Department of Infrastructure and Regional Development

Review of Aged Care in the Indian Ocean Territories

Final Report

February 2015

AHA Australian Healthcare Associates
Australia's largest specialist health and community care consultancy

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List of abbreviations

Abbreviation	Definition
AHA	Australian Healthcare Consultants
CBR	Community Based Respite
C(K)I	Cocos (Keeling) Islands
CI	Christmas Island
HCP	Home Care Program/Packages
IDC	Immigration Detention Centre
IOGTA	Indian Ocean Group Training Association
IOT	Indian Ocean Territories
IOTHS	Indian Ocean Territories Health Service
MPS	Multi-Purpose Service
NFP	Not-for-profit
NRCP	National Respite for Carers Program
PHC	Primary Health Care
WA	Western Australia

1. Executive summary

The Department of Infrastructure and Regional Development contracted Australian Healthcare Associates (AHA) to conduct an aged care review of the Indian Ocean Territories (IOT).

The IOT comprises the external territories of Christmas Island and the Cocos (Keeling) Islands. The ageing population, combined with the isolation of the territories and unique governance arrangements, underpinned the Department's decision to review current and future aged care needs.

This report presents the findings and options to inform future decisions relating to aged care services on the Islands.

The stated objectives of the project were to:

- Evaluate the current services and facilities in the IOT

- Assess the aged care needs of the IOT community

- Engage stakeholders including the community to understand their expectations in relation to aged care services

- Evaluate the current capacity and feasibility of the Indian Ocean Territories Health Services (IOTHS) to deliver on the needs and expectations of the IOT community

- Evaluate the services and facilities provided in comparable remote communities

- Evaluate the potential for not-for-profit and private sectors to be involved in delivering aged care services, and the incentives required to generate interest

- Evaluate current aged care/health programs and grants and their applicability to the IOT

- Provide options or models of aged care service provision suitable for implementation in the IOT.

In late May 2014, AHA sent two highly qualified and experienced senior consultants to Christmas Island (CI) and the Cocos (Keeling) Islands C(K)I to undertake the IOT aged care review on behalf of the Department of Infrastructure and Regional Development. The key findings and options for addressing the aged care needs of the IOT communities are presented below.

1.   Executive summary

Finding 1: There is a need for community and aged care services that is currently not being met. The lack of data collected and reported by the health service limits the ability to accurately quantify unmet need at this stage.

Recommendation 1a: Examine the existing needs of individuals by undertaking holistic, person centred and home based assessment of all at risk aged community members. Investigation of community unmet needs should take into account community factors that may be having a negative impact on the health and well-being of the older population.

Recommendation 1b: A comprehensive range of community-based services should be implemented so, like comparable remote communities, IOT residents can access services to maintain wellness and independence. These services should be sensitive to ethnicity and culture and allow people to age in place where possible. The range of services provided is determined by their care needs as they move through each of the stage of the ageing process and access services along the continuum of care.

Recommendation 1c: Information collection processes should be reviewed to ensure more reliable data is collected and reported.

Finding 2: There is scope to better align the current health service model provided and the availability of community and aged care services with those provided in comparable remote Australian communities.

Recommendation 2: The aged care service responses should include a balance of acute, sub-acute, residential (including respite) and community based services in order to meet the range of care needs of the IOT communities. The services to be provided should be person centred and reflect the changing needs of the population as they age.

1.   Executive summary

Finding 3: There is an opportunity to better utilise existing resources, staff and facilities to support the aged population in the IOT.

Recommendation 3a: An increased engagement and development of the existing relationship between the IOTHS and WA Health should be prioritised. Consideration of a specific memorandum of understanding between the IOTHS and a specific WA Health Service should be considered to better support patient transfer and provide a consistent pathway for referral, consultation and patient follow up.

Recommendation 3b: A review of the current IOTHS services, staffing EFT, workload and flow, expenditure and reliance of mainland services is required. A cost benefit analysis of the current service model could identify cost savings which could be directed to the provision of community based services.

Recommendation 3c: A review of all visiting allied health and medical specialist services should be conducted as part of an IOTHS review. Improvement in access to allied health specialists in the IOT is needed to reduce the time community members are required to spend on the mainland following acute treatment (allied health services to include: physiotherapy, occupational therapy, dietetics and podiatry). The implementation of telehealth should also be investigated.

Recommendation 3d: Additional workforce requirements need to be considered particularly to support the provision of basic home support type services. Training programs (eg Cert III Aged and Home and Community Care) should be investigated with the IOGTA to build local workforce capacity.

Finding 4: Communication between all levels of government, the IOTHS and the Administration could be enhanced to support more effective planning and provision of preventative, public health, community based aged care.

Recommendation 4a: Governance arrangements should be reviewed to ensure planning processes are coordinated to avoid gaps and duplications occurring.

Recommendation 4b: A planning and development framework for aged care service provision and allocation is required to guide future decisions. This framework should consider how all key stakeholders will contribute to the plan for aged care. This planning should also consider the needs of community members requiring disability and palliative care services.

Recommendation 4c: Planning decisions should consider options for caring for people in an appropriate setting. This may mean flexible care beds that could be utilised for aged care in the hospital or medical centre if required within a model similar to MPS.

Recommendation 4d: Planning decisions should take into consideration the current workforce capacity and capabilities through a training needs analysis.

1.   Executive summary

The IOT communities need a systematic approach to aged care that addresses the ageing continuum and that is not reliant on particular staff. This approach should reflect the location of the IOT (and associated difficulties) and the cultural mix of the population. The residents of the IOT deserve to feel safe as they age and have surety that they will be able to stay in their community with appropriate care available.

The implementation of community-based services should be the main priority at the present time.

2. Background and context

The Indian Ocean Territories (IOT) is an external territory of Australia, comprised of Christmas Island and the Cocos (Keeling) Islands. The territories have a unique geography, history, culture, and governance structure, which present a number of challenges and considerations for the design and delivery of aged care services.

2.1.   Geography and history

Christmas Island is a 135 square kilometres island located 2,650 kilometres north-west of Perth.

The Cocos (Keeling) Islands consist of two atolls and 27 coral islands, of which two, West Island and Home Island, are inhabited. The islands are located approximately 900 kilometres south south west of Christmas Island, 2,950 kilometres north-west of Perth, and 3,700 kilometres west of Darwin.[1]

The history of Home Island provides insights into the problems of communication, education, and health and other services provision, particularly for older people.

2.2.   Administrative arrangements

The IOT is administered by the Commonwealth through the Department of Infrastructure and Regional Development. State-type services are provided by the Western Australian government under Service Delivery Arrangements with the Commonwealth.

2.3.   Demographics

This section provides an overview of the population of the IOT, in order to provide contextual information for the examination of the findings of the review and better understand the recommendations.

Overview

The total population of the IOT is approximately 2,622 people.

