Chapter 6

Addressing special social and demographic needs

> It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.
>
> *Hubert H. Humphrey 1911–1978*

Introduction

6.1 This chapter considers the regional variations in the costs of service delivery and the construction of aged care facilities. It also considers socio-economic variations of aged care recipients which impact on the cost and availability of services provided with specific focus on persons of non-English-speaking backgrounds, Indigenous Australians, Veterans and the socio-economically disadvantaged including homeless persons.

Residential and community aged care in rural and remote areas

6.2 People living in rural and remote areas have poorer health than those in major cities and this is reflected in their higher levels of mortality, disease and health risk factors.[1] Rural people have lower access to health care compared with their metropolitan counterparts because of reasons including distance, time factors, costs and transport availability.

6.3 The ageing rural population experience problems with accessing appropriate aged care services: rural and remote aged care providers face significantly higher operating and capital costs compared to their urban counterparts as a consequence of distance and travel requirements; workforce shortages limit the services available; and the dispersed population impacts on the viability of services.

Cost of aged care services in rural and remote areas

6.4 Witnesses pointed to the differences in the provision of services between urban and rural and remote areas and argued that the funding regime did not adequately take into account these differences. Catholic Health Australia (CHA) noted:

> There is no equity between metropolitan and rural and remote Australia in the current capital and operational funding regimes. Failure to correct this

1 Australian Institute of Health and Welfare, *Australia's Health 2008*, p. 83.

> imbalance in the funding arrangements will lead to the demise of many rural services.[2]

6.5 Citing a 2003 unpublished independent report on the financial viability of residential services in rural and remote NSW, CHA argued that generally residential aged care services in remote areas are functioning with both operating and net losses due to a range of extra costs including:

- the small population on which to draw their client base results in a resident mix with a higher proportion of lower dependency residents and hence lesser funding;
- unfavourable occupancy levels sometimes influenced by other residential aged and community care services within the same client catchment areas;
- lower than average Accommodation Bond levels and in some case no capacity to charge a bond or charge due to the family home being unsaleable;
- having to maintain staffing levels that are not necessary when the resident profile changes;
- higher staff recruitment, retention and training costs; and
- higher costs for insurances, medicines, incontinence aids, laundry, food and maintenance.[3]

6.6 Other submitters also commented on the difference between clients in urban and rural and remote areas. Witnesses noted that accommodation bonds in rural areas are considerably lower than in metropolitan areas.[4] Of the situation, Aged and Community Care Victoria (ACCV) stated that 'rural communities will normally have lower income generation capacity at all levels, including more limited resources and sources of bond income for capital raising'.[5]

6.7 HN McLean Memorial Retirement Village in Inverell noted that there is a significantly higher percentage of concessional residents in rural and remote areas. This limits the number of accommodation bond opportunities available to rural provides.[6] The number of concessional residents is particularly high in the Northern Territory, with the Northern Territory Government commenting that the proportion of new residents classified as concessional, assisted or supported residents in 2008–09 was 64 per cent in the Northern Territory compared to 33.4 per cent nationally.[7] Mr Greg Mundy, Aged and Community Services Australia, also commented that in

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2 Catholic Health Australia, *Submission 75*, p. 10.

3 Catholic Health Australia, *Submission 75*, p. 10.

4 Eliza Purton Limited, *Submission 11*, p. 2 and p. 5.

5 Aged and Community Care Victoria, *Submission 89*, p. 7.

6 HN McLean Memorial Retirement Village, *Submission 9*, p. 6.

7 Northern Territory Department of Health and Families, *Submission 25*, p. 1.

rural and remote parts of Australia there is a need for low care that stems from the dispersed population'.[8]

6.8 Mr Gerard Mansour of Aged and Community Care also commented on the size of facilities in small rural communities and noted that many had only 20 or 30 beds 'because that is simply all the community needs'. However, the average viability point is 60 to 70 beds. In addition, there is a move from low to high care and there is a loss of bonding.[9]

6.9 Witnesses also pointed to the higher costs for fresh food, fuel and electricity and construction in rural and remote areas.[10] The high level of construction costs in rural and remote are was canvassed extensively in evidence. Ms Gail Milner of the Western Australian Department of Health, commented that the cost of providing a service in the Kimberley and the Pilbara is more than 50 per cent higher than the metropolitan area in wages, consumables, and transport with construction costs are up to three times higher in the Kimberley.[11] Aged Care Queensland commented that there were widely varying costs for the construction of new beds across Queensland with the average around $200,000 but some in excess of $300,000 in isolated areas.[12] While Aged Care Association and Aged and Community Care Western Australia indicated that in some remote areas costs were in the order of $600,000 per room.[13]

