driven by a whole of government approach. Determinants of health, such as environmental degradation and the sustainability of natural resources, should be urgently considered in the planning and allocation of resources for health.

Strategy 3
Future policy approaches to rural and remote areas must include governments, businesses and communities working together in regional areas in ways envisaged in the 1999 Regional Summit to ensure that, wherever possible, rural and remote communities become sustainable.

Strategy 4
Future approaches to issues in rural and remote areas must ensure that where sustainability in the longer term is unlikely for particular communities for whatever reason, governments, businesses and communities work together to find ways to ensure that people remaining in those communities have the best quality of life possible and have access to a full range of services appropriate to their needs.

A Rural Focus

Overall demographic trends indicating an ageing Australian population are already well documented[2 6] and therefore are not repeated here. Many publications about the ageing of the Australian population focus only on these broad demographic trends. What is often overlooked, though, is that the trends towards an ageing population are more pronounced in some rural and remote areas.

In 1996 a greater proportion of those Australians who were 60 years old or more lived in rural, regional and remote Australia than had been the case ten years earlier.[7]

Looked at another way, the table below also shows that when examined at the broad geographic area level there are indications that the ageing of the population is more

advanced in much of rural Australia than in the capital 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.

Country areas, especially remote ones, have a relatively high proportion of Indigenous residents. This distorts the population profiles for remote areas. Indigenous communities have relatively high birth and death rates. This skews the population distributions in remote areas towards the younger age groups, but nevertheless the health and social needs of these communities are very high. This phenomenon is often termed 'early ageing' and should be taken into account when comparing age profiles. So the demographic of rural and remote areas would be even more skewed to older age ranges if an adjustment were made for the shorter life span of Indigenous Australians. On average their life expectancy is around 20 years less than for other Australians.[8] Policies need in effect to add 20 years to the actual ages of Indigenous people to properly reflect their early ageing.

Population distribution of older Australians by Rural, Remote and Metropolitan Areas Classification

Area Type	Proportion of population in age range 55-64 years	Proportion of population in age range 65 years or older
Capital cities	8.8	11.8
Other urban centres	9.4	13.8
Large rural centres	8.8	12.8
Small rural centres	9.9	15.1
Other rural areas	10.6	13.8
Remote centres	6.6	5.4
Other remote areas	8.2	8.3

Source: AIHW unpublished data derived by projections from 1996 census data

As indicated below, there are considerable differences between these types of rural area ('large', 'other rural' etc) in their population profiles; some of those around small agriculturally-based towns have a marked declining and ageing population, illustrating the great diversity among these categories.

Thus some country Australians are already facing, to varying degrees, the consequences of an ageing population broadly foreshadowed for Australia's future. To date there has been little recognition of, or specific policy action to assist rural communities with, the impact of these demographic trends.

Why rural is different

There are two major factors affecting demographic trends towards an older than average population profile in Australia's rural and remote communities.

The first factor is the out-migration of young people and families, resulting from a combination of agricultural factors such as the amalgamation of family farms and the loss of farm labouring jobs, as well as the contraction of employment and career opportunities

in rural towns due to public and private sector rationalisations (e.g. telecommunications, railways, schools, hospitals, banks). These rationalisations have had other negative consequences too, for example the loss of pharmacies and General Practitioners. These losses further contribute to the downward spiral, adding to the difficulties of retaining or attracting younger people and families into these areas.

The second factor is the in-migration of retirees from cities, major urban areas or inland areas to attractive coastal areas or major regional centres, from southern areas to more northerly ones, and from the mainland to Tasmania. These retirees are seeking a more relaxed lifestyle, a milder climate and, in some cases, access to lower cost housing or the services and facilities of regional centres. These 'newcomers' can be a source of resentment to established families.

Regions of contrast – declining communities with ageing populations

Smaller rural towns and villages west of the Great Divide have shown the most dramatic ageing profile, with the median age well above the Australian average. Areas around towns of 2000 people or less have been the most likely to have declining populations.

> *"Dependence on agriculture was high in inland and remote areas, where employment and population were declining.....Populations decreased in more than half the areas around towns with fewer than 2000 people in inland and remote regions...."*[9]

These demographic changes have resulted in the loss of family and community networks for older and frailer residents in farm and remote communities, increasing the reliance on community and publicly-funded and delivered programs and services.

The demographic trend towards ageing in these areas is combined with an overall declining population. The lowered population base has made it hard for these communities to attract new resources for health and community services when resource allocation formulae use population as a key determinant. Further it is doubtful whether all State and Territory health resource allocation formulae fully reflect the higher costs of providing services in rural and remote areas. [10]

In some of these areas health and community resources might be tied into inappropriate service types, given demographic changes and new approaches to providing care. Often new funding to encourage innovative services is allocated through competitive submission-based processes. Yet many communities with ageing, declining populations, perhaps those in greatest need, do not have the community resources and skills necessary to develop a competitive application. Where communities are able to do this they often miss out, despite having an excellent proposal, as the resources available are small compared with overall need.

The consequences of difficulty in attracting new resources, existing underfunding and services which may no longer be appropriate or efficient are that these already struggling communities are even further disadvantaged in access to both public and private sector health and community services.

Further the centralisation of services in large regional centres has meant that older people and/or their carers must bear more of the costs and inconveniences of accessing service

providers. These can be considerable when regional transport services are either non-existent or based on connections to the capital city rather than the convenience of regional users.

> *"Small communities are being affected by the cumulative impacts of decisions, each made in isolation by different government departments and private business, but the combination of which is often unforeseen and unintended consequences on the quality of life of older people in small rural communities."*[11]

Of further concern is the fact that community services such as meals on wheels, transport to distant services, home maintenance and RSL clubs are very dependent on volunteers who are already stretched because of declining populations and who are themselves ageing.

Regions of contrast – developing or thriving communities with ageing populations

By contrast with the small inland towns, many coastal communities and regional centres have had a major influx of older people and other new settlers, sometimes into newly developing areas. This creates a different set of benefits and challenges.

The thriving coastal towns and regional centres are able to attract a wide range of people and families, often having growing service industries such as tourism and education and new types of agriculture. Several regional centres now have universities of their own or campuses of urban-based universities. Developments in information technology and electronic commerce are enabling professional and other relatively well educated people to work predominantly from home, the location of their family residence no longer constrained by the need to have daily access to employment in the city.

Despite this positive picture there are a number of problems for such places that must be addressed.

For established areas the influx places great pressure on existing services, including those used by older people, such as hospitals and medical services. Some of the resource allocation formulae in use have operated to their benefit, leading to additional health and community services, albeit in some cases with a time lag between the population growth and the provision of services. However other formulae and taxonomies of place have worked against such places, so that they now suffer the double-whammy of declining services and increasing populations.

Anecdotal evidence is that in some of these centres, developments have occurred to meet the needs of the incoming populations that have had adverse consequences for other groups already in the area, including for the older people already there. For example there may be an excellent range of health and community services focussed on older people, and recreational and social activities for them. However there may also be changes to the local housing market that are not beneficial to the original locals. New housing may be designed for relatively affluent people, either retirees cashed up from the upsurge in housing prices in capital cities or relatively wealthy people establishing holiday homes.

Services of all types may not be well developed for young people and families. Housing costs (either for purchase or rental) can become unaffordable. If the costs of living in a particular area become prohibitive, and there are associated inadequate support services and networks, people will simply have to leave.

Retirees have also moved to developing rural, especially coastal, areas in considerable number. Housing development sometimes has preceded infrastructure development so that these areas can be relatively remote from existing health and community services and have very limited local services. Transport options are also often very limited.

While the issues facing older people in these areas are in some ways different from those of their counterparts in inland declining areas, like their inland cousins many of them have moved into a situation in which they risk loneliness and limited support from family and friends in times of need. Isolation, with associated depression and other health problems, can be a major problem for the remaining partner if a spouse dies soon after a couple has moved into a new area.

Regions of contrast - remote Indigenous communities

A number of communities in remote areas are comprised largely of Indigenous Australians. Some of these are good places in which to live and many of them are better than the worst case scenario. However the conditions in some of these remote Indigenous communities have been described as 'third world'.

