Delivery of Services for Aged Care in Remote and Rural Australia

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This session on the delivery of services for Aged Care in rural and remote areas provides an opportunity to explore these issues in the context of the mid-term review of the Aged Care Reform Strategy. The terms of reference for the review are:

- Assess the extent to which community and residential aged care services are effectively targeted and equitably distributed and the extent to which fees policy impacts on targeting.
- Resolve boundary issues between long-term care and acute care of the aged so that the most cost-effective form of care prevails.
- Report on the balance of care between residential and community services and identify ways in which the emphasis on community provision can be strengthened, including better linkages between housing services and aged care.
- Assess the impact of the involvement of multiple levels of government on aged care services and identify ways to remove overlaps and duplication, establish areas of functional responsibility and principles for resource allocations between levels of government.

Several discussion papers are being prepared for the review. The purpose of the discussion papers is to document developments in policies and programs over the last five years, and to canvass options for the remaining stages of the reform strategy, and to provide background for the community consultations being held in the course of the review.

One of the Discussion Papers deals with aged care in rural and remote areas. Another Discussion Paper focuses more specifically on care of older Aborigines and Torres Strait Islanders, while others cover the role of carers, dementia care, care of the ethnic aged. The final three papers are concerned with the planning of services and approaches to establishing the most appropriate balance between different modes of care, across the spectrum of all kinds of residential and community care.

The contents of the Discussion Paper on service delivery in rural and remote areas are as follows:

1. Policy background and initiatives
   Introduction
   1.2 Definition of ‘rural and remote’
Issues in delivery of aged care services in rural and remote areas

The main issues that are frequently raised in discussions of service provision in rural and remote areas fall into three groups: workforce and training issues, flexibility in program planning and service delivery, and administration and management. Many of these issues apply to health and community services generally, and some of the problems of aged care services will be overcome as these issues are addressed in the emerging framework of coordination of services in rural and remote areas. As these approaches develop, it is important that issues which have specific implications for aged care are identified and that all options are canvassed. The following discussion accordingly focuses on aged care perspectives.

3.1 Workforce and training issues

An essential feature in the provision of health services throughout Australia is the direct contact between clients and service providers. A sufficient supply of appropriately trained health workers is pivotal in the delivery of health services.

Historically, the models for recruitment, training and retention of the health workforce and for service delivery have been developed within the urban context, with only minor concessions to allow for conditions in rural and remote areas. Recently, considerable attention has begun to be focused on identifying more appropriate workforce training. It is recognised that training opportunities enhance the capacity of rural areas to retain their young adult population, and that staff trained in a rural area are more likely to remain there. Research into workforce issues in rural and remote areas is now receiving priority attention, and the RaRA Unit will also be giving consideration to workforce and training issues.

3.1.1 Structure of the aged care workforce

The health and community services workforce in rural and remote areas consists of two basic segments:
• the resident workforce: comprising people from the usual workforce categories such as doctors, nurses and social workers. Some of these workers are long term residents in the areas while others are on fixed term contracts. The resident workforce also includes some special categories such as Aboriginal Health Workers and child care workers. The aged care workforce has in the past been largely drawn from generalist trained personnel, and specially trained aged care workers of different kinds are only now emerging with training initiatives being taken in both residential and community care.

Provision of local opportunities for such training will play a major part in enhancing skills in aged care in rural and remote areas.

• a visiting workforce: providing services such as the Royal Flying Doctor Service and flying surgeon services. Some Geriatric Assessment Teams operate in this way to provide coverage to large geographic areas. Having specialist staff visit the person needing care is probably more important for frail aged people than for younger age groups as they are less able to travel long distances.

3.1.2 Issues
The major problems relating to workforce in rural and remote areas revolve around:
• supply, i.e. being able to attract and retain sufficient numbers of each workforce category;
• developing and maintaining skills, i.e. ensuring that the various workforce categories have the necessary range and depth of skills to provide the services required; and
• professional isolation, i.e. inadequate support networks and inadequate continuing education; this issue extends to other aspects of working conditions expected by professional staff, such as education of their children and access to recreation opportunities.