6.10 Aged Care Association and Aged and Community Care WA also commented on the impact of resources boom in Western Australia on the availability of services in remote areas:

> This building crisis has resulted in greater pressure on the community care sector and given the physical distances that need to be covered the current funding does not adequately support these services.
>
> As a result there are many frail elderly who require residential care but there are no places and they exist in a rotation between the hospital and their home.
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> Unfortunately due to the lack of resources, appropriate infrastructure and the capacity to deliver services in some areas; long-standing members of regional and remote towns and communities are forced to move away from their friends, family and home to receive much needed care services. [14]

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8 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 6.

9 Mr G Mansour, Aged and Community Care Victoria, *Committee Hansard*, 20.2.09, p. 40.

10 See BlueCare Unitingcare Queensland, *Submission 18*, p. 29; Darlington Upper Goulburn Nursing Home, *Submission 19*, p. 1.

11 Ms G Milner, WA Department of Health, *Committee Hansard*, 30.01.09, pp 25–26.

12 Aged Care Queensland, *Submission 62*, p. 6.

13 Aged Care Association and Aged and Community Care Western Australia, *Submission 84*, p. 5.

14 Aged Care Association and Aged and Community Care Western Australia, *Submission 84*, p. 6.

6.11 The Council of Social Services of New South Wales argued that there is limited availability of CACPs and EACH in rural areas:

> Often in rural areas there are not high enough numbers in a local area to meet the ratios to get much service, even though there can be significant numbers of older people.[15]

6.12 Rural providers supplied the committee with examples of their worsening financial situation. Capecare in Busselton WA stated that is operation has gone from a surplus of $7.03 per bed per day in 2005–06 to a budged deficit of $11.37 in 2008–09. The turn around in the operating position was due to increases in wages and related costs. Capecare reported that it was subsidising its residential care operations by using capital funding income streams which would normally be earmarked for upgrading and replacing buildings and income streams from other sources.[16]

6.13 Mr Cam Ansell, Grant Thornton Australia, noted that the returns generated in non-urban area are about 30 per cent less than those operating in metro areas.[17]

Government assistance to rural and remote aged care services

6.14 The Department of Health and Ageing (the department) noted that to assist with the extra costs of delivering services in rural and remote areas, additional funding is available through the viability supplement, capital grants and zero interest loans. The viability supplement for residential aged care is designed to assist regional and remote service providers which meet specific criteria. Eligible services are generally those with fewer than 45 places and in less accessible locations. In 2007–08, about $15 million was provided under the viability supplement to 467 residential services.[18]

6.15 The viability supplement for community care programs amounted to around $3.7 million in 2007–08, provided in recognition of the higher costs and recruitment challenges faced by such services. The viability supplement for community care programs is structured such that the more remote the location of the client the higher the supplement. In 2007–08, the average viability supplement per person per day paid to services located in very remote areas was over $8 for CACP and EACH programs, this compares to $3 in non-remote areas.[19]

6.16 The department also noted that capital grants are available for residential aged care to providers who do not have a sufficient capital stream to upgrade and maintain buildings. This often occurs in rural and remote areas where providers do not have many residents able to pay an accommodation bond. The department stated that in

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15 Council of Social Services of New South Wales, *Submission 52*, p. 7.

16 Capecare, *Submission 13*, p. 2.

17 Mr C Ansell, Grant Thornton Australia Ltd, *Committee Hansard*, 30.01.09, p. 4.

18 Department of Health and Ageing, *Submission 114*, p. 22 and p. 24.

19 Department of Health and Ageing, *Submission 114*, p. 24.

2007–08, almost 80 per cent of the $45 million of capital assistance allocated was provided to rural and remote areas. Of this $12.5 million was allocated as Residential Care Grants with the remaining $32.5 million provided through the Regional and Rural Building Fund to assist with the upgrading of buildings or to allow providers to expand.[20]

6.17 Zero real interest loans are available for the development of infrastructure in rural and remote areas.

6.18 The Australian Government, in conjunction with those states and territories that need such services, operate Multi-purpose Services. They operate under the *Aged Care Act 1997* and deliver a mix of aged care, health and community services in rural and remote communities, many of which cannot sustain separate services. The department noted that some health, aged and community care services may not be viable in a small community if provided separately. By bringing the services together, economies of scale are achieved to support the services. Each Multi-purpose Service is financed by a flexible funding pool to which the Australian Government and state and territory governments contribute. This is reviewed regularly. A Multi-purpose Service can use the money to provide a mix of services, including aged care, best suited to its community's needs.