The worst case communities are characterised by some of the following:

- higher rates of hospitalisation (around 2.5 times that of other communities due to lack of access to GPs and community nurses);
- alienation and loss of hope;
- limited leadership and social capital;
- poverty;
- high birth rates but low life expectancy
- high levels of preventable illness and disability despite the relatively low average ages (early ageing);
- substance misuse such as alcohol and petrol sniffing;
- high death rates from injury and suicide, especially amongst young males;
- community violence and crime, including domestic violence;
- low levels of education;
- very poor housing and other infrastructure;
- very limited local access to basic services such as clean water and safe waste disposal, nutritious food, elementary education, sport and recreational facilities and telecommunications; and
- large distances to towns with reasonable facilities over poorly maintained roads and with no public transport.

These communities are not yet 'ageing' in the conventional use of the term, but face many of the problems of ageing societies. Their needs have to be accommodated as the emphasis in public policy and programs shifts to focus more on the consequences of ageing populations. There must be continued priority attention given by all levels of

Governments to assist Indigenous communities to overcome their current enduring disadvantage.

Strategy 5
Future action for remote Indigenous communities must include groups representing Indigenous people and governments working together to develop a specific plan for the ageing of the Indigenous population which recognises the early ageing of this group which perhaps commences from age 35 years.

Conclusions

Population profiles in rural and remote areas are influenced by many factors and vary significantly between different types of rural and remote community. How they will change over the next 40 years is not a simple projection from current profiles. Thus it is important that local population profiles are monitored so that there is a good understanding about the way they are changing and what the population's needs are across all age groups.

As older age groups become a more dominant focus of governments and businesses it is important that the needs of younger groups are not neglected. Providing a suitable mix of services presents special challenges in rural and remote areas: populations are relatively small and there are inefficiencies and other barriers to meeting the needs locally of every group.

Strategy 6
Future action to plan for the ageing population must take into account the needs of all age groups, not simply the elderly, and be based on sophisticated approaches to forecasting future population profiles so that local and regional needs-based planning can occur effectively.

Priority Action 1
All levels of Government should set up coordinated processes that enable future population profiles to be projected realistically as the basis for needs-based planning.

Priority Action 2
Regional consultative forums should be established, where they do not already exist, involving representatives from the community, all levels of government, service providers, property developers and other businesses.

The main role of such forums would be to share information about projected population profiles and the outcomes of needs-based planning. This would facilitate a balanced and coordinated approach to housing development and the provision of services to reflect the needs of the population across all age ranges.

THE KEY THEMES OF THE NATIONAL STRATEGY

The remainder of this submission is structured around the key themes of the *National Strategy for an Ageing Australia.*[2] None of the input from Member Bodies and *friends* of

the NRHA to this submission made reference to the *National Strategy for an Ageing Australia*. This is of concern as it suggests that the Strategy is either not well-known in country Australia or is seen as of limited relevance to the issues faced by rural and remote communities from ageing populations. Indeed the current document makes very little specific reference to rural and remote issues or actions.

Strategy 7
Future approaches by the Government must ensure that the National Strategy for an Ageing Australia appropriately reflects the needs of rural and remote communities; and is well publicised and used as a guide to underpin policy and program development for rural and remote areas.

Priority Action 3
The House of Representatives Standing Committee on Ageing should recommend that the Government urgently revises its *National Strategy for an Ageing Australia* to ensure the Strategy fully reflects the challenges and opportunities for rural and remote communities.

Independence and self provision

This theme was part of the initial terms of reference when the National Strategy was developed. In the current Strategy this theme is focussed on retirement incomes and a changing workforce. Both of these themes are important for the health of country Australians. Other aspects of independence and self-provision are also relevant to this group.

Retirement Incomes

Health is closely associated with socio-economic status. This relationship is thought to apply universally and Australia is certainly no exception.

> *"A recent comprehensive review of the health literature by Turrell confirmed an 'unequivocal' relationship between socio-economic status and health in Australia."*[12]

The Socio-Economic Indices for Areas (SEIFA) are a measure of socio-economic well-being. For Australia these show *"a general pattern of increasing disadvantage with increasing remoteness."*[12] These indices take account of a range of factors including nutrition, housing, transport, education and economic well-being.

Income is an imprecise indicator of socio-economic disadvantage, but it is a useful proxy as incomes levels are relatively well-recorded. In Australia average incomes, both per person and per household, are generally lower in non-metropolitan areas than in metropolitan areas.

> *"In every State, the average household income was greater in the metropolitan area than in other urban and rural areas"*[13]

Thirty-three of the poorest electorates in Australia are rural electorates, with the average weekly earnings of families and individuals in these areas considerably lower than the national average.[14]

Curiously, average household incomes in remote regions are higher than in metropolitan areas, due largely to high incomes in mining and for other professionals working in these areas. However the average in remote areas masks the variability in incomes in these areas: over 26 per cent of households in remote regions around towns with populations of less than 10 000 had incomes of less than $10 400 per year in 1996.[9]

More local analysis demonstrates considerable variation within overall averages. Detailed research has demonstrated that between 1991 and 1996 there was increasing inequality in income distributions within regions, with the proportion in both the highest and lowest income groups increasing. This trend to a bi-modal income distribution is a serious social phenomenon. The contrast between the proportions in higher and lower income groups is most marked in non-metropolitan areas.

> *"In non-metropolitan areas of most states the 1996 income distribution was strongly skewed to low income household. In Victoria, Tasmania and South Australia, around 30 per cent of households had low incomes (under $15 600 per year), while less than 5 per cent of households earned more than $78 000."*[13]

While disposable income is generally regarded as a better guide to relative affluence, the high proportions of people outside metropolitan areas with relatively low household incomes bodes ill for economic security in retirement of many people in country Australia and thus for their health

Evidence offered to the Alliance for this submission shows that country people are already concerned about their rising cost of living. Essentials such as access to quality food, fuel, water, electricity, waste management, telecommunications, farm support and natural disaster relief are very real issues for those in rural and remote communities.

The current *National Strategy for an Ageing Australia* emphasises the importance of adequate retirement incomes which are sufficient to sustain people over extended periods of retirement. It encourages individuals to make more provision through private superannuation or other types of savings.

While this approach is suitable for some groups, it has considerable limitations in country Australia.

Many inland and remote areas are very dependent on agriculture for their incomes, which are comparatively low.

> *"People working in agriculture earn less than people in any other industry division."*[9]

This low income base makes it difficult for many country Australians to seriously plan for their retirements through private saving. Further, a significant amount of employment in agriculture is seasonal or casual, making it less likely that people employed in it will have an occupational pension of any real value. For many of those who have been able to make provision for their retirement, low interest rates and falling stock markets in recent years have seriously eroded their standards of living or their capacity to have a comfortable retirement in the longer term.

For some rural families, retirement security has come from their investment in the family farm. Developments in recent years such as bankruptcies due to high interest rates in the early late 1980s and early 1990s, adverse weather, low overseas prices for their products and associated falling land values have seriously undermined these farmers' capacities to be self sufficient in retirement. Long-standing policies founded on competition policy, globalisation and other broad economic considerations to reduce protection and encourage efficiencies have contributed to these problems. This policy paradigm for agriculture may well be the best for the nation, but its unintended consequences for farmers' retirement have to be considered.

Given the ageing population and the declining economic opportunities in many country areas it is highly likely that older people in many country areas will be reliant on the old age pension or other forms of public assistance. Beyond that, their future circumstance will largely devolve from the success or otherwise of policies to encourage sustainable development and to assist communities where sustainability in the longer term is unlikely.

Consequently it is important for the health of older rural Australians that governments ensure that their economic well-being and other aspects of their socio-economic status are closely monitored. Where there are concerns, governments should assist with remedial action, ensuring that local communities are fully involved in finding locally appropriate solutions. Dedicated funding should be available for initiatives of this type.

Strategy 8
Future approaches to the old age pension must reflect increases in costs of living, including particular market effects in rural and remote areas, and the erosion of capital values in some rural areas, to ensure that retired Australians in those areas have a standard of living comparable with city retirees and consistent with maintaining health.

Priority Action 4
The Commonwealth Government should review levels of the old age pension and other social security payments to see whether there is a case for rural and remote area loadings.