A number of recent initiatives have been taken to address these issues and it is timely to review the appropriateness of these approaches and their potential outcomes in aged care.

3.1.3 Recent Training Initiatives

■ General Practitioners
Perhaps even more so than in metropolitan areas, general practitioners play a central role in aged care. Issues of rural general practice are being addressed through the Rural Health Care Task Force established by the Australian Health Ministers’ Advisory Committee (AHMAC). A National Rural Health Strategy is to be prepared for AHMAC by March 1991, following a Rural Health Conference to be held in Toowoomba in February. One session of that Conference is to address issues of aged care, including the role of general practitioners.

A number of other recommendations made by AHMAC were to be implemented immediately. These initiatives include the development of training programs for general practitioners, involving the Royal Australian College of General Practitioners and Rural Doctors Associations together with the specialist colleges and post-graduate medical committees. Consideration should be given to the development of programs in geriatric medicine and related aspects of aged care
in this framework. The provision of training in conjunction with the work of geriatric assessment teams may be one option. The rural vocational training stream being developed within the Family Medicine Program provides further options.

**Nursing staff**

It is widely recognised that community nurses in rural and remote areas require a wide range of special skills to meet the varying, and at times exceptional, demands that are placed on them. The nature of their work and high community expectations can cause considerable stress for nurses in rural and remote areas especially where they are the sole health care provider. The Council of Remote Area Nurses of Australia (CRANA) has drawn attention to these issues through a study of nursing practices and educational needs of remote area nurses.

The National Nursing Consultative Committee (NNCC), a ministerial advisory body, has recently been asked by the Minister to advise him on these issues. A project is to be undertaken to examine current nursing practice in the field, to identify regulatory and industrial impediments to enhancing the role of nurses practising in rural and remote settings, and to identify the educational requirements to equip nurses for this advanced role. The NNCC's response will be based on research funded through the Department and managed by nominees of the organisations represented on the Committee. The Steering Committee for this project includes representatives of CRANA. It is expected that the Committee will report to the Minister on this issue in November 1991.

**Training for residential care and HACC staff**

Two major initiatives have been taken to provide training for personal care staff in residential care and for HACC staff. The Training and Resource Centre for Residential Aged Care (TARCRAC) has been established at the Queensland University of Technology and is developing modules for in-service training. A feature of TARCRAC's activities that is particularly relevant to rural and remote areas is that all the modules will be delivered through distance education and will include resource materials. A further development would be to have a TARCRAC consultant specialising in supporting the modules in rural and remote areas.

A similar training package for HACC staff has been developed at Deakin University, a recognised centre for distance education. The HACC Training Package has been field tested in rural settings and includes a rural area case study.

The self-contained module approach taken in both these training packages facilitates their use in rural and remote areas. It also has the potential to incorporate special modules on topics such as the ethnic aged, older Aboriginal people and remote communities, so that the packages can be tailored to particular settings.

**Rural Health Skills, Education and Training Program**

The program will provide increased resources for the education and training of a range of rural health workers. In 1990-91, $1m will be provided for consultation and development work. In addition, $5m will be available annually for the program from 1991-92. Details of this program will be decided in consultation with the professions concerned and State and Territory governments.

Input from aged care services to the consultation and development stage will be required to ensure their training needs are recognised.
**Staff of DCSH**
The Department has developed a consultancy brief for the development of a training package to address the socialisation and acculturation problems which arise for DCSH staff when they first encounter a country town or remote area ethos. The first stage of this consultancy, needs identification, has been let to the University of New England’s Distance Education Centre.

**Relationships between service provision and training**
Two factors in the relationship between service provision and training warrant special consideration. First, a number of more specialised aged care services that have been introduced in recent years can serve as centres for training. These services enhance the overall working environment for all aged care workers, and training can further these benefits. For example, the contribution of Geriatric Assessment Teams, with a range of professional staff, in overcoming isolation of individual practitioners can be extended by using them as a base for in-service training. A similar “seeding” role might be taken by hostels with special dementia care programs.