The 2011 census recorded a total population of 550 people in C(K)I with approximately 80% (440 people) of the population residing on Home Island, and 20% (110 people) on West Island.

The West Island community is small and predominantly comprised of English-speaking government workers who are well educated and who return to the mainland at the end of their contracts (typically two to three years).[2] Due to the transience of the population, West Island is not a significant consideration in this assessment of aged care services and therefore, the majority of our observations about the aged population of C(K)I relate to Home Island.

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[1] http://www.regional.gov.au/territories/Cocos_Keeling/index.aspx
[2] http://www.regional.gov.au/territories/cocos_keeling/enviro_herritage.aspx#pop

2. Background and context

The Home Island community is predominantly made up of Cocos Malay people, the majority of whom speak only the Cocos Malay language.

According to the 2011 census data, the resident population of CI is 2,072 people. The ethnic composition is predominantly Chinese, Malay, and Caucasian. Christmas Island demographic data does not include those in the Immigration Detention Centre (IDC).

Language and literacy

A high proportion (15.2%) of the people on C(K)I do not speak English, 73.3% speak Malay at home compared with only 23.8% who speak English at home. Around 37.2% of people on Christmas Island speak English at home; 20.3% speak Malay; 17.4 % speak Mandarin; and 10.3% speak Cantonese at home.

Education, employment and income

Many of the older people on the C(K)I finished school at around 12 years of age. This may have impacted on their literacy and makes many aspects of health education difficult to convey. Now, many of the younger residents of the IOT go to the mainland for post-secondary education and employment.

On the C(K)I, the unemployment rate is higher and the workforce participation rate lower than the Australian average. Personal income for people on C(K)I is lower than the Australian average.

On CI, the unemployment rate is low, however, the proportion of the CI population employed in health care and social assistance sector is about **half** the national average.

3. Methodology

3.1. Key steps

AHA has completed the following steps to meet the objectives of the review:

1. **Initiation**: A teleconference was held with nominated Departmental representatives to discuss objectives, timelines, logistics and site visits.

2. **Off-site data and document review**: Available IOT background information and documentation was reviewed and the lack of data available was discussed with the Department. The aspects reviewed were:

    - Population demographics and background, including cultural considerations
    - Aged care models in comparable communities, including communities with:
        ~ Similar geographical characteristics (islands)
        ~ Population size
        ~ Health expenditure
    - Models and levels of aged care service provision. The strengths and weaknesses of different models were considered
    - Potential for not-for-profit and private sector involvement
    - Evaluation of current grants and programs for aged care and health.

3. **Development of tools for stakeholder consultation**: Four different sets of questions were developed for: community members (general); carers; care provision management/administration; and staff delivering services.

4. **Plan and implement a range of information gathering strategies**: A range of information-gathering methodologies were used to meet the stated objectives of the review. A wide variety of views were obtained from IOTHS management, the Administration, IOT Shire representatives, the IOGTA management and the general community.

    Interpreters were used where needed, and questions were modified appropriately for people with low levels of health literacy.

3.   Methodology

3.2.   Methodological considerations

There were several issues that impacted on the review:

3.2.1.   Data availability

The lack of available data was a significant constraint in the conduct of the review.

Gaps in quantitative health and community service data has meant we were not able to quantify the number of people potentially requiring aged care services in the IOT.

3.2.2.   Stakeholder engagement

The IOT is composed of small, close knit communities and most people seemed to know the aged care review was in progress. Stakeholder engagement was excellent. We were conscious of meeting as many people who wished to speak with us as possible.

On C(K)I we spoke to 72 people (55 community members and 17 health care/administrative workers).

On Christmas Island we spoke to 76 people (61 community members and 15 health care/administrative workers).

Excellent – and often spirited – contribution to the focus groups and interviews by community members and other stakeholders allowed us to reach thematic saturation.

3.2.3.   Future options

It was challenging to evaluate services and facilities provided in comparable remote communities. The vast distances over the sea, the unique funding and cultural context of the IOT mean that while some aspects of other remote communities are comparable, others are not.

The small population means that only a very small number of people would require aged care services at any time. This and the isolation of the IOT would have a significant impact on whether any private provider would consider service provision as financially feasible.

We were able to evaluate the current capacity and feasibility of the IOTHS to deliver on the needs and expectations of the IOT community to some extent.

Current aged care/health programmes and grants were examined to ascertain their ability to assist the IOT in meeting its population's aged care needs.

4. Community aged care needs and expectations

This section provides an overview of community life on Home Island and Christmas Island so that the issue of aged care may be understood in context. We look at the social and cultural considerations such as community engagement and leadership; employment; home and family life.

4.1. Community needs and expectations

4.1.1. Community engagement

Based on interviews with individuals and groups, our impression is that there is an overwhelming sense of social inertia and boredom among the older members of the IOT community, especially on Home Island.

There are very few organised, meaningful and purposeful activities for seniors in the IOT, with the exception of an exercise group on CI and C(K)I, and an arts and crafts group on C(K)I. Older people who do not participate in these groups are not engaged with their community in any formal way.

Key concerns

Home Island C(K)I

Older community members reported significant worry about what will happen to them as they age. Most are scared of having to be medivaced to Perth where they would be alone or face huge costs to accommodate a family member close to the hospital or nursing home. One woman told us (through an interpreter), 'they can throw me in there, to the sharks [gesturing towards the sea] rather than send me to Perth'. This sentiment was strongly echoed by many of the people we spoke to on Home Island. It was common to hear 'I was born here, worked here, raised a family here and I want to die here.'

Christmas Island

Focus group participants expressed frustration and anger over the lack of community-based services, and their expectation that they will be transported off the island towards the end of their life. The people we spoke to feel powerless and are worried about what will happen to them in the future.

Community leadership

Home Island C(K)I

Generally speaking, the Cocos Malay people are a quiet 'unassuming' population. A number of the older people we spoke to indicated that they were not really able to take the lead and make a difference for themselves.

4.   Community aged care needs and expectations

Christmas Island

There are a small number of community leaders that do the best they can to advocate for their communities, but there is a pervasive feeling there is no point continuing to talk about the problems; solutions are needed but are not forthcoming.

Community members expressed concern about the Shire of Christmas Island, and some people felt the shire should be a stronger advocate for the people of CI.

The communities expressed frustration about the government's lack of response to community concerns, noting that 'there have been many consultations in the past but nothing has happened as a result'.

4.1.2. Employment

It was evident that there is a significant issue relating to employment in the IOT, particularly for young women. This issue is most pronounced on Home Island.

The Indian Ocean Group Training Association (IOGTA) and the Centrelink officer also reported that many people are under-employed or are 'hidden' unemployed, i.e. they have not been able to find work despite looking for a considerable length of time and have consequently assumed other roles such as caring for family.