Strategy 9
Future approaches to health in rural and remote communities must involve Governments closely monitoring the socio-economic status of residents in rural and remote areas on a small area basis, and responding when it is clear that the health of people in certain areas is seriously impacted by their socio-economic status.

Priority Action 5
The Commonwealth Government should establish a pool of funds dedicated to funding local initiatives to improve socio-economic status in communities where it is impacting on health status.

A changing workforce

Having employment, or being able to make other meaningful contributions to the community by other means, contributes directly to good health. Employment for older people is therefore an issue that must be addressed by Australia as its population ages.

The National Strategy for an Ageing Australia[2] outlines issues arising from the falling supply of younger workers nationally as the population ages. However many rural and remote areas are short of younger workers for a second reason: because there are few educational and employment opportunities in the local area. Levels of unemployment in many small towns are very high so that residents of all ages find it difficult to gain employment.

Unemployment and lack of meaningful activities are major issues in remote Indigenous communities, where higher birth and death rates mean that the populations generally have a younger profile.

Providing increased employment opportunities and other meaningful activities across all age ranges will be vital if these types of communities are to thrive in the future. But there are many barriers to be overcome. High levels of unemployment contribute to ill-health and disability; skill and educations levels are low. These factors make such areas unattractive for new employers, adding to the cycle of disadvantage.

Some other rural and remote areas are thriving in employment terms. They are likely to face problems similar to those of city communities as their populations age. The main emphasis for them will be for employers to have more positive attitudes to the contribution that older workers can make in the workforce and to adopt policies which support older employees. Areas for improvement include:

- more flexible working hours;
- a commitment by employers, governments and education and training providers to invest in mature age employees to ensure their skills are maintained and enhanced;
- changing attitudes in society overall, but especially among employers, to eliminate discrimination against older people; and
- employers having a greater capacity to assess the existing skills and knowledge of mature employees or potential employees and to be creative in using those attributes in the workplace.

Limited access to education and training in rural and remote areas also affects the skills and competence of managers, whether they be paid or voluntary. An area of concern in some rural areas relates to the managers and board members of small residential aged care facilities. Many of them have few formal skills and qualifications for this important work.

In recent years the aged care industry has faced many changes and considerable pressures, all of which demand a high standard of governance and management. There are concerns that many of these facilities are unaware of emerging threats to their financial viability. Should they close, rural areas will be further deprived of valuable local services and valuable local people.

"In summary the College suggests that the aged care industry, particularly in rural Australia, is facing challenges of change, fragmented delivery of care between health, community and aged care providers often funded by different levels of government, increasing standards and rising costs and expectations.

The College believes that the education of senior managers and Boards to face and respond appropriately to these challenges is a critical issue to be addressed and that adequate resources need to be applied to that education and development. Given the difficulties of distance the College favours a concept that would help network and integrate providers and where technology could be deployed to assist the process."[15]

Strategy 10

Governments, business and community leaders must work to put in place a set of policies, programs and public attitudes that will underpin a transition to a culture of investment in the older workforce, development of new skills for older workers, and employment systems that accommodate their needs.

Priority Action 6

Opportunities for education and training in rural and remote areas must be enhanced for lifelong learning by people in all age groups and to retain young and old workers in those areas.

Priority Action 7

Special attention should be given by training institutions and the aged care sector to the training, educational and support needs of managers in the sector in rural, regional and remote areas.

Housing and other accommodation

Trends of population shifts are increasingly to regional coastal areas. These are under-resourced in terms of infrastructure, driving the cost of housing up and subsequently driving the elderly and low-income earners out into rural areas and away from the services available in the regional centres.

Housing needs and provision in Australia are changing rapidly, influenced by increased expectations about the quality of housing, the higher number of single households, the needs of blended families, the needs of older Australians, trends to apartment, townhouse and villa living and smaller urban blocks, the trends to inner city living in capital cities and other major urban areas, policies of de-institutionalisation and the growing numbers of homeless people.

Access to comfortable, affordable and appropriate accommodation is a key factor in maintaining health. While this is important for all people, in rural and remote areas there are particular challenges for older people.

In rural and remote areas there is generally much less choice of housing types. Where the areas have little capital, the housing stock may be old and not readily adapted to the changing needs of the residents. As people age, maintaining independence requires suitable accommodation. As their needs change towards requiring more support to maintain independence so too their accommodation type needs are likely to change. Thus ideally communities would have a range of accommodation types, ranging from the original home, possibly adapted to make it easier for older people to remain there,

through various levels of supported accommodation to a residential aged care facility with both low and high dependency facilities. This is what would be required to make 'ageing in place' a reality for rural areas.

> *"There is a lack of supported accommodation facilities in rural areas. We have recently had a situation where a lady was in a Nursing Home for respite for 2 weeks, and due to the stable environment and support she received, her general health condition improved to the point where she was assessed as not requiring nursing home level care, now she has returned home as their was no other more independent living type accommodation available, and the family are quite concerned about her being on her own for most of the day/week."*[16]

Achieving this mix of accommodation types is very difficult in areas with sparse populations. As the population ages the difficulties in arranging an appropriate mix of accommodation types are likely to increase. The demand for residential aged care accommodation might increase, but this type of accommodation is expensive to build, service and maintain. It is likely that governments will want to keep the number of places in residential aged care limited while encouraging people to stay in lower cost accommodation with increased community support

There are other accommodation needs in remote and rural areas not well met. For example housing for health students on rural placements, single people taking up jobs locally and various type of workers on short-term projects in the area. Balancing these accommodation needs will require innovative approaches and flexible buildings that can be used for a range of purposes, as well as capital injections in areas with a low economic base.

Strategy 11
Future approaches to accommodation must enable rural and remote communities to develop a plan for their current and future accommodation requirements to meet the accommodation needs of all their members and taking into account projections for their future population profiles.

Priority Action 8
The Federal and State Governments should provide expertise and where necessary, capital grants, to enable rural and remote communities to invest in a more appropriate accommodation mix to meet their current and future needs.

Transport

Access to transport is a key issue for older people seeking to maintain their independence. It is vital so that they can readily use services in their local town or at more distant centres, whether they be medical and community health and aged care services, banking, shopping, recreational and educational facilities or visiting friends and relatives.

Many older country Australians do not have their own vehicle, whether because of disability, other impediment to their driving long distances or 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.

Where community buses are available some residents are concerned that they are not suitable for their needs. For example, entry on community buses is inappropriate for the clientele; community buses are uncomfortable; services are inadequate and access is based on first-in, first-served; and school buses are not available to the wider community.

State Governments provide varying degrees of financial assistance for rural and remote residents who must travel large distance 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. 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.

In some rural and remote communities there is little coordination between different government agencies, each of which provides transport in some form. 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 some use for public transport.

Healthy Horizons, a Framework for Improving the Health of Rural, Regional and Remote Australians, first adopted by Health Ministers in 1999 and currently being updated by Ministers, identifies access to transport as being a priority for inclusion in flexible funding arrangements. [7]

The NRHA and its constituent organisations have long called for a strategic approach to providing accessible, convenient and affordable transport for rural and remote communities. All residents would benefit from such provision, but it would be particularly valuable for older people. 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.

Strategy 12
Future approaches to transport and communications in rural and remote areas must involve Governments, businesses and communities working together to ensure integration of transport and communications systems to provide a mix of these services which is affordable and effective, enabling all community members to access services and information which are important in their lives and which takes into account the changing needs arising from an ageing population.

Priority Action 9
Governments (including local authorities) and rural and remote communities should explore whether there could be a better mix of vehicles operating locally, and to what degree they could be used in part for public transport.

Priority Action 10

State Governments in consultation with representatives from remote and rural communities should examine the current and longer-term adequacy of their IPTAAS (or equivalent). In doing this they should take into account the cost to governments of providing highly subsidised access to public transport through seniors' cards, available to urban older people, but from which many rural and remote people do not benefit as they have little access to public transport.

Provision of support services

There is a wide range of support services or aids available to help older people to remain independent. However the degree to which these services and supports are available and affordable varies substantially across the country and between different groups.