6.19 Around 86 per cent of all aged care places provided by Multi-purpose Services are for residential care Multi-purpose Services located in outer regional areas, such as Broken Hill, provided just over half of all places for this program.[21]

6.20 Whilst it was recognised that the rural and remote viability supplement was provided in recognition of the difficulties faced in relation to high cost burdens, providers maintained that the supplement was 'inadequate' to meet the additional costs faced in such areas. Anglicare Australia maintained that despite the additional funding, many rural and remote providers struggle:

> The cost of providing services in such locations in unsustainable, even with supplements, for many providers. In addition, both residential and community care providers face difficulties in attracting and keeping good staff.[22]

6.21 Aged Care Association and Aged and Community Care WA commented that the existing viability supplement is a 'one size fits all' approach based on remoteness rather than on need. The association stated that it would be more advantageous to have a viability supplement that is based on actual costs.[23] The Northern Territory

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20 Department of Health and Ageing, *Submission 114*, p. 25.

21 Department of Health and Ageing, *Submission 114*, p. 27.

22 Anglicare Australia, *Submission 67*, p. 4.

23 Aged Care Association and Aged and Community Care Western Australia, *Submission 84*, pp 6.

Government also commented that 'these supplements are considered by the aged care sector as too low and it is uniformly applied across Australia irrespective of local cost of living or how remote is a remote locality'.[24]

6.22 Aged and Community Services Australia commented that the current viability supplements measure remoteness to assess eligibility but, like the aged care program as a whole, makes no realistic empirical assessment of actual costs.[25] Aged and Community Services SA & NT held that ensuring quality service provisions in rural and remote communities as well as to those with special needs required support beyond the rural viability supplement which is 'measured by remoteness':

> The current funding does not cover the cost of components such as culturally appropriate training, interpreter services, recruitment, complex needs and culturally sensitive relationship building. Nor does it acknowledge that there are other issues directly related to the organisation delivering services or the economic capacity of the community in which the organisation is based which will have an impact on the quality of service delivery.[26]

6.23 The Aged Care Association Australia maintained that the viability supplement was a 'poor distributor of additional subsidy to reflect cost variables in rural and remote locations'.[27] The association was of the view that a revised system of service cost and capital cost should be developed which reflects the significant variations in rural and remote areas.

6.24 In addition, Aged and Community Services Association of NSW & ACT commented that in some instances where providers have merged to maintain viability, they have been penalised through loss of the supplement, yet have managed to remain operational.[28]

6.25 Witnesses proposed a number of ways to assist providers with the additional costs of providing services in rural and remote areas. The Shire of Kojonup submitted that the viability subsidy is the appropriate mechanism for addressing regional variation but that it 'needs a higher weighting towards the size of the facility as this is the key driver of viability'. The subsidy also needs to be fully indexed to account for cost escalation.[29]

6.26 Share & Care Community Services Group recommended that the Government consider an additional 'Rural Payment' for organisations outside metropolitan

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24 Northern Territory Department of Health and Families, *Submission 25*, p. 2.

25 Aged and Community Services Australia, *Submission 61*, p. 5.

26 Aged and Community Services SA & NT, *Submission 90*, p.1.

27 Aged Care Association Australia, *Submission 92*, p. 21.

28 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 4.

29 Shire of Kojonup, *Submission 70*, p. 3.

regions.[30] While Eliza Purton considered that a tiered structure of funding that better recognised and supported regional issues (such as smaller bonds and higher costs) was required.[31]

6.27 Aged and Community Services Australia recommended that:

> …we should adjust the value of those rural and remote supplements to reflect some robust index of what the actual costs are, rather than setting it as a fixed amount and then indexing it by CPI every year. Even if it was right on day 1, it would not be right two years down the track.[32]

6.28 Mr Greg Mundy, Aged and Community Services Australia concluded:

> In terms of the viability of rural and remote aged-care provision, I think here is no escaping the fact that, if you want to guarantee access to services in all parts of Australia, there are some places where it will cost more to do that for a whole range of quite obvious reasons. We just need to bite that bullet and acknowledge that that is the case. We currently measure the eligibility for those rural supplements. We support the concept of supplements with huge precision using ARIA measurements—the precise number of kilometres from health facilities and so on. However, we do not measure the amount of money that you need to bridge the gap with any sort of precision at all. So we test eligibility within an inch of its life, but we do not actually have any robust, tested, researched estimate of what it actually costs to provide aged-care services anywhere in Australia or, therefore, the extra costs of doing it in rural communities.[33]
>
> One is that ensuring access to aged-care services in rural and remote parts of Australia is going to cost more, so we need to bite that bullet. It is partly about the value of the subsidies and whether the rural and remote additional subsidies actually do cover those costs.[34]