4.1.3. Home and family life

In the IOT, it is traditional for three generations of a family to live in the one house. While some members of the community see this as acceptable, other members of the community reported that such arrangements are often less than ideal for older residents, as there is no peace or relief from family life. In addition, older people are sometimes used as carers for young children, even though they may be frail themselves.

We were advised during the consultations that some older people on both the C(K)I and CI and would prefer to live in smaller self-contained, ground floor accommodation that is close to their family and community but afforded them respite from the busy extended family life or removed the need to negotiate stairs.

Non-working women on C(K)I are typically expected to do the work of caring for the elderly and people with disabilities. Traditionally, the youngest daughter was expected to provide care for older or disabled family members; however, more young women now leave the island to pursue mainland studies and employment leading to the potential for greater need for formal care services in the future.

4.1.4. Community expectations

Our observations and discussions with health professionals confirmed the lack of community services and the lack of knowledge in the community about the range of options that could be made available to them. The vast majority of community members on Home Island and many on Christmas Island did not have any concept of the range of 'community services for older people' available in comparable remote communities.

4. Community aged care needs and expectations

Infrastructure and physical facilities have a significant impact on the physical and mental wellness of older people, and can have an enhancing or detrimental effect.[3]

4.1.5. Housing

During the consultation process, it became apparent that many of the presenting aged care issues are intertwined with housing issues in the IOT.

In the C(K)I there are no small houses, or any vacant houses (of any size) resulting in people having no option but to live in multi-generational situations.

There are currently 100 houses on Home Island, arranged in about five streets around the centre of the town where the public buildings are located. Much of the housing on CI is older three-storey flats which have a staircase at one end of the buildings and no lifts or ramps.

We were told of several families where people either had to stay with another family member or friend who lived on the ground floor, or be carried up and down the stairs, including the story of one man, who, for years, carried his disabled adult son up and down the stairs on his back. Waiting lists for ground floor housing are very long.

On CI, there are smaller flats, but due to a housing stock shortage, if a person requires a ground floor flat due to illness or general frailty, this is most often, not possible.

Many of the residents we spoke to reported that the lack of alternative housing is a problem for older people, and that there is a need for smaller unit type accommodation that older people can move into. Residents we spoke to felt that purpose-built independent living units or flats are needed for older people's safety, security and quality of life.

Further investigation of housing options for the future should be undertaken, keeping in mind access for people with mobility issues.

4.1.6. Communication

There are a number of issues related to communication in the IOT, including both technological infrastructure, and language and literacy barriers.

Communication with house-bound people on Home Island is problematic, door-to-door communication methods must be employed to reach these people. The level of English proficiency reported in the 2011 census was higher than we observed amongst the older people we spoke to in the IOT.

Telephone and internet services are reasonably reliable on Christmas Island but there is little technology uptake amongst senior citizens. Television and radio is in English and is unreliable, and internet use is extremely low in the community overall, but particularly amongst the older residents.

Although we visited each community facility and the hospital we did not see any health information that was translated from English.

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[3] Caltabiano ML, Byrne D, Sarafino EP (200*) Health Psychology: Biopsychosocial Interactions. An Australian perspective. (2nd Ed.)(Milton: John Wiley & Sons Australia Ltd.

5. Review of current services

This section identifies and reviews the current services for older people in the IOT, including both clinical services and community-based services.

5.1. Indian Ocean Territories Health Service (IOTHS)

The Commonwealth's Indian Ocean Territories Health Service (IOTHS) is responsible for delivering health care services on Christmas Island and the C(K)I. This section provides a brief overview of the IOTHS workforce and services. The health service budget is approximately $20 million per year.

5.1.1. Health workforce

There is one doctor, two registered nurses and two health workers on the C(K)I. All personnel divide their time between Home and West Islands. The two nurses are rostered to provide a 24-hour telephone service.

There are usually three or four GPs on Christmas Island at any one time. The CI nursing staff are all hospital-based, and the hospital provides a 24 hour service with two nurses rostered on at all times to ensure that patient emergencies can be accommodated. The actual number of inpatient beds days was not available, but staff indicated that inpatient bed days are low and that there are often no inpatients.

Very few home visits are performed by staff in the IOT. When needed, a very limited palliative care service can be provided. Aged care respite services are not provided.

There are no resident allied health professionals on the IOT, the only access to these services is through the visiting health professional program. The lack of resident allied health staff is not in itself problematic and it is in line with many other remote communities. The issue, which will be discussed later in this chapter is the lack of availability of allied health professionals either through the visiting specialists program or via telephone or telehealth service provision.

General practitioner ratios

There are currently four GPs on CI and one GP on the C(K)I and this is considered to be the optimum number by the members of the health workforce interviewed. The four GPs on CI have the equivalent of 518 patients each compared to 885 patients for doctors in other remote areas of Australia. Similarly on the mainland, GPs have the equivalent of 700 patients each.

The one GP on the C(K)I has a complement of 550 patients compared to 885 patients in other parts of remote Australia. [4]

The numbers of GPs on CI are adequate and the ratio of GPs per patient is higher than the average in other remote communities.

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[4] ABS Australia's Health Workforce. 4102.0 - Australian Social Trends, April 2013,
http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20April+2013#p5

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5.   Review of current services

5.1.2. Visiting professionals

We were told by health service staff that there are planned four day visits by specialist health professionals every 3-4 months. However, residents informed us and IOTHS staff confirmed, that these visits often do not occur. A variety of reasons for the lack of visits were provided by IOTHS including practitioner availability and willingness to make the journey to a remote location.

Considering the well-equipped health service, complement of staff, hospital bed availability and infrastructure, it appears that a larger range of services could be provided within existing resources. In other parts of remote Australia there are teams of allied health professionals available to respond once there is more than one referral to a particular location. However, it is recognised that these locations may not be as isolated as the IOT and may have transport arrangements which allow ready access to the location.

The impact of no resident allied health practitioners and rescheduled visits includes:

- spectacles may take months to be organised.

- obtaining dentures is problematic, and we heard stories of some people flying to Malaysia to get dental work done.

- minor injuries may have longer recovery times if not properly rehabilitated. Function or mobility may be adversely impacted in an ongoing way.

- Podiatry services are important for older people, particularly those with diabetes. We observed many people who had not had recent access to podiatry services.

5.2.   Reviewing aged care service provision in the IOT

A simple but effective way to assess the services provided to a community is to look at care as a continuum over a particular life stage. This works particularly well in aged care as the progression people experience with the process of ageing often involves staying healthy and preventing illness for the longest possible period and decreasing the impact of the decline in health over time.

The following aspects of aged care services are examined in this section:

- Staying healthy and preventing illness

- Obtaining assistance to maintain independence (even when illness is having an impact)

- Managing chronic disease well to limit its sequelae

- Minimise periods of hospitalisation

- Obtaining and accepting increasing levels of assistance as the ageing and disease processes continue and accelerate (the role of the IOTHS and travelling to access care)

- End of life care.