For example the Department of Veterans' Affairs has quite a comprehensive program of support for its clients, provided at no direct cost to the client. Its model of service and care is a good one. Other population groups are dependent on subsidised Home and Community Care Services or not-for-profit and private services, the cost of which varies across the country and between providers. For these others there is a confusing array of programs that have different avenues of access, eligibility criteria and standards.

Anecdotal evidence provided to the NRHA for this submission suggests that community-based services in country areas are often too few or too expensive for people to remain at home with a reasonable quality of life. Survey results confirm that there is unmet need for community care nationally, with one quarter of Australian households of people aged 65 or over in 2001 reporting that their needs for community care were not fully met.[17] In a situation of overall national shortage, it is not surprising that rural and remote areas are particularly poorly supplied.

Prevention of falls

Independence to care for oneself and to participate as fully as possible in community activities can be seriously limited as a result of disability. A substantial contributor to reduced mobility and independence in elderly people is the high incidence of falls and subsequent levels of disability. There is already a range of programs in place to minimise falls, for example through the Department of Veterans' Affairs. The Limestone Coast Division of General Practice is implementing a 3 year Regional Action Plan in south-east South Australia, *Farewell to Falls,* "to lower the incidence of falls and to lessen the extent of falls injury in the region's elderly (over 65)".[18]

Strategy 13

Future approaches to the prevention of falls must identify best practice approaches suited to rural and remote areas and extend programs based on these to older people in rural and remote areas.

Priority Action 11

Best practice approaches to the prevention of falls in rural and remote areas should be urgently identified, and widely publicised and adopted through government and private sector programs.

Attitudes, Lifestyle and Community Support

Under this head the National Strategy for an Ageing Australia deals with the capacity of people to make ongoing financial contributions, lifestyle issues, housing, transport, communications and technology, and attitudes. The relatively poor financial situation of rural and remote people has already been described above, as well as the particular issues they face in the area of housing and transport.

The lifestyle aspects of rural and remote areas are very well-known and provide some of the strongest reasons why people want to remain there as they get older. But even in good health there are some facilities that people will not risk being without. Reasonable access to a doctor, a hospital, a sporting club and access to friends and family have been commonly suggested as some of the minimum requirements.

Community support is a key part of what these days is called 'social capital', which has always been supposed to be stronger or better in country areas. However the sustainability of a country community depends on the minimum levels of hard income and services, as well as on networks, connectivity and 'soft services'. This is even more the case for older people as the risks associated with lack of services become greater.

Country communities cannot survive only on their 'way of life', and older people are the last who should be expected to put up with such a situation.

Healthy Ageing

> *"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."*[19]

> *"For individuals to enjoy health in old age, and for societies to reduce the burden of caring for the chronically ill, we need to adopt a 'life course' perspective. That means beginning with today's children, and with the young just reaching middle age."*[20]

Approaches to healthy ageing

In recent years there has been a growing interest internationally in the concept of 'healthy ageing'.

Achieving healthy ageing requires action on two key fronts. Firstly there must be effective ways to assist people of all ages to maintain and enhance their health, to avoid preventable health problems and to cope effectively with unavoidable diseases and disabilities. Secondly older people who may already have, or are at risk of, developing health problems and disabilities 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.

The health of country Australians

The lower socio-economic status of people living in country Australia and its relationship with poor health has been referred to earlier in this submission. There is considerable, well-documented evidence to demonstrate that Australians living in rural and remote Australia have poorer health than their urban counterparts. For example:

- death rates show a graduated increase with increasing remoteness, including for children and young adults;
- the health of remote area residents is generally poorer than that of their urban counterparts in each of the seven National Health Priority Areas (and for rural residents too, for some of the seven);
- hospital admission rates generally increase with increasing remoteness; and
- dental health is generally poorer in rural areas, with residents of remote and rural areas being less likely to visit a dentist and, when they do so, for it to be for attention to a problem rather than for preventative care.[8]

In addition, residents of remote areas score higher on several health risk factors, directly linked to preventable health conditions. For example by comparison with metropolitan areas:

- a higher proportion of men in remote areas have high alcohol consumption;
- a higher proportion of remote area residents smoke;
- a lower proportion of men in remote areas walk for exercise; and
- a higher proportion of women in remote areas are overweight.[8]

Given this higher level of burden of disease and risky behaviour in rural and remote areas, achieving healthy ageing for those country residents already in their later years as well as for those at earlier life stages presents special challenges.

Barriers to healthy ageing

Factors such as social isolation, extreme weather and very limited access to recreation facilities contribute to risky behaviour and consequential ill-health. Shortages of health professionals combined with higher health needs mean that health professionals in remote and rural areas are often stretched catering to the day-to-day health care needs of residents. They have little time and may not have appropriate skills to adopt preventative or health promotion approaches. There are few specialist health promotion or illness-prevention professionals in country areas. Funds that are made specifically available are often short-term for pilot activities. Communities do not have the resources to fund such programs after the pilot is over, however successful it has been.

Many rural and remote communities have insufficient resources – including too few health professionals – for a population-based approach to health promotion and illness prevention. Until relatively recently the financing arrangements for General Practitioners and other health professionals discouraged multidisciplinary team approaches to population health.

Strategy 14

Future health policies and planning must give population health approaches an increased priority in rural and remote areas, with dedicated long-term funding available to support population health programs.

Priority Action 12

Commonwealth and State Governments should each provide funding into an ongoing rural and remote area population health pool. This pool would be allocated long-term to local areas for population health programs designed using

local epidemiological data. Accountability and reporting requirements would be simplified, perhaps with State Governments receiving reports from each local area and then providing overviews to the Commonwealth.

Priority Action 13
State Governments should assist local communities to develop population health programs based on local epidemiological data with clear objectives and targets across the lifespan.

Healthy ageing for older people

For older people who are already facing the consequences of declining health and reduced physical capacities, the key issue is to preserve health as long as possible and to reverse some of the trends to reduced capacity wherever possible.

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

- remaining in suitable accommodation in their own town;
- retention and enhancement of existing services eg meals on wheels, supported accommodation, (often established by community fundraising with limited government assistance), community nurses for home visiting;
- retaining access to recreational facilities which provide exercise and enhance healthy ageing such as swimming, golf and bowls. Access will be threatened unless rural communities, especially those with declining and ageing populations, receive assistance for the upkeep of such facilities;
- access to affordable nutritious food;
- mental stimulation;
- access to transport to enable older people to participate in activities not available locally eg shopping, recreation, health and welfare services; and
- finding ways to reduce social isolation for older people.

Strategy 15
Future approaches to assisting older people in rural and remote communities to maintain health and reverse trends to reduced physical capacity must include action by State and local governments and businesses to preserving and enhancing aspects of community life and local facilities which contribute to this.

Priority Action 14
The Commonwealth Government should provide funds for research to identify new ways to assist older people in rural and remote areas maintain health and reverse trends to reduced physical capacity where there are very limited community facilities to help them do this.

Priority Action 15
The population health fund for remote and rural areas referred to in Priority Action 12 should be made available to support infrastructure and activities which are demonstrated to be effective in maintaining health and reversing trends towards physical incapacity for older people.

Maintaining a sense of worth and social acceptance is important to maintaining health. Some older people are not yet ready for services such as day centres, as they feel they are still capable of contributing to their communities or participating in more demanding activities.

Yet the range of activities for older people can be very limited in some rural and remote areas. There should be greater use of existing community skills to run education programs, for example through University of the 3rd Age, on things like computers and the internet, local history, languages other than English spoken in the community, natural history, environmental issues, and arts and crafts. More flexibility in access to publicly funded infrastructure and facilities could provide some resources for projects of this type.

A further concern is that opportunities to contribute are declining with concerns about public liability insurance cover for older volunteers (for example hospitals are less willing to use volunteers for things like flower arranging), just when the proportion of older people is increasing. Contributing to the community by being a volunteer is an important aspect of healthy ageing. Implementing more effective ways in rural areas of enabling older people to enhance their contributions as volunteers would serve many purposes including:

> *"keep them busy, give them self esteem and productivity, keep them free of physical and medical symptoms, provide a social network, enhance wellness."* [21]

Strategy 16
Future approaches to initiatives related to an ageing population in rural and remote areas must have initiatives to enhance older members' opportunities to contribute meaningfully to their communities' well-being as a central facet.