Workforce issues in rural and remote areas

6.29 A key concern raised by a number of submitters was of the difficulties in attracting and retaining qualified staff in regional and rural areas.[35] Rural communities already face substantial challenges in relation to workforce recruitment and retention. Providers noted that it was extremely difficult to attract and retain staff, particularly in areas where there was competition from mining companies. In addition, the cost of housing was seen as a major impediment to attracting staff with Ms Evans of St

30 Share & Care Community Services Group, *Submission* 5, p. 5.

31 Eliza Purton Limited, *Submission 11*, p. 5.

32 Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 10.

33 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 2.

34 Mr G Mundy, Aged and Community Services Australia, *Committee Hansard*, 20.2.09, p. 10.

35 See for example, Villa Maria, *Submission 38*.

Bartholomew's House stating that most of the remote areas do not have the infrastructure for housing of care workers.[36]

6.30 Training was also raised as a concern with providers stating that training was either not available or not convenient given the time required to travel to and from training courses. As most training courses are provided in metropolitan areas, providers find it difficult to release staff and pay additional costs such as fuel and overtime.[37] Ms Merril Hecker of the Share & Care Community Services Group commented on the difficulties of providing training in rural and remote areas and the need for a coordinated approach:

> We access the training where we can, but we are limited as to how many numbers can attend. We cannot allow all our staff to attend a training session if it is an all-day session, say in medication. Advocare I think only do a couple of hours. You can allow your staff to go to that. If it is only for a couple of hours, that is good, but your medication session may take six hours…
>
> In the rural area in particular, you work on those that are around you and invite them in. That way you can do a couple of sessions over a month or whatever, so that everybody gets trained. Half your staff will be there for the six hours at one session while the other staff are out covering your clients, and then at a later session you reverse it. We have done that in the last 12 months, working with a couple of other providers, and I find that that works really well.[38]

Impact of distance

6.31 Many submissions raised the issue of the impact of distance on the provision of aged care services particularly community care and on the availability and cost of training aged care workers.

6.32 Share & Care Community Services Group informed the committee of the disadvantage that they face:

> Our biggest concern at present are the travel costs involved in servicing consumers. In rural areas it is not uncommon to travel 20 kilometres to service clients. The additional miles in rural areas and the costs associated need recognition and additional funding applied.[39]

6.33 According to the Aged and Community Services Association of NSW & ACT, the capacity of care services to meet the needs of older persons is impacted by the travel distances required and that:

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36 Ms L Evans, St Bartholomew's House, *Committee Hansard*, 30.1.09, p. 75.

37 Share & Care Community Services, *Submission 5*, p. 5.

38 Ms M Hecker, Share & Care Community Services, *Committee Hansard*, 30.1.09, pp 74–75.

39 Share & Care Community Services, *Submission 5*, p. 5.

> Transportation costs in conjunction with a lack of competition for market resources also contribute to higher costs. Availability of appropriate workers and the increased costs of education and training as a result of limited community infrastructure and the need to replace employees for longer due to travel requirements further impacts on the cost of service delivery.[40]

6.34 Similarly, the Productivity Commission noted in its 2008 report:

> In rural and remote areas, the costs of education and training are higher due to a lack of local infrastructure and the need to replace workers for longer when they travel for training.[41]

Meals on wheels

6.35 Australian Meals on Wheels, a service which enables aged persons to live at home in the community for longer, receives up to 30 per cent of its funding from the HACC program whilst the sale of meals accounts for most of its other income. However, according to the body, services around the country are struggling with costs, volunteer support and regulatory compliance and changing demand:

> Meals on Wheels is a 'needs based' service. Meals numbers are growing only modestly however total client numbers are increased to a greater rate as more clients go on meals for less than 5 days per week with the opportunity to attend day care and other services (also important for their well being). However, it means that the unit cost per meal increases as total costs rise and meals numbers remain constant even though client numbers are in fact increasing.[42]

6.36 Australian Meals on Wheels maintains that if prices rise (to meet costs) to a level where clients cut their spending and have to reduce the number of meals they need to sustain their nutrition requirements, 'their health will be compromised and the likelihood of requiring higher and more expensive hospital care is inevitable' and:[43]

> A day in the public hospital system costs $1,117; a day in residential aged care costs $100; Meals on Wheels receives less than $2 per day.
>
> The message we advocate is simple – an increase in funding at the Meals on Wheels 'beginning' part of the health and wellness continuum can save a lot of public money at the residential aged care and hospital 'end'.[44]

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40 Aged and Community Services Association of NSW & ACT, *Submission 61*, p. 4.