Whilst IOT residents experience the same sorts of issues as all other Australians as they age, there are some particular issues associated with staying healthy and preventing illness that warrant discussion.

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5.   Review of current services

5.3.   Healthy ageing and illness prevention

Preventive medicine (including screening) has become an increasingly important aspect of public health models that seek to prevent or reduce the burden of illness in an ageing population and limit the associated cost.

In line with these philosophical underpinnings, the Royal Australian College of General Practice (RACGP) Guidelines for Preventive Activities in General Practice suggests that older people should have several general preventative strategies in place, initiated by their GP:

- Older people should have appropriate immunizations

- They should also be regularly screened for falls risk and physical activity levels.

- Eye testing and dementia screening should be undertaken[5]

We are unable to verify whether these activities are being undertaken in the IOT. The lack of data was a continual issue and made assessing the clinical care provided to older residents by the IOTHS particularly problematic.

The only preventative strategy we saw for older people in the IOT was the Otago program[6] strength and balance exercises that are conducted with some of the aged population. Nurses on C(K)I have recently started doing some regular aged care health checks for the elderly but it is unclear what this entails.

5.4.   Obtaining assistance to maintain independence

As the ageing process continues and the impacts of chronic diseases become more problematic, it is important that people are supported to remain as healthy and active as possible and are able to live in a safe environment modified for their needs.

In the IOT, the vast majority of care is undertaken by family carers in the care recipient's home. It is unlikely this will change, however it is likely in the future, there will be more people who are not able to rely on family for all of their care needs. Many of the younger residents are leaving the islands for education and employment opportunities. In addition to the obvious difficulty with patient care, this situation is reportedly leading to intergenerational conflict in some circumstances.

5.4.1.   HACC/Home Care services

While very small amounts of home care services are provided from time to time by the IOTHS, more advice about how a person may obtain these services should be provided. There is no personal care or domestic assistance, no referral or assessment for care, or care planning.

The doctor and the nurses we spoke to on C(K)I thought that HACC-like home care services would improve the health and well-being of older and/or disabled residents, but said they were doing as much as possible for these people.

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[5] Royal Australian College of General Practice (RACGP) *Guidelines for Preventive Activities in General Practice* (8th edition), http://www.racgp.org.au/your-practice/guidelines/redbook/
[6] Otago Home Exercise Program.
http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/publications_promotion/prd_ctrb1 18334.pdf, accessed 23 Sept 2014.

5. Review of current services

5.4.2. Carer stress

There are currently a number of families on C(K)I providing care for increasingly dependent elderly family members. These carers reported feeling stressed by their caring roles. This stress is compounded, for some community members, by the responsibility of caring for different generations at the one time. Some women have reported having to relinquish paid work to look after elderly family members, and some frail older people are also engaged in looking after young children.

Currently, the only service available to support carers in their role is home modification undertaken under the guidance of the IOTHS by the Shire, and some equipment loaned to residents by the IOTHS. No other support such as residential, home or community based respite, such as day services, are currently provided to carers of the aged.

5.5. Managing illness and avoiding hospital

In *Section* 5.3 we discussed the apparent lack of preventive care being provided to older IOT residents. These issues were also apparent in the general clinical care review that was undertaken. We were told of – and were able to observe – several instances where clinical care of older IOT residents is sub-optimal. However, it should be noted that in the absence of reliable clinical data to evaluate clinical care it is not possible to definitively comment further on the management of chronic illness or clinical care.

5.6. Travelling to access care

5.6.1. Medical, surgical and rehabilitation care in Perth

Patients are transferred to Perth for medical and surgical care and specialist opinion and review, which is broadly consistent with arrangements in other remote communities across WA. All transferred patients who are either medivaced for acute illness or flown to Perth for planned appointments on commercial aeroplanes have to stay in Perth for the duration of their treatment as there are no follow-up services available in the IOT. This causes considerable financial stress as accommodation costs on the mainland are high and the government subsidy provided under these circumstances ($60 per day) does not cover the expense.[7] Although hospitalised patients do not face accommodation expenses themselves, any person accompanying them will have to pay for motel accommodation if they do not have friends or relatives to stay with.

Considering the staffing and infrastructure in the IOT, it is our view that people could return home to the IOT to continue to convalesce and rehabilitate much earlier than they reportedly do at the present time.

A formal comparison of rates and duration of transfer to the mainland should be undertaken with the IOT and a community which is of a similar size and in a similar remote location.

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[7] Under the Patient Assisted Travel Scheme (PATS) eligible patients are subsidised $60 a day for commercial accommodation; this increases to $75 if they are travelling with an approved escort. (http://www.wacountry.health.wa.gov.au/index.php?id=628)

5. Review of current services

5.6.2. Aged care services

We were advised that members of the IOT community have moved to the Australian mainland or to Singapore or Malaysia for aged care services. This has both social and financial impacts. Socially, leaving a close knit community which people have called home for many years has a potentially significant effect on people's wellbeing, social connection and links to family. The expense involved in shifting to the mainland or another country is clear. As the majority of IOT citizens are Australians (70% on CI and 93.8% on C(K)I), aiming to maintain residents in Australia and preferably on the IOT is preferable. In similar remote communities on the mainland, when home based care is no longer suitable, the primary aim of care provision to older people would be to keep them close to their home and family utilising either an aged care facility if available or a flexible care option such as a Multi-Purpose Service.

5.7. End of life care

There is currently no palliative care or end of life service operating in the IOT, and nurses report that there has been no professional development in aged or palliative care. People are either transferred to Perth for end of life care or they stay in the home and have some (albeit minimal) support from the IOTHS nurses. Many times during the course of the consultations, people expressed the need for a 'nursing home' on their island. On further exploration, this phrase was a proxy for things such as 'I have lived all my life on this island, I want to die here and how will that happen if I have no family to care for me?'

5.8. Concluding remarks

AHA observed a need for aged care that is not currently being met. Increased community based care such as domestic assistance, respite (both in home and centre based), transport, assistance with meals and medications, and personal care services are needed.

5.   Review of current services

Finding 1: There is a need for community and aged care services that is currently not being met. The lack of data collected and reported by the health service limits the ability to accurately quantify unmet need at this stage.

Recommendation 1a: Examine the existing needs of individuals by undertaking holistic, person centred and home based assessment of all at risk aged community members. Investigation of community unmet needs should take into account community factors that may be having a negative impact on the health and well-being of the older population.

Recommendation 1b: A comprehensive range of community-based services should be implemented so, like comparable remote communities, IOT residents can access services to maintain wellness and independence. These services should be sensitive to ethnicity and culture and allow people to age in place where possible. The range of services provided is determined by their care needs as they move through each of the stage of the ageing process and access services along the continuum of care.

Recommendation 1c: Information collection processes should be reviewed to ensure more reliable data is collected and reported.