Priority Action 16
The Commonwealth Government should provide funding for research to assist rural communities to:

- identify opportunities for older members of the community to contribute meaningfully to community well-being; and
- develop models of implementing coordinated approaches to linking older members of the community to community needs.

Women in Australia have on average longer life expectancy than men. This pattern also occurs in rural and remote areas, though life expectancies in these areas are generally lower than in urban areas.[22] An important aspect of healthy ageing in older women is the effective management of menopause and related issues. There is a dearth of specialised services in country Australia that provide services and information on these matters, especially advice on alternatives to hormone replacement therapy and wider issues related to sexuality and ageing.

World Class Care

A long way from the ideal

Many parts of Australia's health and aged care services are world class. In recent years there have been a large number of activities to increase the quality and safety of health care services. Some of these have been seen to disadvantage rural and remote communities, for example restricting the range of services that can be provided in rural hospitals.

There will always be tensions in how best to balance safety in health care against consideration of relatively easy access. As populations age, though, issues of ready access will become more important because of the limited mobility of older people. This will be a particular problem in rural and remote areas.

Where people have access to health and aged care in Australia, they are more likely than not to be provided with high quality care. The limitations in the health and aged care systems for country Australians, especially for older people, relate to problems of access, and an inequitable resource allocation. These issues are inevitably interconnected, but are discussed separately below.

Inequitable health/aged care resource allocation

Because of the complexity of Australia's health financing system there are no reliable comprehensive Australia- wide data which link per capita expenditure on publicly funded health and aged care services to geographic region. When specific programs are examined a picture emerges that suggests that there is a relative underfunding of health and aged care services in rural and remote areas compared with urban areas.

Part of this underfunding relates to the nature of some major programs which have features which inevitably result in higher per capita payments in urban areas. Another part of the underfunding is due to the fact that the higher costs of providing services in rural and remote areas are not reflected in allocations.

Overall, rural and remote areas are characterised by relatively poor access to services funded by Medicare and provided by private doctors.

The number of Medicare-funded services per capita falls dramatically with increasing remoteness, leading to a significant skewing of Medicare Benefits funding towards metropolitan areas, and even those areas are demonstrating a decline in GPs who bulkbill. This situation generally applies to all types of medical services whether provided by General Practitioners or specialists.[12]

This occurs despite substantial evidence that rural and remote residents have on average poorer health and face a higher level of some health risk factors than their urban counterparts.[22] Thus those with higher health needs in rural and remote areas have less ready access to private medical care funded by Medicare than those in more urban areas with on average better health.

The skewed funding distribution arises directly from the basic structure of the Medicare program. Medicare Benefits are in general only paid for services provided by private

doctors. This means that the distribution of private doctors is the key factor influencing access to Medicare-funded services and the geographic distribution of Medicare benefits.

The Australian medical workforce is concentrated in metropolitan areas. The ratio of General Practitioners per 100 000 population decreases steadily with increasing remoteness. In 2000-2001 this ratio ranged from 85 per 100 000 population in capital cities to 44 per 100 000 in other remote areas.[23]

Further there is a steep decline in access to specialists as rurality increases. In 1995 capital cities and large rural centres had a ratio of specialists per 100 000 population, substantially exceeding the overall ratio in Australia while other rural and remote areas had a ratio substantially less.[22]

People living in rural and remote areas are relatively high users of public hospitals, but low users of private hospitals.

The private health insurance rebate, a major use of public funding, appears to be a smaller benefit to rural and remote areas overall due to lower rates of private health insurance in non-metropolitan areas. This further skews the distribution of health resources away from rural and remote areas.

One submission to the Alliance for this submission suggests that in Western Australia the proportion of people with private health insurance is similar to that in Perth and that country people claim at the same rate. However they are of course faced with higher costs due to their need to travel to access services. Health funds therefore need to consider how to improve access to services for those who are privately insured. This could be done by providing travel and accommodation support in a rural health package and by developing models to provide increased capital grants for health and aged care services in rural areas.

Aged care facilities in rural areas have to cope with a low volume of entry, which precludes them from generating major revenue flows from clients, particularly given the low incomes characteristic of many rural areas. This needs to be reflected in greater Commonwealth support for capital for rural aged care, and in the approach to how institutions are to be upgraded and reaccredited in future.

There are a number of reasonably sized private hospitals in regional areas employing local people and providing services to older privately insured patients and lower income earners. Greater support for such private hospitals and improved public/private hospital partnerships would therefore benefit older people in the non-metropolitan regions and the rural catchments around them. Other initiatives could include rebates for e-health and telehealth and guaranteed support in out-years for programs such as the Medical Specialists Outreach Assistance Program (MSOAP).

There is a range of supplementary health programs available only in rural and remote areas, such as the Royal Flying Doctor Service and Regional Health Services, which go some way to redressing the balance in resource allocation.

Despite these compensatory programs, a recent project examining health financing arrangements in rural and remote areas concluded that:

- overall, rural and remote residents receive a lower proportion of health resources than would be expected taking into account their health status and the costs of providing services;
- there is considerable variation within rural areas, with large regional centres and some coastal locations generally having much better local availability of health services than small inland towns;
- remote and many rural residents face higher direct and indirect costs and greater disruption and inconvenience in utilising health services;
- patterns of health service utilisation differ between metropolitan, rural and remote areas and across States. In particular, lack of access to primary care services with increasing remoteness is associated with increased use of in-patient hospital care.
- resources overall are not distributed according to relative health needs and the costs of providing services;
- there is no assurance that services are effectively targeted to meet local priorities or to reach those in greatest need[24]

Recent research on the distribution of aged care services concluded that there is a considerable trade-off within geographic types between residential aged care and provision for aged care packages, and HACC services ie areas with relatively high provision of residential aged care place tended to have lower levels of community-based services and vice versa.[25] This research did not attempt to assess the relative adequacy between geographic types of overall aged care resources, numbers, types and balance of services provided or what constitutes the benchmark for appropriate service levels.

This apparent overall imbalance in resources for health and aged services is of major concern in rural and remote areas. As regional populations in some areas age and decline it is possible that the discrepancy will increase.

The multiplicity of programs and the sometimes competing roles of different levels of government, and the changing roles of health and community services, demands a more efficient, flexible and effective funding system and a more coordinated approach between different levels of government. New funding systems should be suited to the types of services that are emerging in rural and remote areas and which are likely to be more important as the populations age. They should also seek to redress the current inequitable distribution in health resources between urban and rural areas

One goal of *Healthy Horizons* is to "develop needs-based flexible funding arrangement for rural, regional and remote Australia".[7]

Strategy 17

Future approaches to public funding for health and aged care must ensure that health and aged care resources are distributed equitably, taking into account health needs and the realistic costs of providing services, with a special emphasis on increasing resources to rural and remote communities with relatively poor health.

Priority Action 17
The Commonwealth Government's future approach to the private health insurance rebate should recognise that its rebate is of lower value to people in rural and remote areas and re-direct some of these funds to measures to improve access to necessary medical services in country Australia. Options for releasing some of these funds include means testing the rebate, removing it from ancillary health services and abolishing it entirely.

Priority Action 18
Commonwealth and State Governments should move in the longer term to rationalise their roles in funding and providing heath and aged care services in rural and remote areas, to make the system more focused on need, to end 'cost shifting', and to reduce confusion and complexity for patients and other consumers.

Access to health and aged care services – financial barriers

People in rural and remote areas have comparatively limited access to services locally. This derives from several factors, including financial barriers and the shortages of health professionals.

One important financial barrier is the low rate of bulk billing in country Australia. The rates are generally much lower than in urban areas.[26] This is a matter of serious concern to residents in these areas and raises many issues. Having access to bulk billing is highly valued by country Australians. Regrettably bulk billing rates generally decline with increasing rurality, as highlighted previously.. In 1997-98 bulk billing rates for out-of-hospital services ranged from 80% in capital cities to 62% in remote areas.[12] Rural doctors state that their high level of practice costs are a major factor in the lower rates of bulk billing in rural areas. Other commentators believe that these lower rates are related to the stronger market position of rural GPs arising from the lower level of competition they face.[27]

It is important to understand the complexities associated with doctors' choices about whether or not to bulk bill specific services. Their choices reflect personal beliefs and values as well as technical issues about billing arrangements. Examining the factors which influence doctors' billing practices would be a useful avenue for research to inform policy decisions about Medicare.