41 Productivity Commission, *Trends in Aged Care Services: some implications*, Research Paper, September 2008, p. 151.

42 Australian Meals on Wheels, *Submission 7*, p. 1.

43 Australian Meals on Wheels, *Submission 7*, p. 1.

44 Australian Meals on Wheels, *Submission 7*, p. 2.

6.37 Ms Carol Jones-Lummis of Share & Care Community Services Group commented on the changes facing Meals on Wheels and the volunteers who support it:

> Meals on Wheels is probably, as you say, the service that uses the most volunteers. About eight years ago the local town had the Meals on Wheels service and was run completely by volunteers. They no longer could cope with the accountability and reporting requirements and all the rest of it. They were predominantly aged. In fact, I think one of the youngest was in her sixties or something and there was an elderly lady of about 80. They asked Share and Care to take it on. The biggest issue, of course, is that volunteers like to come in, they want to do their volunteering hour or two hours, and they want to go home.
>
> Unfortunately, because of the litigious society we live in, as an organisation I am now required to have working with children checks—because we also do younger and disabled, if required—and police clearances. We need to make sure that they are put through that system. Then they have training. We are required by our insurer to make sure they do training, so they are then required to come in and do all this training. We have looked at probably a 90 per cent drop in the last eight years. That is huge. At the moment, we are starting to see a few more come in, but not enough. Meals on Wheels was built on the fact that it would be managed by volunteers. Unfortunately, that is no longer the case among many of the organisations that supply it.[45]

6.38 The Share & Community Services Group also maintained that funding provided to Meals on Wheels should be increased.[46]

Conclusion

6.39 The committee considers that the demands placed on providers of aged care services in rural and remote Australia are unique. While the Department of Health and Ageing provided evidence of the extent of the Commonwealth's assistance through the viability supplement and other programs, the committee believes that there remain difficulties in the delivery of aged care services in non-urban areas and that there is evidence of poor long term viability of providers. The committee considers that this is a matter that should be addressed by the recommended sectoral review.

Recommendation 15

6.40 The committee recommends that the all-encompassing review specifically consider the provision of aged care services in rural and remote areas and the effectiveness of the current viability supplement to support service provision.

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45 Ms C Jones-Lummis, Share & Care Community Services, *Committee Hansard*, 30.1.09, p. 68.

46 Share & Care Community Services Group, *Submission 5*, p. 5.

Norfolk Island

6.41 The committee received two submissions addressing the particular circumstances of aged care in Norfolk Island.[47] The following issues were highlighted:

- funding levels for Norfolk are insufficient to meet the expected quality services provision outcomes;
- there is not funding or infrastructure currently available to provide in home services;
- veterans living on Norfolk Island are unable to access home care services currently available to veterans residing in Australia;
- the hospital provides the only aged care facilities but there are limited beds available and no secure area for clients with dementia or psychiatric disorders; and
- medication is more expensive on Norfolk Island.

6.42 Mr D Hogan noted that in July 2008 discussions had taken place on a proposal to develop homecare services. However, this proposal has not progressed.[48]

Recommendation 16

6.43 The committee recommends that the Commonwealth and Norfolk Island Government initiate discussions in relation to a proposal to develop homecare services on Norfolk Island.

Persons of non-English speaking and culturally diverse backgrounds

6.44 According to the ACCV, a 2006 report from Nous Group noted that by 2011, in Victoria 30.8 per cent of all older people will be from culturally and linguistically diverse backgrounds, which is a rise from 23.1 per cent in 1996.[49]

6.45 The issue of discrimination in aged care against the aged of non-English speaking backgrounds and those from culturally and linguistically diverse backgrounds was raised with the claim that such persons are financially disadvantaged and not in a position to pay either accommodation bonds or accommodation charges. This leaves them vulnerable to discrimination: 'If given a choice of which resident to admit, the provider will choose a resident who can pay. This leaves older Australians from Non-English Speaking Backgrounds at the end of many waiting lists'.[50]

47 Mr D Hogan, *Submission 95*; Mr A Tavener, *Submission 98*.

48 Mr D Hogan, *Submission 95*, p.3.

49 Aged and Community Care Victoria, *Submission 89*, p. 10.

50 Management Consultants and Technology Services, *Submission* 42, p. 1.

6.46 Ms Derryn Wilson of the Municipal Association of Victoria also commented that among some members of the ethnic community, where success in Australia is very marked by home ownership and giving it to your children, there is a reluctance to go into care if a bond has to be paid.[51]

Conclusion

6.47 The committee considers that the needs and expectations of clients from non-English speaking backgrounds are an important consideration in the provision of aged care services. They should be taken into account by the review of the aged care sector.