6. Comparable communities

One of the objectives of this review was to utilise information from comparable communities on the Australian mainland or islands. The intention was to inform the discussions about the service system and aged care in the future.

6.1. Health care in rural and remote Australia

Humphreys and Wakerman suggest that, while many rural and remote communities will never have access to the range of medical services available in urban areas, this 'should not be a matter of major concern, so long as rural and remote Australians have adequate access to appropriate high quality primary health care services as and when they are required.'[8]

The authors go on to identify a number of impediments to providing adequate primary health care (PHC) services in rural and remote locations.

Humphreys and Wakerman argue that remote service models should be flexible, and focus on ensuring key service requirements and community needs are met. This often requires systemic changes, such as:

- Flexible service models designed to maximise access to appropriate, comprehensive PHC
- Financing to resource communities independently of workforce availability
- Service focus on health promotion and early intervention
- Multidisciplinary teams that maintain strong medical input
- Adequate infrastructure to support an appropriate medical and nursing workforce; and
- A mechanism for monitoring progress against agreed indicators and targets, ensuring quality and accountability for all players.[9]

Implications in the IOT

Several of the problems identified in the above work impact on the ability of the IOTHS (as it is currently configured) to provide good quality services to the older population of the IOT islands, namely:

- The islands are isolated due to their distance from both the Australian mainland and tertiary health services
- It is an external territory with a unique legislative structure
- There are two levels of governance on the islands, with health services provided by the Commonwealth and through a Service Delivery Arrangement with WA Health
- The unique population and history of the IOT.

Many of our recommendations for meeting the needs of the aged community in the IOT in the future align with the work of Humphreys and Wakerman.

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[8] Humphreys J & Wakerman J. *Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform*. A discussion paper.
[9] Humphreys J & Wakerman J. *Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform*. A discussion paper.

6.   Comparable communities

6.2.   Comparing the IOT to other communities

Candidate comparison communities were examined for closeness of fit with the IOT in terms of population size, remoteness, and, in some cases, health expenditure. In general, the communities were found to lack comparative closeness, however some aspects of the models could be applied to the IOT.

6.2.1.   Results and discussion

Examination of the available data from comparable communities did not reveal a consistent pattern in service delivery across communities. Some communities had purpose-built aged care facilities and some had a multi-purpose centre with aged care beds funded under a more flexible model.

Similarly, population size was not necessarily a predictor of facilities – a community with a small population size may have a large number of aged care beds while a larger community may have no aged care beds. For example, in Halls Creek, with a population around 1,500 people, there are 21 high-care residential aged care beds, whereas in Exmouth, with a population of 2,000 people, there are 3 high-care beds and 8 community care packages. The most likely explanation for the differences in bed numbers and configuration of services is that some small towns act as a central hub with a 'catchment area' of communities in their geographical vicinity.

Utilisation of comparator communities to draw conclusions about service need in the IOT is useful and valid, but to a limited extent. There are several reasons that comparing mainland communities to the IOT is fraught with difficulty. The population structure in the IOT is different to mainland remote communities. In general, Aboriginal and Torres Strait Islander people are the major group of people residing in remote locations on the mainland. Their particular health and aged care needs are quite different to those of the IOT population in that they have high levels of chronic illness and are considered eligible for aged care services from the age of 50 rather than the age applicable to the non-indigenous community, 65. This age acknowledgement of poor health and the need for aged care services at an early age means that many more services are required in these areas than would be expected in the IOT (where there is a negligible Aboriginal and Torres Strait Islander population). For this reason, it is not possible to effectively use the comparison sites and drawing parallels may lead to erroneous conclusions. A unique solution to the aged care issues in the IOT needs to be developed.

A further complication encountered when comparing the allocation of aged care beds and packages on the mainland and the IOT is how aged care beds and packages are allocated by the Commonwealth Department of Social Services (previously by the Department of Health). The allocation process is legislated in the *Aged Care Act 1997,* and is based and dependent on the age and the size of the population in particular catchments. A compounding factor is that Commonwealth funded aged care services can only be delivered by "Approved Providers", the *Aged Care Act 1997* legislates the requirements for providers. Also a factor is the availability of approved providers in a given location, this compounds the difficulties when examining or predicting the location of aged care beds. This may be one explanation for there being large numbers of residential care beds in some locations (disproportionate to the population of that town), and fewer in other areas.

It is also important to take into account the fact that family caring is generally preferred in the IOT and the health services are geographically located in the centre of very small populated areas.

6. Comparable communities

Notwithstanding the difficulties outlined above, four towns were selected as comparators for the IOT as they had been previously found to have similar health expenditure to the IOT.[10] Of the four towns, one town (with half the population of the IOT) had no aged care services. The other three had between three and 26 high-level care aged care beds available and some low-care services in place. Of these three towns, two had around half the population of the IOT.

A further 19 towns were considered as potential comparator communities based on their population size or having been selected as comparators for the IOT in previous work. The following towns were selected based on comparable population size and remoteness; Fitzroy Crossing, Halls Creek, Exmouth, Ceduna, Esperance and Shark Bay.

All of the towns selected have aged care and/or home care packages available. These range in complexity from general and level 2 packages combined with three aged care beds at Exmouth, through to 84 residential aged care places at Esperance. All communities except Shark Bay have at least low-care services, and three of the six communities have designated respite beds.

King Island has a population of around 1500, two resident GPs and a small number of nursing and allied staff. This includes a Child and Family Health nurse, two Community Health nurses, a Health Promotions Officer, a Specialist Rural Worker, a private psychologist and a private physiotherapist. King Island District Hospital and Health Centre provides a Multi-Purpose Centre with six acute care beds, eight high care and six low care residential aged care beds. The centre also coordinates the delivery of a broad range of community services, visiting service and support groups such as community nursing, child health, dental services, ante-natal clinics, alcohol and drug services, home help, personal care, a home maintenance service, a Day Centre and telehealth services.

Although the examination of comparative communities does shed light on the services provided in similar communities, the exercise makes it clear that the IOT requires a unique solution that takes into account the needs of the community and the available workforce and infrastructure.

Most of the comparable communities had access to aged care beds and/or community-based service provision. At the moment, older IOT residents and their families are experiencing difficulties due to the fact they do not have these supports in place.

There is an unmet need for aged care services that suit the population, geography and the cultural needs of the IOT communities. The IOT population's ethnic origins provide different challenges to other remote places in Australia.

Finding 2: There is scope to better align the current health service model provided and the availability of community and aged care services with those provided in comparable remote Australian communities.

Recommendation 2: The aged care service responses should include a balance of acute, sub-acute, residential (including respite) and community based services in order to meet the range of care needs of the IOT communities. The services to be provided should be person centred and reflect the changing needs of the population as they age.