The table below shows the recent trend to falling rates of bulk billing across Australia for services provided by General Practitioners, with the impact greatest in rural, rather than remote, areas. These averages mask the true picture for specific local areas; in many small communities there is no access at all to bulk billing.

Proportion of General Practitioner attendances bulk billed by region

Region	1996-97	1997-98	1998-99	1999-00	2000-01	*June 2002
Capital city	85.9	85.6	85.4	85.2	83.8	79.5
Other metro centre	81.3	80.1	79.5	78.6	76.2	71.0
Large rural centre	65.7	63.7	61.7	60.8	59.8	59.0
Small rural centre	64.8	63.1	61.7	61.7	60.9	59.0
Other rural area	62.1	59.6	59.1	58.6	57.7	56.5
Remote Centre	56.0	56.7	57.6	59.0	60.0	58.9
Other remote area	70.1	69.6	70.1	70.1	69.5	70.8
Unknown	68.8	70.3	71.4	73.4	72.7	NA
Australia	80.6	79.8	79.4	79.1	77.6	NA

Source: Department of Health and Aged Care

* **Figures for June quarter are from material attached to a media release from the Shadow Minister of 12 February 2003 and are for unreferred attendances**

In 2002 the trend towards falling bulk billing rates in many rural areas accelerated. Falling levels of bulk billing may be an indicator that the real costs of providing services are rising faster than Schedule fees, for example because of rapidly rising medical indemnity costs. At the same time as bulk billing levels have fallen the average out of pocket costs have risen substantially, adding further to the costs faced by many rural and remote area residents in accessing medical services.

Because the rate of bulk billing is generally lower in rural and remote areas, a higher proportion of services is charged at the higher fee levels in these areas. Hence relatively more people face out-of-pocket costs than in urban areas. This is an added concern because of the overall low socio-economic status of many country areas.

The higher distances travelled to see a doctor, combined with possible lost income from having to take time away from work to travel for a medical service, the lower levels of bulk billing and the generally higher levels of charging, can create substantial cost barriers for rural and remote area residents with medical needs, including the elderly.

The increase in bulk billing shown in the Table for remote centres is believed to be related to the increased use of Medicare billing by Aboriginal Medical Services.

As the population ages, doctors who bulk bill pensioners will be under increased financial pressure. Older people are in general heavier users of medical services than the rest of the population so that a higher proportion of services by General Practitioners will be to bulk billed pensioners, squeezing the margins of bulk billing doctors even further. This could lead to a fall in bulk billing levels for pensioners and other older residents, or to higher charges for residents not bulk billed. Either way, cost barriers to access are likely to increase.

Rural people tend to use hospital emergency departments for after-hours primary medical care. This occurs either because there is no after-hours provision by private General Practitioners or residents are unable to pay the out-of-pocket costs of private General Practitioners who do not bulk bill. One consequence of this is that public hospitals,

already operating under stretched budgets, carry the cost of what should be covered by Commonwealth Medicare Benefits.

This is one of many examples of so-called 'cost shifting' which occurs because of the complex health financing arrangements in Australia. As health care costs increase with the ageing population, the tendency of governments to want another level of government to pick up the tab is likely to increase. Implementing a more systematic allocation of responsibilities for the provision and funding of heath care between levels of government is required if increased wasteful debates and subterfuges to achieve cost shifting are to be avoided as health costs inevitably rise. New approaches should also enable governments to increase their focus on how best to provide high quality, cost effective services in rural and remote areas. This all adds further weight to the action suggested above at Priority Action 18 for rationalisation of overall funding of health and aged care.

Access to health and aged care services - a more limited range of services

There are many issues about the capacity of smaller towns in rural and remote areas to sustain the full range of services required to cater effectively for the health care needs of elderly residents. These concerns extend across the whole range of health and community services and are not just limited to aged care services per se.

Residential aged care beds are not evenly distributed so that older people can be far away from their communities, making it difficult or impossible for friends and relatives to visit and for the older person to maintain community contacts and networks.

One innovative service model which has proved effective in rural areas is the Multipurpose Services (now Regional Health Services) Program, which has a focus on proving services for the elderly.[28]

> *"The Regional Health Services Program's flexibility stems from the knowledge that no two communities are alike, and that there is no single solution for service-mix or activity. In order to find the right mix, the Regional Health Services Program allows communities to consider a mix of services including (but not limited to) the following: illness and injury prevention; women's health; children's & youth health; community nursing; mental health; podiatry; physiotherapy; occupational therapy; speech pathology; nutrition and dietetics."*[30]

One issue related to improving this approach is the need for aged care education programs for rural nurses moving from working in acute care hospitals to regional health services. Providing appropriate residential aged care requires skills and knowledge about the social and lifestyle aspects of aged care not required for acute hospital nursing. Another issue is that residential aged care standards do not apply to residential aged care beds funded through this program. Hence there are concerns that poor levels of care could be provided without the safeguards offered by these standards.

Small towns have a limited capacity to provide for the needs of people with dementia or other mental health problems experienced by the elderly, such as schizophrenia, delirium, mood disorders or mania. The needs include both effective diagnosis of and ongoing care for people with such disorders, which includes access to timely and local respite care services to provide relief for carers of people with dementia. With the likely increase in

the incidence of dementia as the population ages, this will become an even more critical issue. There are already some good examples of innovative approaches to this problem. For example Kojonup in Western Australia has recently received Commonwealth funding for 16 dementia beds to be used as a regional facility attached to the existing Frail Aged Lodge.[29] Another proposal in Far East Gippsland has been that a local house should be renovated and staffed to provide emergency respite care in small towns.[30]

Access to hospitals is another issue. It appears that some elderly people avoid seeking health care if they fear that treatment will require them to be hospitalised away from their home town.

Even when a particular service is available locally there may still be constraints which prevent timely access to it. For example budgetary restrictions can mean that access to the home care services necessary to enable elderly people to return or remain in their own homes is unreasonably delayed. This seems like a false economy and without the allocation of extra resources will become an even more significant issue as the proportion of elderly in rural and remote areas continues to increase.

Older people generally have greater needs than the general population for specialised health services. Often specialised services are not locally available. Also, waiting times can be excessive and costs beyond the reach of many residents of rural and remote areas. Where there is little of no access to specialised services, generalist health providers sometimes carry them out instead, which raises a number of concerns.

Medical Specialists are predominantly located in urban areas or major regional centres. While there are schemes to enable medical specialists to visit smaller communities, most rural and remote residents from these areas who require specialist care have to visit larger centres. This affects older people particularly because they often have complex care needs that require specialist attention.

Access to specialist appointments in cities by older people often requires volunteer drivers or family assistance with transport. Incentives for volunteers are very limited and flexibility for appointments at public hospitals is not sufficient to fit in with transport availability.

General access to dental services is poor in rural and remote areas, many of which also do not have the oral health benefits that flow from access to fluoridated water supplies. The problem of access to dental health services in these areas has been exacerbated by the withdrawal of the Commonwealth Dental Health Program in 1996.

Poor dental health is sometimes regarded as a relatively trivial issue. However there is a growing recognition that poor dental health is very closely linked with other major health problems such as cardiovascular disease, stroke, diabetes, endocarditis, and nutritional deficiencies in older adults.[31] There is both a causative and associative relationship between poor oral health and diabetes, especially in remote Aboriginal communities where there is premature ageing. [31]

Medically necessary dental care is also important in the effective treatment of a range of conditions which especially affect the elderly eg cancers requiring head and neck radiation or chemotherapy, diabetes, heart defects and renal problems requiring dialysis.[31]

Without much greater attention to and resources for dental health care in rural and remote Australia, which ensures good dental health throughout life, dental health problems affecting elderly people in rural and remote areas will become a major issue as the population ages.