Recommendation 17

6.48 The committee recommends that the all-encompassing review specifically consider and address the expectations and needs of persons from non-English speaking backgrounds.

Socially and financially disadvantaged persons

6.49 Concerns were also raised about the availability of aged care services to persons who are socially and financially disadvantaged. Homeless persons, older persons living in caravan parks and boarding houses and those who are socially marginalised were identified amongst this group. Mr Bryan Lipmann of Wintringham noted, however, that it not just the homeless on the street, but also those in rented accommodation who are at risk and this can only worsen:

> …a huge number of people who are just pensioners struggling in rented accommodation who are one incident away from becoming homeless. This is the group that is significantly at risk. If I have learnt anything from all these years of working in this, it is that a percentage of those people at risk do become homeless—and it can only get worse with the booming ageing population plus the financial meltdown.[52]

6.50 Wintringham outlined the problems of accessing adequate aged care services for this group of people who often have no resources other than their pension, no family support, and are sometimes reluctant to accept services:

- destitute and marginalised people have few resources to assist them to purchase the provision of aged care services, for example, it is very difficult to supply a Community Aged Care Package to a client of 'no fixed address';
- many disadvantaged people do not have the ability or anyone to support them through the complex health system to receive appropriate referrals;
- aged care providers may be required to take on the entire 'burden of care' for people without families or friends, with insufficient funding to meet the costs

51 Ms D Wilson, Municipal Association of Victoria, *Committee Hansard*, 20.2.09, p. 19.

52 Mr B Lipmann, Wintringham, *Committee Hansard*, 20.2.09, p. 54.

of providing this level of care providers of services to the elderly homeless face higher operating costs;

- providers of services for disadvantaged persons are unable to charge fees or access accommodation bonds so that services are limited and funding for new facilities is restricted;
- maximum residential ACFI funding of $29.71 a day is provided for residents the highest level behavioural care needs however, this makes access to specialist opinions extremely difficult given that as an example, a neuropsychiatric report can cost between $650 and $2,000.[53]

6.51 Wintringham also noted that the model of care required of its residents is different from that usually provided in aged care facilities. For example, care for traditional ageing dementias such as Alzheimer's disease requires a rigid lifestyle. However, for the client group cared for by Wintringham 'you need to keep them alive, aware and changing, and they can learn—they have not lost the ability to learn. They can still participate.' While the model of care is available, Wintringham commented that the problem is how to fund the service to ensure that this particular client group remains as healthy and active as possible.[54]

6.52 Ms Sally Kingdon-Barbosa of St Bartholomew's House commented that homeless people with complex needs find it difficult to be placed in mainstream high-care facilities.[55] In addition to these problems, the Grant Thornton Australia survey of 700 aged care facilities established that the deteriorating financial position of not-for-profit providers had necessitated more 'commercial' policies in relation to resident aged care admission often at the 'cost to the financially and socially disadvantaged people in these programs'.[56]

6.53 While acknowledging the bipartisan support for the plight of the elderly homeless, Mr Lipmann of Wintringham commented that the Aged Care Act does not allow the minister or senior bureaucrats in Canberra sufficient flexibility. Mr Lipmann stated:

> For a very many number of years, I have been travelling to Canberra, pleading the need to create a special needs category for the elderly homeless. There are a few special needs categories, which you may or may not be aware of, such as veterans and rural and remote. We argued that if we could create homelessness as a special needs category it would then allow all ministers, future ministers and all bureaucrats during the planning

53 Wintringham, *Submission 43,* pp 1–4.

54 Mrs H Small, Wintringham, *Committee Hansard,* 20.2.09, p. 55.

55 Mrs S Kingdon-Barbosa, *Committee Hansard,* 30.1.09, p. 66.

56 Grant Thornton Australia Ltd, *Submission 29,* p. 6.

> process, through the ACAT et cetera, to seek to address the special needs of the elderly homeless.[57]

6.54 St Bartholomew's House also recommended that recognition be given to those facilities which are currently providing quality aged care to the homeless, with strategies in place to assist them to be classified as extra service facilities, or similar, which recognise and adequately fund the intensive and specialised support in the provision of that care.[58]