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[10] Commonwealth Grants Commission, *Report on Indian Ocean Territories 2007*, p.30

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7. Assessment of IOTHS capacity

One of the aims of the review was to assess the capacity of the IOTHS to deliver aged care services in the IOT. This chapter outlines our observations of the IOTHS and the enablers and barriers to the delivery of aged care services within the IOTHS as it is currently configured. We believe that health service reconfiguration is needed. The comments in this section particularly reflect that basis for the assessment of capacity.

7.1. Infrastructure and management

The IOTHS has excellent physical facilities that could provide a base for reorientation of the services currently provided to include aged care services. On each of the inhabited islands of the C(K)I there is a medical centre that is well equipped to deal with emergency situations and has enough physical space to provide other services. The CI hospital was built in around 1995 and has had extensions since this time. It is a bright, new looking building with excellent amenity. These assets stand ready to support the changes needed in the care of the ageing populations of the Islands with very little need for refurbishment.

Responsibility for the health service has reportedly shifted between government departments every few years, and IOTHS management reported that the continual shifting of responsibility compounded the issues associated with planning. Based on the consultations and our observations, perhaps the major barrier to implementation of a new service configuration is that there is an emphasis on providing health services within the hospital environment. There is no health service board to guide service delivery and the IOTHS has no plans for a coordinated approach to screening, health promotion, chronic disease management or aged care.

Service planning and provision and the need for service reorientation are hampered by several factors that require management leadership. There are significant issues with data collection, and no reporting or requirement to submit even basic throughput data to any governing Board, funding body or Department. The C(K)I Health Service does not currently produce any reports for the IOTHS administration on Christmas Island. Professional development is currently provided in an ad hoc manner. Coordinated effort in these areas would enable changes to be made based on the latest evidence about community need and best practice provision of community based care.

7.2. Professional relationships and care provision

There is a formal Service Delivery Arrangement (SDA) arrangement between the Australian Government and WA Health covering the provision of advice and training to the IOTHS and a programme of visiting specialists. Referrals are also made to specialist services in WA. This provides obvious benefit, but there is also a need for more localised links with a specific health service on the mainland that would be beneficial to IOTHS staff and patients.

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7. Assessment of IOTHS capacity

There are few (if any) pathways of care or protocols to follow. Telehealth and regular formalised links to another service on the mainland are non-existent. It was reported by health professionals interviewed that telephone advice is rarely obtained (access to mobile phone coverage is very limited but non-mobile services are available). The GPs working at the IOTHS reported not having regular or planned communication with professionals on the mainland for secondary consultation, advice or support.

Clear pathways of care would support consistent patient care; referral and follow up processes. A reliance on personal connections becomes problematic when staff changes occur. The existing SDA relationship is at a State and Federal level, there is a need for an ongoing relationship between the IOTHS and a mainland health service with tertiary or quaternary facilities. Such a relationship would improve access to services which may help reduce the need for patients to be transferred to the mainland.

7.3. Health service culture

Despite observing a clear need for health and/or community services among the people we spoke to and visited, we were surprised that there was not a strong emphasis placed on screening and early intervention activities. With the generous numbers of medical and nursing staff there are clear opportunities for more outreach, screening and early intervention activities to occur. These activities would allow for a better understanding of individual needs in the community and assessment of service gaps.

The cultural and social background of many of the IOT residents contributes significantly to the older population's reluctance to ask for services or understand what is available to them. Building strong relationships with the community is necessary to overcome some of these cultural inhibitions while ensuring people have access to the service they need.

AHA's observations and consultations informed the view that a small number of aged residents in the IOT require community based care at the present time. AHA visited or heard about approximately eight people who are in need of varying levels of assistance at the moment; however we suspect there is a larger number of people who would benefit from support services.

Older people who have young relatives or someone else to advocate for them appear to be much more involved and likely to access services than those who do not. Health service staff believes that clients would come to them if there was a problem and there was no need for home visits by doctors (and only rarely by nursing staff from the hospital). Despite claims that the IOTHS offers a broad range of acute and community-based health programs through a Primary Health Care model,[11] we observed no evidence of such a model operating. We concur with findings from the Joint Standing Committee on the National Capital and External Territories report from 2004, which states 'there are shortcomings, especially in community nursing resources and public health generally'.[12] These short comings have

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[11] https://crana.org.au/members/corporate-members/indian-ocean-territories-health-service/ accessed 10 June 2014

[12] The Parliament of the Commonwealth of Australia. *Indian Ocean Territories. Review of the Annual Reports of the Department of Transport and Regional Services and the Department of the Environment and heritage*. Joint Standing Committee on the National Capital and External Territories. August 2004 Canberra. Chapter 6 (section 6.22)
http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=10&ved=0CFYQFjAJ&url=http%3A%2F%2Fwww.aph.gov.au%2Fparliamentary_business%2Fcommittees%2Fhouse_of_representatives_committees

7. Assessment of IOTHS capacity

been exacerbated over the past ten years as the resident population ages, and this trend will continue in the future unless the issues are addressed.

Strong leadership will be needed in the future to effect cultural and attitudinal change.

> **Finding 3:** There is an opportunity to better utilise existing resources, staff and facilities to support the aged population in the IOT.

> **Recommendation 3a:** An increased engagement and development of the existing relationship between the IOTHS and WA Health should be prioritised. Consideration of a specific memorandum of understanding between the IOTHS and a specific WA Health Service should be considered to better support patient transfer and provide a consistent pathway for referral, consultation and patient follow up.

> **Recommendation 3b:** A review of the current IOTHS services, staffing EFT, workload and flow, expenditure and reliance of mainland services is required. A cost benefit analysis of the current service model could identify cost savings which could be directed to the provision of community based services.

> **Recommendation 3c:** A review of all visiting allied health and medical specialist services should be conducted as part of an IOTHS review. Improvement in access to allied health specialists in the IOT is needed to reduce the time community members are required to spend on the mainland following acute treatment (allied health services to include: physiotherapy, occupational therapy, dietetics and podiatry). The implementation of telehealth should also be investigated.

> **Recommendation 3d:** Additional workforce requirements need to be considered particularly to support the provision of basic home support type services. Training programs (eg Cert III Aged and Home and Community Care) should be investigated with the IOGTA to build local workforce capacity.

8. Models of care

This chapter provides the results of our examination of the applicability of the different aged and community care programs currently operating in mainland Australia, to the IOT. We acknowledge the unique legal and governance arrangements that apply to the IOT as an external territory. Whilst this discussion focusses on specific aged care programs funded outside the Department of Infrastructure and Regional Development, it is the service aspects of the programs that are of importance whilst the nuances of the funding arrangements are beyond the scope of this report. It is important to note that our observations support the idea that a reorientation of the model of care provided by the IOTHS is the major issue. With a health service budget of $20 million per year, we suggest it is most likely possible to achieve the desired improvements in care provision in the community without the provision of additional funds.