Other specialised services needed by elderly people but not readily available or accessible specifically mentioned in input to the NRHA's submission include:

- palliative care
- allied health services such as hearing, sight, and podiatry;
- specialised care for menopause and sexuality in older age;
- geriatricians and psychogeriatricians;
- management of bladder and bowel conditions; and
- radiography.

One suggested approach to improving access to specialised services especially for older people was the use of mobile vans which could transport and serve as a clinic for a range of allied health professionals.

Strategy 18
Innovative service models must be the basis of future approaches by funders and providers to improving the access in rural and remote areas to a range of specialised services needed by the elderly.

Priority Action 19
Governments, research organisations, professional groups and organisations representing rural health groups should cooperate in giving priority to identifying, disseminating and extending ways of improving access to specialised services in rural and remote areas which have been demonstrated to be successful.

Priority Action 20
The Commonwealth Government should allocate some existing health services research and development funds to trialing new approaches to providing specialised care in rural and remote areas, focusing on types of care for which there has little research into establishing effective models.

Access to health and aged care services - shortages of appropriately educated health professionals in rural and remote areas

The shortage of health professionals in rural and remote areas in Australia including, but not limited to, doctors, is well established and documented. [32 22 33]

The Alliance continues to be involved in a range of issues related to the rural and remote health workforce, including as an advocate for the existing rural GP and pharmacy programs, and for extension of support for the recruitment and retention of nurses, allied health professionals, specialists, dentists and Indigenous Health Workers. Discussion of

rural health workforce issues brings up the important but still contentious matter of substitution of health professionals in rural communities, including through upskilling.

Some correspondents to the Alliance for this submission asserted that certain providers resist the efforts of community organisations (such as church groups) to increase access and choice in health care by recruiting trained professionals themselves. To the extent that this happens it is presumably to maintain an effective monopoly and the associated level of charges and waiting times. For rural people the only choice is then to travel to another centre which can be hundreds of kilometres away and accessible only by private car, irregular public transport or possibly an expensive journey by air. While this is a problem for all members of the community, older people are particularly hard hit because of their limited mobility and frequent low incomes.

Certainly the professional Colleges are inconsistent in their assessment and recognition of the qualifications of OTDs and sometimes appear to frustrate the efforts of OTDs seeking recognition in their area of speciality, and an HIC provider number, to work privately in an area of need.

In recent years governments have tried a range of measures to attract and retain health professionals in rural and remote areas. While initially these were focussed mainly on General Practitioners, more recently they have extended to medical specialists, nurses, pharmacists and allied health professionals. There is also a growing shortage of dentists in rural and remote areas with little attention so far given to improving their distribution. Other measures have included expanding schemes which support short term visits by health professions to rural and remote communities and encouraging universities and organisations providing post graduate health education to place more trainees in rural and remote areas. (The Alliance has been directly involved as national administrator in two of these schemes, the John Flynn Scholarship Scheme and the Rural Australia Medical Undergraduate Scholarship Scheme.)

As the population ages in rural and remote areas more quickly than in urban areas the relative needs in rural and remote areas for the services of all types of health professionals will increase. The pressure will be greatest for health professionals who cater specifically to the needs of elderly people and who are already in short supply and difficult to access, such as psychogeriatricians. Thus there will be an even greater emphasis than now on the importance of devising effective measures to enable older people to have access to the full range of health professionals.

The shortage of health professionals in rural and remote areas puts added pressures on those who do work there, for example in excessive overtime, inability to get back-up for continuing professional development or leave, increasing demand without additional providers and having to provide services which would in better supplied areas be provided by other types of heath professionals. Adverse consequences from this are burnout, leading to rapid turnover and extra stress for those working in circumstances where their skills may be out of date.

These problems affect all health professional to varying degrees in rural and remote areas including the members of the Aged Care Assessment Teams who play a vital role in assisting older people maintain the best quality of life.

Rapid turnover of health professionals disrupts continuity of care. This can be a major issue for older people who sometimes have complex health needs and for whom continuity of care is very valuable.

A further issue is that health workers in rural and remote areas often need special or advanced skills for effective practice. There are concerns that some health professionals currently working in rural and remote areas do not have all of the necessary education and skills for safe and effective practice. Thus the shortage of health professionals overall is exacerbated by insufficient skills, for example in aged care, mental health, for isolated practice and in a variety of procedures.

Nurses are a useful case study of the issues facing health professionals in rural and remote areas. Nurses are the most numerous health occupation in rural and remote Australia. They play a vital role in caring for older people in rural and remote areas, both in aged care and in wider health and community services. There is a growing shortage of nurses across Australia, particularly in the aged care sector, which is becoming critical in rural and remote areas. There are many factors contributing to this, including lack of parity in pay for aged care nurses compared with hospital nurses.

A wide range of issues affecting the recruitment and retention of nurses in rural and remote areas, including aged care nurses, was canvassed at a recent workshop, *Action on Nursing in Rural and Remote Areas* and in its associated background paper.[34] The workshop endorsed a Seven Point Plan[35] as the first steps to improve the situation for nursing in rural and remote areas. The Plan covers:

- increased incentives, especially locum relief and mentoring;
- improved workplace environments to attract and retain nurses for rural and remote areas;
- better risk management in the workplace;
- marketing a positive image of nursing in rural and remote areas;
- a greater emphasis on rural and remote area nursing in nursing education programs;
- improved access to reliable information technology, with support and training; and
- funding for appropriate postgraduate education programs for rural and remote area nursing.

Nurses have identified a wide range of industrial issues to be resolved for nurses to be available in sufficient numbers and with relevant skills to meet the increased needs for nursing in rural and remote areas as the population ages. These are covered in some detail in a separate submission to the Inquiry from the Australian Nursing Federation.[36] Some States are currently trialling Nurse Practitioner roles within a number of different settings, including aged care. The success of these trials offers great hope for aged care services in rural and remote areas where a chronic shortage of health professionals has resulted in poor staffing levels and resultant difficulties in the provision of adequate services.

Strategy 19

Future approaches to ensuring world class care in rural and remote communities must recognise that the availability of a readily accessible, appropriately skilled

and educated, and properly supported health and community services workforce is crucial.

Priority Action 21
Commonwealth and State Governments should work closely together to consolidate and expand their efforts to attract and retain sufficient health professionals in rural and remote areas from all health disciplines, to meet the full range of health needs of country communities, especially those arising from population ageing.

Priority Action 22
Commonwealth and State Governments should ensure that programs designed to increase the availability of health professionals in rural and remote areas are fully evaluated, with future programs based on initiatives of proven efficacy.

Priority Action 23
Health and community service employers, professional bodies, regulatory authorities and eduction provides should cooperate to ensure that all health professionals working in rural and remote areas have appropriate initial education and skills for country practise, including competence in the care of older people, and that these capabilities be maintained and up-dated throughout the professionals' working life in country areas.

Improving quality and appropriateness

Evidence based practice suggests that the preferable approach to successfully managing health issues arising from a rapid growth in the proportion of older people in communities is a wellness approach. This implies a reorientation away from an emphasis on sickness and treatment towards focussing on how older people keep themselves healthy. At least one rural community in Victoria has completed a project to work out how to re-shape its services using such a wellness approach.[37]

There is an increased focus in Australia on the identifying and using best practice in health and related services. It has been suggested that aged care organisations are not as far forward in these developments as mainstream health services. With an ageing population there will be increased pressure for aged care facilities and their professional staff, mainly nurses, to adopt best practice. This will occur both because of the importance of ensuring high quality care and because the pressure for efficiencies in aged care will increase as the need for aged care escalates with the ageing population.

> *There is a cost to inefficient clinical management of common aged care problems to both the aged care resident and the Commonwealth. Efforts to help nurses and carers and their management use evidence based practice (EBP) to improve care standards and reduce high cost nursing practices associated with aged care, should be introduced. This is especially important for rural and regional aged care where access to updated information is often difficult. The national network of University Departments of Rural Health has the capacity to assist in this area.*[38]

Strategy 20
Future approaches to the provision of health and aged care in rural and remote areas must encourage facilities to identify and adopt relevant evidence based practices in their services.

Priority Action 24
Some existing health services research and development funding should be allocated specifically to developing evidence based practice approaches in rural and remote health and aged care.