Second, the requirements of the Training Guarantee Levy mean that providers will be seeking more local training opportunities. While many service providers are non-profit organisations and so are exempt from the levy, there are growing community expectations that all organisations will give attention to the training needs of their staff and service providers have shown a willingness to become involved in this aspect of aged care. If provision for training can only be met by sending staff to other areas, the benefits for rural and remote areas will not be fully realised.

**Research**
Nine research projects concerned with the health and community services workforce in rural and remote areas have been funded under the Health and Community Services Research and Development Grants Program (RADGAC). These projects cover issues relating to recruitment practices, health service provision, educational needs, support services and evaluations of innovative projects specifically designed for rural and remote areas. Although none of these studies focuses specifically on the aged care workforce, the findings will have implications for these workers and could lead to further research.

Another avenue of research is the evaluation of services, and a number of these projects are underway in rural and remote areas. Evaluation of the Community Options projects should yield information that will be useful in further program development.

**Planning and Service Delivery**

**Needs based planning**
Planning services for communities in rural and remote Australia involves developing strategies for directing resources to those in greatest need. To give maximum effect to resource allocation, planning strategies depend upon the adequacy of needs assessment and the availability of relevant data. Key indicators commonly employed in needs based planning may be inadequate or inappropriate for the assessment of need in rural and remote Australia. The definition of financial disadvantage, as noted above in discussing access to residential care, is a case in point. The priority accorded to different needs is likely to differ both
within rural and remote areas, and between these areas and metropolitan areas, and these priorities have to be established through local consultation as well as by means of data analysis and other techniques.

Needs assessment is highly dependent upon the availability of data. A major problem facing DCSH is the inadequacy or absence of data on the presence and degree of need throughout rural and remote Australia and on the provision of health and welfare services on a regional basis.

The Kununurra Conference identified the need for information on:
- the needs of individual communities;
- the resources available to meet these needs; and
- the factors that influence the rate and direction of change in rural and remote communities.

The RaRA Unit is developing a remote areas information base that is to include demographic and other statistical data and information on service provision. In the context of needs based planning, this data base will assist in planning services to achieve access and equity objectives of aged care programs and in monitoring these outcomes in the provision of residential care and HACC services to rural and remote communities.

The population dynamics of small areas, in some cases undergoing rapid growth or steady decline, also need further attention. Research undertaken at Flinders University has provided reliable local area population projections for South Australia and Victoria, and the ACAC Review has recommended that be developed on a consistent basis for all States and Territories.

3.2.2 Program support
Planning of services in rural and remote areas cannot assume that the same level of infrastructure will be available as in metropolitan areas. Several examples can be given. Public transport is often inadequate or completely unavailable. Staff housing rarely has to be provided by urban services but this is not uncommon in rural and remote areas. Filling positions when staff take leave may be difficult as there is not a pool of skilled labour to draw on, and considerable disruption to services may occur when staff vacancies cannot be filled without long delays. While technology is increasingly overcoming some communication problems, the cost can be high for small services.

These kinds of shortcomings in program support mean that planning in rural and remote areas has to take into account a range of factors additional to those which have to be considered in metropolitan areas. The implications for costs of program support are readily apparent.

3.2.3 Flexibility in service delivery

- Flexible service structures
Rural and remote areas often lack elements of the social infrastructure that is readily available in metropolitan areas and assumed in program structures. Program responses often have to develop ways of compensating for these shortcomings, and in doing so, build on other potential advantages of local settings.
The wide range of size and spread of rural and remote settlements, and their diversity of social and economic characteristics further means that there is no single model of service delivery that is suitable for all areas. Attention needs to be given to relationships between the level of services that can be provided in larger centres and those suited to smaller centres so that the "best" combination of services can be achieved.

There are potentials for tension here between the efficiencies of co-location whereby some centres may gain several services while others lose, and the need to maintain some basic services in all centres. Many of the kinds of services required for aged care are such basic services; meals services and day care, for example, serve relatively small areas and populations. If these services are not locally available, the options for care recommended by assessment services and preferred by older people and their carers can be unduly limited.