When we discuss Home and Community Care (HACC) services, Home Care Packages (HCPs) of service, Multi-Purpose Services (MPS) and Centre Based Respite (CBR) in this section, it is the service provision relating to these care models rather than the funding associated with them that is important. We will refer to these services as they would be operationalized in the IOT as the funding model would be different, as HACC-like, HCP-like, MPS-like and CBR-like services.

8.1. The case for community-based care in the IOT

It is our view that there are currently no HACC, HCP, MPS, CBR or similar services available in the IOT. The possibilities of working collaboratively with the not-for-profit (NFP) sector and the IOTHS to begin to address this issue will be explored in *Section 8.1.6* of this report.

Implementing HACC-like services, with a view to the future need for HCP-like services would alleviate much of the concern and stress relating to aged care in the IOT community, and it is likely that that implementing general HACC-like services now would alleviate the need for HCP-like services in the short- to medium- term. In the near future, the IOT would be able to commence building a case for a small number of HCP-like services (the number would be determined by an assessment of the population by qualified aged care assessors).

Flexibility in the health service should be developed so that in-hospital care is available if needed. This should cover high and low care needs and particularly be utilised for respite, stabilisation, rehabilitation and palliative or end of life care. This would be a valuable addition to the community.

8.1.1. Flexible care

Flexible care arrangements are the most likely viable option for utilisation in the IOT to meet the needs of the small but ageing population. In other parts of this report we have discussed the need for the provision of alternative accommodation for older people who can continue to live independently with community care assistance. Once community based care becomes too complex, the older person will need to move to a residential service of some sort, this could be accommodated within the IOTHS.

The type of flexible care that is most relevant to the IOT is the Multi-Purpose Services (MPS) arrangement.

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Multi-purpose services (MPS)

It has been recognised for some time that the traditional hospital structure and models of care have needed to change to better reflect the needs of rural and remote communities. These models are typically client-focussed, responsive to the community's needs, and offer better integration of services.

On the mainland, each state has their own model for flexible care however each includes the 'pooling' of both state funding for acute health, community health services and commonwealth funding for aged care services. This offers opportunities to integrate a range of health services, including acute care, sub-acute care (including respite and palliative care), emergency, allied health, oral health, primary health and community services. MPS are primarily located in small rural hospital settings, where MPS providers are state governments.

In the case of the IOT, the IOTHS would be responsible for service provision. The flexibility inherent in the program enables response to the specific needs of each community and allows for change as the community's needs change.[13] Typically in a MPS, some beds in a traditional hospital are allocated and funded as 'aged care beds', this can include high care, low care, respite, transitional care. There are also acute care beds, emergency or urgent care beds. The community care program includes basic home care services and can also offer packages of care delivered in the community. If aged care beds are not required, the funding can be utilised to provide more community based care. If a resident of an aged care bed becomes ill they do not have to 'move' but can be cared for within the same facility by the 'acute' care team.

A very important requirement in all models of MPS service provision is robust service planning and community support. This allows the health service to reconfigure services to better meet local health needs and to provide staff with flexible work-setting options across a range of services.

As an example, the objectives of the MPS delivery model in NSW are:

- Improved access to health and aged care services available in the local community
- Increased service co-ordination through integration, innovation, and flexibility in the delivery of health and ageing care services
- Improved economic viability and cost effectiveness of service delivery
- Improved community participation in the planning of local health and aged care services.

An MPS-like model would be a suitable model to provide for the needs of the aged residents in the IOT.

8.1.2.   Respite services

The absence of a respite service to relieve the burden carried by carers is a high priority issue identified by carers during the consultation process. In the future, it is important that respite services are seen as a high priority in the IOT. In particular, the following services are required:

- In-home respite services
- Centre based respite (CBR)
- Residential/facility based respite.

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[13] Productivity Commission, *Report on Government Services* 2014, Chapter 13, p.7 (13.7)

8.   Models of care

In-home respite services may involve the provision of care in the home or community environment. For example, staff or volunteers provide care for an elderly person in the home, take them shopping or on an outing whilst the primary/usual carer does their own shopping or leisure activity.

Centre based respite typically runs on a varying number of days per week, with the elderly person attending for a day or part of a day, meals are often provided. A program of activities is designed to meet the specific individual care and support needs of the older people who attend. The new aged care room at the IOTHS on Christmas Island, and the cyclone shelter on Home Island (to move to the Senior Citizens Centre when it is built) would be suitable venues for this type of respite.

Residential/facility based respite would be provided by nursing staff or care workers in the hospital/medical facility environment. This type of respite can be for one night, a weekend or for several weeks. This may be in situations where the usual carer is unwell or needs a longer physical break from their caring role.

8.1.3.   Solutions – Indian Ocean Group Training Association (IOGTA)

The Indian Ocean Group Training Association (IOGTA) is federally funded to provide access to vocational and group training, and part of its remit is to provide skills development and work opportunities for unemployed people.

The IOGTA ran a 'work for the dole' pilot program on Home Island in 2013 to train young women in health assistant type work (people on NewStart need to work in order to claim benefits). The program commenced with six women who were trained by IOTHS Registered Nurses (RNs) to visit community members at home and assist them to do the Otago program.

The IOGTA recognised the lack of opportunities for employment as well as the lack of services for older people, particularly on Home Island. The initiative addressed the two issues together and was seen to be a good idea which would provide wide-ranging benefits to older community members and the trainee workers.

The program ran for several months and then ceased due to concerns about insurance and the fact there were no paid positions available for the trainees at the conclusion of the training period. It is worth noting that the program did not include any provision for additional staff and the RNs provided training to the women in the program in addition to their usual daily tasks. Feedback on this program (provided to AHA by the IOGTA and one of the trainees) suggests that this was a worthwhile activity that was well-received by the community on Home Island. It assisted older citizens to socialise, do strength-building exercise, and go for walks accompanied by a worker, while also supporting skill development and vocational training for younger residents.

8.1.4.   Solutions – hospital utilisation

In the future, a small number of people may need to be cared for 24 hours per day in a 'nursing home environment'. The numbers of people requiring this, given that only a very small proportion of older people ever need this level of care is prohibitive to the idea of building a nursing home. There should be a strong emphasis on community based care on each of the IOT islands. Existing hospital/medical clinics should be utilised to provide aged care services (including residential aged care, respite and end of life care). A MPS-like model should be implemented at the IOTHS to allow a person to be admitted into an

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'aged care bed' if needed. Some alterations would be needed to ensure a more 'home like' environment is available in the bed areas to be used for aged care purposes.

8.1.5. Solutions – IOTHS staff

Given the current staffing profile of the IOTHS, there is capacity to provide an aged care response, including community nursing, respite and palliative care services in the person's home and for a limited time (for respite or condition stabilisation) in the hospital or medical clinic/hospital. Community based palliative care models are now embedded in many Australian communities and provide people with a range of options rather than being transferred to Perth in the last stages of their life.