6.55 Mr Lipmann went on to conclude that if funding is not adequate then the alternatives are unsatisfactory:

> That is the significant problem with aged care. If you have someone whose needs cannot possibly be met through the Aged Care Act, you either institutionalise them and lock them into a padded cell, which is inhuman, or our staff can look after him—they are skilled enough to look after this guy. We were able to get money from the state under a disability issue to care for him, and he is still going, but it is an extraordinarily difficult process. It seemed to us that the Commonwealth should address the needs of those extremely difficult clients.[59]

6.56 The ACCV noted that affordable rentable housing for the elderly is required of a diversity of styles in different locations in order to ensure that people feel at home and remain connected to their established communities.[60] The ACCV maintained that the issue of homelessness should be incorporated into the planning and service responses of all mainstream health and welfare services and supported by a public communication strategy.[61]

6.57 Catholic Health Australia argued for an expansion of the capital grants programs for the development of residential services that target lower socio-economic communities:

> These communities, most often found in rural and regional areas, often have a higher proportion of concessional residents – as well as lower property value. Consequently residents who do pay bonds, pay a low bond rate.[62]

6.58 Similarly, views were raised that more needs to be done to assist those with a disability or complex medical need or illness.[63]

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57 Mr B Lipmann, Wintringham, *Committee Hansard*, 20.2.09, p. 54.

58 Ms S Kingdon-Barbosa, *Committee Hansard*, 30.1.09, p. 66.

59 Mr B Lipmann, Wintringham, *Committee Hansard*, 20.2.09, p. 55.

60 Aged and Community Care Victoria, *Submission 89*, p. 10.

61 Aged and Community Care Victoria, *Submission 89*, p. 14.

62 Catholic Health Australia, *Submission 75*, pp 10–11.

63 Aged and Community Care Victoria, *Submission 89*, p. 11.

6.59 The committee appreciates the specific challenges to homeless elderly persons and recommends that the department review the implications of the incorporation of 'elderly homeless' as a special category under the *Aged Care Act 1997.*

Recommendation 18

6.60 The committee recommends that the Department of Health and Ageing conduct a review into the implications of 'elderly homeless' incorporated as a special needs category under the *Aged Care Act 1997*.

Recommendation 19

6.61 The committee recommends that the suggested all-encompassing aged care review specifically consider and address the expectations and needs of the homeless and other socio-economically disadvantaged persons.

Indigenous Australians

6.62 A number of submissions including that of the ACCV acknowledged that the needs of Indigenous communities are different from those of the non-indigenous community and that a lack of resources in rural and remote communities can have greater consequences.[64] The Northern Territory Government noted that frail elderly Indigenous people often choose for cultural and spiritual reasons to remain in their communities and as a consequence, receive less support then they would if they were living in a regional centre.[65] Ms Maureen Sellick, Advocare, commented on the difficulties of those with high care needs:

> I think that is also particularly the case for Aboriginal people in rural and remote areas. For example, in the Kimberley I believe there are very few high-care places for people generally. You might have an older Aboriginal man, for example, who needs high care. There are no places in the Kimberley, and he has to then live in a place in Subiaco. It just does not work out for him at all, so he is not able to survive. You might have, again, someone in the Kimberley—say Kununurra—who can only get a place in Derby, for example, well and truly away from his supports.[66]

6.63 In addition, due to many socio-economic and lifestyle issues, Indigenous people in general require aged services well before they reach 70 years. [67]

6.64 The Council of Social Services of New South Wales (NCOSS) noted that Indigenous communities tend to make 'less use of residential aged care and consequently require higher levels of community care support'. NCOSS further noted that Indigenous persons with disabilities do not utilise many community care services:

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64 Aged and Community Care Victoria, *Submission 89*, p. 10.

65 Northern Territory Government, *Submission 25*, p. 2.

66 Ms M Sellick, Advocare, *Committee Hansard*, 30.1.09, p. 58.

67 Dubbo City Council, *Submission 2*, p. 2.

> NCOSS notes the employment of culturally appropriate staff and volunteers can ensure that services are appropriate and are utilised by Aboriginal people. But emphasis must also be placed on improving the responsiveness of generalist services to Aboriginal communities.[68]

6.65 Commenting on the current usage rate of community services by Indigenous Australians, NCOSS noted:

> Because Aboriginal people have lower life expectancy than other people in the population, their timely access to aged care services can be delayed and the appropriateness of those services can be diminished without attention to individual needs and cultural responsiveness. Additionally, the number of older people in Aboriginal and Torres Strait Islander communities is increasing. Consequently, the usage rate of many community support services by Aboriginal people is unacceptable and disproportionately low.[69]