Improved transport has undoubtedly reduced the barriers of distance in many cases, yet it is older people who may miss out on these gains because of their lack of access to private transport. Further, the Isolated Patients Travel Assistance Scheme (IPTAS) is perhaps less relevant to older people than younger people, as in contrast to trauma or acute care which may only be available at selected locations to which the person must travel, much aged care is more routine and assessment and planning of on-going care most appropriately takes place in the person's normal environment.

History plays a major part in the present structure of services in rural and remote areas. For example, small country hospitals which no longer offer significant acute care have come to accommodate nursing home type patients. While the legacy of services from the past is not always appropriate to present needs, communities are understandably cautious about change, the outcome of which may be not be clear until well into the future.

Cross border issues
State borders pose artificial boundaries through service regions in many rural areas, and especially in remote areas of central Australia. While some mechanisms have developed for dealing with these issues in more closely settled areas, they have yet to develop in remote areas.

A workshop was held in Alice Springs in December 1990 to address issues of servicing 19 remote communities in the border areas of South Australia, Western Australia and the Northern Territory. All the communities regarded Alice Springs as their service centre, and problems arose in dealing with distant State administrations.

There are no residential care facilities operating in these remote communities, and integration of HACC services and modified residential care services was seen to offer the most appropriate approaches to providing services. A key consideration in achieving positive outcomes for older Aboriginals is enabling them to remain in their in their own community. However, the division of administration of HACC between the Commonwealth, two State and one Territory Government posed considerable difficulties in achieving this development.

Evaluation of service delivery
In recent years experimental models of service provision to rural and remote areas
have been trialled. Such developments include:

- case management/brokerage models of service delivery;
- rural outreach programs;
- the employment of Aboriginal liaison staff;
- Aboriginal outreach workers;
- mobile services;
- multi-service units such as Geriatric Assessment Teams;
- multi-purpose services; and
- a number of evaluations are underway to measure the effectiveness of these services. The role of these formal studies in future service development is usefully complemented by on-going local input to established advisory committees for HACC and residential care.

Community consultation provides a third source of input on the experience of these new approaches to service delivery. The Consumer Forums for the Aged are also reporting on developments. One particular issue the Forums have identified is the need for flexible arrangements for respite care in rural and remote areas where family carers may require relatively long periods of respite, possibly up to six weeks at a time, if they are travelling to capital cities. It has also been noted that the respite care has a different meaning for older Aboriginals and Torres Strait Islanders and involves different care provision.

- **Environmental issues**
  While environmental problems affect all Australians, some are particularly prevalent in rural and remote areas. These include natural hazards such as fire and flood, with evacuation posing particular difficulties for older people.

  Environmental conditions also pose problems for the design and operation of aged care facilities. For example, air conditioning in residential care facilities could avoid problems associated with extremes of temperature, but at the same time can cause problems for those with respiratory conditions. Alternative solutions, such as specialised building design, may be more satisfactory. Other difficulties can arise with the supply and storage of drugs.

- **Outcome standards**
  Flexibility in the application of outcome standards may be required in recognition of the special circumstances of services in rural and remote areas. This is not to claim exception from outcome standards, but rather to emphasise the relevance of standards. For example, some attention has been given to the need for hostel outcome standards to take account of cultural practices and preferences in monitoring services for older Aboriginals and Torres Strait Islanders.

  Accountability requirements designed for large scale providers can sometimes be onerous for small agencies, and again while not avoiding proper accountability, flexibility is needed in applying these procedures.

3.3 **Management Issues**

In addition to the staffing issues already discussed, a number of other management issues affect service delivery as service structures rely heavily on the quality of available support. Disruptions in developing and maintaining effective support can arise because of:

- poor communication and limited understanding of central policy goals;
poor translation of policy into practice; and
instability of membership of advisory groups and management committees.

3.3.1 Flexibility in Administration

Program administration
Problems in program administration arise when national administrative guidelines and program boundaries are not readily applicable to services in rural and remote areas. These difficulties have most frequently been raised in relation to program funding, and variations have recently been made to capital funding of residential care facilities in recognition of higher costs of construction, as noted above, but higher operating costs are still at issue. Examples frequently cited are the higher costs of vehicle maintenance and the high cost of specialist materials, such as cleaning agents, that may only be required in small volumes.