For some staff, further training would be required and formalised links with aged care providers and palliative care specialists would need to be established. In time, a trained health worker workforce could take on many of the roles initially undertaken by members of nursing staff.

8.1.6. Solutions – potential not-for-profit and private sector involvement

There is potential for the NFP sector to be involved in aged care and community care provision in the IOTHS. Investigation should be conducted into the feasibility of contracting a NFP that is currently involved in the provision of aged care services to provide these services and work with the IOGTA in training local community and aged care workers.

The major issue with the involvement of not-for-profit or private entities in aged care in the IOT is the small numbers of people who will require care at any particular point in time.

Consideration of how the model could look requires a strategic lens involving a number of key stakeholders to ensure community buy in and longer term sustainability. A committee formed of IOGTA, a university partner and a NFP could work with the Shire, the IOTHS and the Administration to implement suitable governance, accountability, integration and coordination process should be considered. The implementation and embedding of the new community care model will need to be focused on change management as the medical, hospital centric model of care that currently exists in the IOT will need to move to a more patient centred, community care model.

8.2. Implementation plan

It is important that there is a holistic approach to the development, implementation and monitoring of the reconfigured services that are put into place.

It is reasonable that one community care system should be developed across the IOT; however, there needs to be strong leadership, communication and planning that involves all stakeholders. A community care manager should have the seniority to ensure that there is systematic assessment of the three IOT communities and the needs of their populations and to work determinedly and according to an agreed plan, to ensure community care services for the aged (and disabled) population of the IOT are implemented as quickly as possible in a stepwise manner.

It will also be necessary to make decisions about the utilisation of facilities, funding and human resources to meet community needs.

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Finding 4: Communication between all levels of government, the IOTHS and the Administration could be enhanced to support more effective planning and provision of preventative, public health, community based aged care.

Recommendation 4a: Governance arrangements should be reviewed to ensure planning processes are coordinated to avoid gaps and duplications occurring.

Recommendation 4b: A planning and development framework for aged care service provision and allocation is required to guide future decisions. This framework should consider how all key stakeholders will contribute to the plan for aged care. This planning should also consider the needs of community members requiring disability and palliative care services.

Recommendation 4c: Planning decisions should consider options for caring for people in an appropriate setting. This may mean flexible care beds that could be utilised for aged care in the hospital or medical centre if required within a model similar to MPS.

Recommendation 4d: Planning decisions should take into consideration the current workforce capacity and capabilities through a training needs analysis.

9. Findings, recommendations and conclusions

The section summarises the key findings and options for addressing the aged care needs of the IOT communities.

9.1. Key findings

Key Finding 1: There is scope to better align the current health service model provided and the availability of community and aged care services with those provided in comparable remote Australian communities.

Key Finding 2: There is a need for community and aged care services that is currently not being met. The lack of data collected and reported by the health service limits the ability to accurately quantify unmet need at this stage.

Key Finding 3: There is an opportunity to better utilise existing resources, staff and facilities to support the aged population in the IOT.

Key Finding 4: Communication between all levels of government, the IOTHS and the Administration could be enhanced to support more effective planning and provision of preventative, public health, community and aged care services.

The key findings illustrate the four main areas that need to be addressed to improve aged care in the IOT. A new model for aged care service provision that is community based and person centred is needed in order to meet the current unmet needs of the older people in the IOT. There are opportunities for existing resources to be utilised in different ways to more effectively deliver services. Communication between all stakeholders is required to ensure effective planning and provision of a full range of services to support the needs of community members as they age.

9.2. Recommendations

In response to the key findings, we have developed a set of principles to inform the underpinnings of the recommendations we have provided.

The aims of the recommended 'way forward' for aged care in the IOT:

- People should be cared for as they age to the standard expected in a similar remote mainland Australian community.
- People should be supported in their own homes as much as possible as per their stated wishes.
- To take into account the cultural considerations relevant to the community, noting the community diversity.

9.   Findings, recommendations and conclusions

- To ensure that older people can feel safe to age with the surety that, in most instances, if they wish, they will be cared for and die in their community.

- That a redesigned community based model of aged care in the IOT should support the premise that no one should have to go off-island at the end-of-life unless this is their wish or unless there is an acute emergency situation.

- Care should be available on island for the very small number of people who may need residential aged care.

- Existing facilities and staff can be better utilised to meet the health needs if all members of the community.

Recommendations

In response to the key findings, taking into account the above principles, we have developed a set of recommendations for aged care requirements in the IOT:

- A range of basic services available to meet a person's activities of daily living.

- A Community Care/Aged Care Certificate III training program.

- Aged Care Assessment capability.

- Access to respite facilities.

- A CBR program to ensure older people have access to engaging, meaningful, stimulating activity.

- Formal arrangements between the IOTHS and mainland hospitals and medical practitioners (including arrangements for the provision of telehealth services).

- Case management/care coordination capability that ensures community-based care is delivered as planned. An Active Service Model philosophy that includes, as central tenets, care planning, client-directed care. Implementation needs to be carefully orchestrated and planned to ensure the community is not further disempowered by a 'service provision' mentality.

- Future consideration of housing options on Home and Christmas Islands to ensure the aged and people with a disability have access to suitable housing options.

- Consideration of respite facility options as part of the housing solution.

- Recruitment of nursing and medical staff should include candidates with aged care or community care qualifications and experience.

- A community based care culture needs to be promulgated.

- Consideration of the costs for relatives who go to the mainland to support patients transferred for medical and surgical care and how the impost may be reduced (renting a house may be cheaper than hotel fees. Is there any accommodation available through the hospital?).

- The current IOTHS should be organised as a MPS-like facility so that individual admissions for care that cannot be managed in the community can be facilitated.

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9. Findings, recommendations and conclusions

9.3. Conclusions

The IOT communities need a systematic approach to aged care that addresses the ageing continuum and that is not reliant on particular staff. The residents of the IOT deserve to feel safe as they age and have surety that they will be able to stay in their community with appropriate care available.

We formed the opinion that there is capacity for the IOTHS to provide some services in the future relating to the aged care continuum but the need to change the approach to care from a sickness model to a wellness/health promoting one is pivotal. Contemporary healthcare practice sees a massive shift into the community. Switching the focus from episodic intervention in a crisis to continuity of care, self-management and improving health literacy in the community would greatly benefit the IOT population.

The implementation of community-based services should be the main priority at the present time.

There is already infrastructure in place and adequate staffing numbers to provide the care required, with the exception of a Community Care Manager and community care workers. It is possible that a review of the IOTHS could result in redeployment of some staff to a community health portfolio, and that community care workers could be trained on the islands whilst current IOTHS staff commences the community care service delivery needed.

Improvement in aged care services in the IOT should not be an onerous task. It will, however, require leadership and commitment from a specialist community care practice perspective with a senior person involved in change management. The current health service needs to work closely with the new community care services to ensure a seamless end-to-end aged care service.