6.66 NCOSS recommended that in light of the lower life expectancy of Indigenous Australians, the access age for aged care and community care support services should be lowered to 45 years in line with the HACC program.[70] Dubbo City Council considered that a separate disability factor recognising the Aboriginal population of a Local Government Area should be a component of any aged care service/facility allocation needed in NSW due, in part, to the Indigenous people need to access aged care services before the aged of 70 years.[71]

6.67 The Department of Health and Ageing noted that the National Aboriginal and Torres Strait Islander Flexible Aged Care Program assists older Indigenous Australians access appropriate care as close as possible to their communities, which are mainly in rural and remote locations. The Program provides a mix of residential and community places, however the mix has a higher proportion of community places (38 per cent compared with 14 per cent). Over half of all places in this program are provided in remote areas.

6.68 There are 30 services funded under the Program providing aged care services to approximately 600 older Aboriginal and Torres Strait Islander people. In 2006–07, an additional 150 places and funding of $15.1 million over 4 years was provided for Program.

6.69 In 2006–07, the Remote and Indigenous Support Services Program was established with funding of $42.6 million over five years. This program is targeted to aged care services provided by Aboriginal and Torres Strait Islander owned or operated organisations anywhere in Australia and by services located in remote and very remote locations providing community, flexible and/or residential care.

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68 Council of Social Services of New South Wales, *Submission 52*, p. 5.

69 Council of Social Services of New South Wales, *Submission 52*, p. 5.

70 Council of Social Services of New South Wales, *Submission 52*, p. 6.

71 Dubbo City Council, *Submission 2*, p. 2.

Additional assistance provided under this program includes peer and professional support services, emergency support services and capital funding.[72]

6.70 The committee recognises that more can be done to address the specific expectations and needs of Indigenous Australians in relation to the provision of appropriate aged care. Indeed, it appreciates that aged care services must be client-focused in order to accommodation the diverse range of requirements including that amongst Australia's Indigenous communities. For this reason, it encourages the suggested overarching review of the sector to specifically consider aged care services for Indigenous Australians.

Recommendation 20

6.71 The committee recommends that the suggested all-encompassing aged care review specifically consider and address the expectations and needs of elderly Indigenous Australians and their communities.

Recommendation 21

6.72 The committee recommends that the Department of Health and Ageing consider further initiatives to attract culturally-appropriate staff in consultation with involved stakeholders including Indigenous clients.

Veterans

6.73 The National Ex-Service Round Table on Aged Care (NERTAC) noted that whilst the accreditation process requires aged care providers to provide information in relation to its address of the special needs of Indigenous Persons and culturally and linguistically diverse groups, there was no such requirement in relation to veterans. Of the current situation, NERTAC stated:

> Feedback from our visiting welfare officer system is that many facilities do not identify veterans and war widows or the wider ex-services community…If the aged care provider does not identify veterans then how can they respond to these needs? A suggestion has been that the accreditation process could be enhanced to require providers to detail the focus which they put on services for veterans special needs group.[73]

6.74 The committee heard that veterans in aged care often had special needs relative to the general community. According to t Mr Ross Smith, representing the National Ex-Service Round Table on Aged Care, the rate of alcohol and non-medical drug abuse is higher in the veteran community as a result of post-traumatic stress disorder and other military exposures.

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72 Department of Health and Ageing, *Submission* 114, p. 29.

73 NERTAC, *Submission 8*, p. 2.

6.75 Mr Smith also drew the committee's attention to the special emotional needs of veterans in aged care as a result of their military service:

> If someone has been through life as a farmer and has been through droughts and that sort of thing, they are happy to talk about them, whereas the ex-services community generally is not. Some of the conditions we now know as post-traumatic stress disorder are often hidden. They are well publicised in the case of Vietnam veterans, but we know that they will come out in later life. They will come out in the World War II veterans, who are typically 80-plus years of age. Some of that, we believe, is accentuated by conditions such as dementia and depression and often mixed up in those two things. They are causal factors, anyway. It is fairly difficult to unscramble all those things, but as people age the incidence of dementia will cause those things to come out and may trigger an event of post-traumatic stress disorder which has not been diagnosed in the last 50 or 60 years.[74]

6.76 Mr Smith stated that there is a need to better diagnose these mental conditions as part of the admission process, and that this was also a general issue for the community and not restricted to aged care alone.

6.77 The committee notes that veterans are specified under the Allocation Principles as a special needs group. It appreciates the particular circumstances faced by veterans and respective challenges that may be faced by their carers. This is further evidence of a need for a client focused approach in the aged care sector.

74 Mr R J Smith, NERTAC, *Committee Hansard*, 7.4.09, p. 52