Management of services
Increasing management expertise is a feature of many health and community services. Rural and remote areas may be disadvantaged not only in attracting suitably qualified staff, but in having to adapt standard procedures to local circumstances.

Where small scale services face problems of financial viability, managerial viability is often a compounding problem, and reducing overheads becomes a key incentive for co-ordination of services. Promoting exchanges between rural and remote service providers could assist in the development of management guidelines based on their experiences and which could then be tailored to individual local circumstances. The evaluation of Community Options Projects should give some indications of the scope for change here.

3.3.2 Community involvement in service management
A traditional strength of rural and remote communities has been the involvement of residents in their local services, ranging from fund raising to serving on management committees. A number of factors have markedly reduced the capacity of some communities to sustain these roles. Country women in particular are facing increasing pressures in balancing their community support roles with demands of workforce and family roles.

At the same time as strong local identity can add to the support of local services, it can act as a barrier to rationalisation which may threaten the autonomy and independence of local services and committees. Adherence to established ways of doing things can also inhibit adoption of new service delivery models. The fragility of community based management committees for services in mining towns and other settlements which have a high population turnover has been noted as a particular problem. In company towns there may also be problems associated with determining how far the responsibilities of the company extend in service provision, and where community management is preferable.

Aboriginal and Torres Strait Islander communities are developing yet another set of community management structures. The evolution of these structures and approaches to their on-going support will be taken up in the Discussion Paper on care of older Aboriginals and Torres Strait Islanders.
Conclusion

As in many areas of health and community services, development of policy for the provision of aged care services in rural and remote areas involves interaction between experience of programs on the ground and the refinement of policy guidelines. Consultation with local communities is an essential part of this process. The diversity of communities in rural and remote areas adds an extra dimension to this communication.

The first five years of the Aged Care Reform Strategy have facilitated a number of new approaches, and these have been taken up in rural and remote areas. Examples of the ways in which programs have become more responsive to the needs of rural and remote communities include:

- modifications to the Geriatric Assessment Program in the Northern Territory to cover all age groups;
- the inclusion of specific strategies for rural and remote areas in the State Strategic Plans guiding the growth of general HACC services;
- the planning and implementation of localised Community Options Projects;
- revisions to capital funding of residential care facilities and attention to the development of residential care appropriate to older Aboriginals and Torres Strait Islanders;
- the development of Multi-purpose Centres; and
- the establishment of the Rural and Remote Areas Unit as a vehicle for on-going policy development.

These specific initiatives have developed in a wider policy context that is recognising that different approaches are needed in rural and remote areas. The social and economic fabric of these areas is also changing, and improved services for care of the aged can complement other health strategies to enhance rural and remote communities not only for their older residents but also for other age groups.

While there have been advances in the planning and delivery of aged care services, outcomes have only been realised on a limited scale to date. Much further development is required before adequate and appropriate aged care services are generally available in rural and remote areas. The Community Consultations to be held in the course of the Mid Term Review of Aged Care provide an opportunity to review the progress that has been made and to canvass options for further development.

This Discussion Paper has drawn on a wide range of source material and identified three sets of issues requiring further consideration: workforce and training issues; planning and service delivery issues; and management issues. It has only been possible to address these issues very briefly and in general terms. While these issues provide a broad framework for further discussion, consideration of options for resolving these and other issues that may be pertinent to particular communities will involve much further consultation and input from service providers and consumers from communities across rural and remote Australia.

Case Studies of Service Development

To illustrate the range of developments that have occurred in the last five years, as documented in the second section of the Discussion Paper, four case studies were presented by individuals who had first hand involvement. These case studies and the presenters were:

The Toowoomba Geriatric Assessment Team:
Dr. Kathy Kirkpatrick, Chief Medical Officer.
General Practice:
Dr. John Gillett, Miles, Qld.

Developing Aged Care Services in a Country Hospital:
Mrs. Julie Wilsch, Board Member, Loxton Hospital, SA.
The First Multi-Purpose Centre – Avoca, Victoria
Ms Margaret Dawson, Nursing Officer, Victorian Bush Nursing Association.

Discussion

A summary of questions and discussion follows.