Priority Action 25
Improved communications should be established to disseminate evidence based approaches to health and aged care services in rural and remote areas, including effective use of information technology and mobile teams to visit services to explain evidence based practice in specific aspects of care and to assist health and aged care services to implement evidence based approaches.

CASE STUDIES

These case studies are drawn directly from input to the NRHA's submission from those living and working in country areas. All of the case studies illustrate issues about health and aged care services in rural and remote areas.

Some of the case studies are examples of successes, where communities have managed to achieve improved services to meet the needs of older people; others are examples of ongoing challenges or reduced services. Other examples of case studies on successful innovative aged care services can be found in *Delivering Quality Aged Care in Rural and Remote Australia.*[39]

Case Study 1
Western Australia: Sceptics become true believers
Many Wheatbelt towns and South West communities have gone with a Multi Purpose Service approach which allows them to pool state and federal funds together and achieve more flexibility in providing health services. Communities that have taken this approach have found that the aged care demands are met through Home and Community Care services, hostels or nursing homes and wouldn't have been able to achieve this via the old hospital system. Many rural consumers who went through this change were at first resistant to the idea but now positively comment on the benefits of the MPS. This only works between populations of 1000 to 5000 but with a declining rural community some towns may have to look at this option.[40]

Case Study 2

South Australia: Flexibility to meet a wide range of community needs

The Dunjiba Aged Care Program at Oodnadatta tells of their service which has 22 clients who are a mixture of frail aged and young disabled Aboriginal and non-Aboriginal clients. Out of town clients can also be catered for.

Services provided include domestic assistance, preparing and cooking lunchtime meals, banking, social outings including collecting bush tucker, assistance with personal care. Staff speak both English and Antikirinya. Clients with dementia are cared for in Port Augusta.[41]

Case Study 3

Tasmania: Community tensions from newcomers

A real concern here in Tasmania is the rise in our aging population due to the many people from other States that come here to retire because of the weather being not as harsh as the mainland and the cheaper cost of housing for people in rural Tasmania in comparison to the mainland cities.

This is creating problems in rural Tasmanian towns where residents of these towns and surrounding areas have worked all their lives to build good age care facilities in the knowledge that some day they will need them or members of their family.

When the time comes they can't use these facilities because people who have moved into the town for a year or two, sometimes less, have taken the places that would have been available for the long- term residents, then these people have to go on long waiting lists or in many cases have to go into aged care further distances from their loved ones, adding to the family stress.[42]

Case Study 4

NSW: Increasing needs in a coastal retirement area, but declining services

I live in the Eurobodalla Shire, which covers Bateman's Bay, Moruya and Narooma with small towns in between, ie Mogo, Bodalla etc. Ten years ago we had an ACAT (Aged Care Assessment Team) based in Moruya Community Health Centre, which comprised of a team of a Geriatrician, a RN, a Social Worker, an Occupational Therapist with an Administrative Assistant, all who worked full time.

This team worked very well and were kept busy as there is a very high population of older people in the Shire, and a great need for Aged Care. Today there is only one RN, who works 4 days a week and an Administrative Assistant who works 2 days a week.

Funding has been blamed, but the fact is as well, that few people in this area are thinking of Aged Care, and money goes elsewhere!! There is a job advertisement for a Community Based RN, in local papers but no mention of Aged Care.[43]

Case Study 5
South Australia: Major transport and other issues in a remote town
Coober Pedy Hospital & Health Services
Transport difficulties: No public transport or taxis operate in Coober Pedy. Therefore for the aged clients to attend appointments etc they have to be collected by paid staff in fleet vehicles. This is often difficult to co-ordinate as the clients make their own appointments/arrangements and advise us of them having to be picked up at too short notice. Transport for clients to attend appointments out of town eg: Whyalla, Adelaide is very difficult to organise as well. This is due to the extensive distances that they have to travel, often unescorted. The bus to Adelaide takes approximately 12-hours. If the client has an appointment in Whyalla it poses a situation where the client may have to wait 12 hours for a connecting bus. Whilst we have an air service 6 days per week it is a very expensive mode of travel and only flies between Adelaide - Coober Pedy.

Housing: There are four single units for public housing for non-indigenous clients in Coober Pedy. Therefore clients must either rent privately, which is often expensive, or are left with no other option than to live in poor conditions, with no running water or electricity etc.

Clients in larger cities and towns in South Australia have the advantage of being able to access services from a broader range of providers and are supported with a large infrastructure. In the past we here in Coober Pedy have tried to access services or funding from other agencies out of town to provide extra services.

Obviously, recruitment and retention are of huge concern in a remote area. Having the staff on the ground who are suitably qualified and also to backfill aged care staff whilst on leave or staff development courses, workshops etc.[44]

Case Study 6
South Australia: Aged care services in remote areas with scattered populations
Quorn/Hawker/Leigh Creek and Flinders & Outback Health Service
From our perspective, the current models of 'residential aged care' are not applicable under the current methods of funding for aged care services.

Funding is tied to the number of people over a certain age within the defined geographical collection area, this makes it extremely difficult to provide appropriate services to people in sparse areas, where there may only be two to three people who may require aged care services.

The model for our area would require the flexibility to provide services as currently defined through Community Care packages, but requires the financial flexibility to make it possible to provide this service to a small number of people over distances that may stretch as far as or greater than 250-300kms.[44]

Case Study 7

Western Australia: service development in a small town to meet the needs of an ageing population

Kojonup WA (2,180 population)

Through forward planning, community consultation and a commitment from many community members, the town has a modern six- bed nursing home attached to the hospital. The frail aged lodge is co-located, with a capacity for 22 residents, respite care and "ageing in place". Dementia has become a huge issue in Kojonup – 21 of the current residents are at some stage of dementia and there is a large waiting list from the Great Southern Region. Kojonup Shire has been successful in obtaining capital funding, through its submission to Commonwealth Department of Health and Ageing, to build a 16 bed "dementia specific" wing. This is currently under construction.

The Frail Aged Lodge is an accredited facility: staff are trained in dementia care and it is operated by Local Government, despite Kojonup being part of a District MPS. The Shire Council is keen to retain its elderly residents in the community and through being proactive in the area of aged care, is attracting people from outside the district to reside in Kojonup. Employment opportunities have also increased in the town.

Adjacent land has been purchased for the construction of independent living units (5 are occupied now and more will be built as demand increases). These units are keenly sought after by residents who have lived on farming properties in the district, but are no longer able to drive and need help with basic household duties. Residents living in these units are able to have meals at the frail aged lodge and have a 24-hour emergency bell. HACC services are also available in Kojonup.

Community Health services are now also available in Kojonup through the formation of the District MPS. Allied Health staff work from the hospital and regular Men's and Women's Health clinics are held. The hospital has 7 acute beds, a palliative care unit and an A & E which is serviced, under contract, by a solo General Practitioner.[45]

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APPENDIX A
MEMBER BODIES OF THE NRHA AS AT FEBRUARY 2003

The National Rural Health Alliance has 24 Member Bodies:

AARN	Association for Australian Rural Nurses
ACHSE	Australian College of Health Service Executives (rural members)
ACRRM	Australian College of Rural and Remote Medicine
ADGP	Rural Sub-committee of the Australian Divisions of General Practice
AHA (RPG)	Rural Policy Group of the Australian Healthcare Association
ANF	Australian Nursing Federation (rural members)
ARHEN	Australian Rural Health Education Network
ARRAHT	Australian Rural and Remote Allied Health Taskforce of the Health Professions Council of Australia
ATSIC	Aboriginal and Torres Strait Islander Commission
CRHF of CHA	Catholic Rural Hospitals Forum of Catholic Health Australia
CRANA	Council of Remote Area Nurses of Australia Inc
CWAA	Country Women's Association of Australia
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
NARHERO	National Association of Rural Health Education and Research Organisations
NRHN	National Rural Health Network
RDAA	Rural Doctors' Association of Australia
RACGP	Rural Faculty of the Royal Australian College of General Practitioners
RFDS	Australian Council of the Royal Flying Doctor Service of Australia
RGPS	Regional and General Paediatric Society
RPA	Rural Pharmacists Australia - Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health