Volunteers

As a volunteer based organisation we have genuine concerns about the lack of understanding of the role of volunteers in community care and the apparent dismissal of their importance by bundling them with informal carers in the Issues Paper (p25)

This is not to dismiss the role of informal carers. They are the largely unrecognised and badly supported framework of the care system. Most struggle with lack of resources, information and not enough breaks from their caring roles. We support any improvements to the life of informal carers.

Most volunteer based human service providers know that the term volunteer is a salary classification and their volunteer workforce are trained professionals who operate within the same statutory and regulatory frameworks as paid workers. Peak bodies such as Volunteering Australia and the NSW Centre for Volunteering will have statistics, guidelines, standards, recommendations and policies about volunteers involved in the aged care sector.

In this submission we would like to show how our volunteers deliver service in a rural and remote area of the Far South Coast of NSW. We are a HACC funded service that provides 28900 meals, 4731 hours of social support, 7913 hours of centre based day care and 1520 hours of respite to people who are frail and aged, have disability or are carers. We achieve this with a paid workforce of 4.5 FTE and 280 volunteers.

As an organisation we have worked hard to establish, train and maintain our volunteer base. We believe that our business is to recruit, train, support and recognise volunteers to provide direct care. This direct care takes the form of home delivered meals (hot, chilled or frozen), assisted shopping, shopping buses, community access, social clubs, a community cafe, respite, a fishing bus, and home visits. Because of our policy of recognition of volunteers as valued professionals we have adequate volunteer numbers and no major difficulties with recruiting. We also deliver training to other volunteer based services in the Bega Valley and Bombala Shires. Our Board of Directors are volunteers.

This level of professionalism does not come cheaply. Being a rural and remote service provider our volunteers travel approximately 70,000 klms per year within the Bega Valley Shire. It is our policy to reimburse our volunteers fuel according to the provisions within the SACS award (currently $0.57/klm). This policy is one of the reasons we are able to maintain our volunteer base, because no volunteer needs to be out of pocket unless they choose to forgo this reimbursement. Our budget for volunteer fuel reimbursement is $50,000 per annum, which is approximately 10% of our funding. Volunteer training is allocated $2000 per annum from HACC funding and whatever small grants e.g. CDSE or Volunteer Small Equipment Grants we are successful in obtaining. Apart from an orientation for all new direct care volunteers, each year we deliver non-accredited training packages in

- assisting people with a dementing illness
- recognising elder abuse
- grief and loss
- stress management
- privacy and confidentiality
- diabetes

- challenging behaviours

This enables our volunteers to deliver high quality care within the bounds of our funded target group and also enables them to recognise when our service users needs have increased and a higher level of service or re-assessment may be required.

We welcome the NSW Government report into red tape reduction, especially anything regarding the portability of volunteer police checks. These police checks are now no longer paid for by ADHC but have become our financial responsibility with a patently inadequate payment of $300 to cover these costs.

It is our belief that the current cohort of the early aging 55-70 year olds will be the next group of volunteers for us. Aged care volunteering tends not to be attractive to people until they have some experience of need and services available through family or friends. "Baby boomers" tend to be very community service oriented, so will probably volunteer in large numbers. They will expect professionalism and good communication from organisations or will take their offer of volunteering to somewhere else.

In conclusion to these comments on volunteers we would like to emphasise that without the proper recognition of the role of volunteers and the commitment to funding their support, training and management, community based care for older Australians will suffer.

Are the aged care services that older Australians require available and accessible?

Availability and accessibility are two different things.

Services are often available but people are unsure as to how to access them. Our organisation receives several calls a week from people who need basic information and think "Meals on Wheels will know". This is something that we are not funded for but are happy to assist with, but at a cost to our workloads. People often tell us that the information is just not "out there", but it is our experience that there is plenty of information available - the issue is that people who need the information do not know where to start looking for that information. The uptake of the Carelink database in rural areas is poor.

1300 and 1800 numbers are viewed with suspicion in rural areas because they believe (and often rightly so) that they will be speaking to someone from out of the area who has only limited knowledge of what is available on the ground. The move towards centralised access and referral points of entry will only exacerbate this. We have made comments on access points elsewhere in this document.

Competitive tendering, which has resulted in statewide or national agencies winning tenders, has lead to services being unavailable or poorly supervised in rural and remote areas. Local service providers are then requested to provide information or assist with service user backgrounds to these larger out of area agencies, again something we are not funded to do and effects our workloads. One area of concern, particularly with national contracts e.g. DVA yard and garden maintenance, is the lack of service the further from the cities people live. The Bega Valley Shire has had no DVA gardening contractor for 3 years, and no-one will subcontract, because the hourly rate after the agencies administration fee has been taken makes it unprofitable for a contractor to accept the work.

Are there gaps that result in the loss of continuity of care?

There are not enough CACPs or EACH and EACHD packages. We believe there is too big a gap between people whose needs are low to moderate and people who are assessed as being CACP eligible.

Apart from Homecare there are often no HACC services available to people who still want community access. Volunteer based transport and social support is limited to people with low to moderate needs. Paid care workers for transport and social support, even if just assisted shopping, would allow more community access, socialisation, reduced risk of depression and prevent falls. NRCP guidelines allow care workers to provide out of home respite for the frail aged. HACC funded respite allows in home respite only.

A continuum of CACP based care 2/4/6hrs per week may provide a better scale of care.

Is there sufficient emphasis within the current system on maintaining a person's independence and on health promotion and rehabilitation?

The service system is fragmented and very broad, especially the interface between the health system and community based care.

Episodic and short term case management works well to integrate people from the health to the HACC system, but there are not enough hours or packages such as COMPACs available

Phone based case management for "quick and dirty" multi referral (say no more than 3 low to mod needs, e.g. Meals On Wheels, Community Transport, Domestic Assistance could save families from negotiating the system themselves.

The wellness or re-enablement model has been part of the Victorian HACC system for several years. For service users this may be a better model for providing choice and the possibility of leaving the HACC system if possible. Service users once in the system tend to stay, and this leads to dependency, lack of choice and an emphasis on their failings.

How well does the aged care system interface with the wider health and social services sector?

The silo mentality between residential care and health and community care causes concern for our organisation, especially for people entering residential care and receiving residential respite.

Interface with service providers is often not taken until Community Care service users are at the door of these institutions, either discharge or admittance. There is a lack of comprehension by health based services about timelines for community care organisations to establish or restore service to people discharged from hospital or returning to their homes from respite.

Should there be greater emphasis on consumer directed care in the delivery of services and would this lead to more choice?

Consumer directed care can lead to more choice for urban service users. The choice is often limited in rural areas as there may be a limited supply of service providers available.

Consumer directed care cannot be an excuse to cost cut. Services need to be aware of potential risks that people may fall through the cracks because of inability to make a choice for themselves or others.

Services will need to be trained in supporting consumers to direct their own care.

It is likely that consumer directed care is going to happen anyway – baby boomers will demand it, vouchers will make consumers vote with their feet. Self directed funding may lead to aged care consumers making private arrangements with individual carers and leaving the service system all together. The user pays concept is also ingrained in next generation of aging, who may be prepared to subsidise their own care for better result. Service providers will need to come up to scratch to attract business.

Objectives of the aged care system

High quality affordable appropriate health and aged care

Choice and seamless, timely transitions

All this is possible with right level of funding, especially issues of quality and timeliness.

Quality is not negotiable, it is always a priority.

Choice as a priority should not be decided by private income.

Choice cannot just be yes or no I want/ can afford that service.

A voucher system will allow people to choose from several agencies if they desire and where these are available.

Better communication between human service agencies is essential. This needs to be formalised through networks, co-ordination groups and interagencies. However these groups only work if they are funded and supported and have good facilitation.

Broader conception of care and disability policy more appropriate than present system? Aged Care part of the continuum

Ageing is more than failure and disability– even younger people with disability don't define themselves as their condition. There is more to ageing issues than mobility or loss of function.

Some aged care service providers could benefit from the huge developments that disability policy and practices have made in human rights, especially around the issues of choice, dignity of care, advocacy and provision of a wide range of services.

P20 Self directed care – provision of vouchers

How will a voucher based system ensure small NGO's (repeatedly shown to deliver more cost effective service than either government departments or for profit providers) still get to keep their market share?

Glossy promotion from national or multinational service providers with large promotional budgets could sway consumers more than quality of service. A transparent accreditation system which is accessible to consumers, e.g. the schools performance website, may be one solution.

P23 Roles of different levels of government

Will the announced changes in government roles benefit aged care users and improve the administration of the aged care system?

The proposed COAG model looks like providing another layer of bureaucracy, not less. Bureaucracy always means more masters for service providers and therefore more paperwork. This means funds are switched from service provision to administration – our service users miss out.

Aged care services users will not particularly care who is funding their care. Most people only care about service that works for them.

Common system entry points. Community Options access points trial has been running for over 3 years with no results released to date. Service providers in rural areas expect there to be problems with shallowness of assessment, consumer resistance (locals will still call their local Meals on Wheels office or Community Transport). There are concerns that self selecting out of the service system may occur with common system access points if service users are from CALD or ATSI backgrounds, developing a dementing illness or have a general distrust of speaking to someone from out of the area (rural & remote areas in particular).

Common system entry points are popular with governments because they appear to save money and over-servicing. Are these entry points then really just a way to ration care?