Chapter 1
Introduction

Essentially, older people are well, healthy and living fulfilling, independent lives, which represents a significant achievement in its own right (AIHW 1998:82; Schulz 1997:84). Yet, there are many myths about older people, such as that they need 'looking after', 'can't learn', 'are lonely' and 'don't socialise' and are a 'great economic burden' to the health care system. These myths detract from the wisdom and the contribution that older people make to society (NSW Department of Ageing & Disability 2000; Schulz 1997).

While it is a fact that older people make greater use of health care and community services, generally this is because they are living longer and represent an increasing proportion of our population. Some argue that they have a deferred entitlement to the use of these services. Despite concerns to the contrary, there is evidence that suggests that the older population is going to become increasingly healthier, wealthier and politically influential and that handicap and disability in older people is being compressed into the very last years of life (Mathers & Robine 1998).

Aged care services are moving from residential care to home care and care in the community. This represents challenges for the residential aged care sector, as they have to respond to that change while continuing to meet the demand for residential services from an increasing older population in circumstances of capped public funding. Smaller rural communities have to confront the viability of those services they still have and the risk that fragmentation and divided responsibility has to access to services for their older residents.

Compounding the viability of aged care services in small rural communities is the impact of changes to the nature and direction of the full range of community services. Health services that have traditionally met many communities' aged care residential needs in acute care beds in local hospitals are threatened by the heightened debate over Commonwealth-State responsibilities in community service provision and the application of organisational and service delivery solutions by central urban-based government bureaucracies. These commonwealth and state agencies often fail to understand the differences in need

and approach between urban and rural communities, despite research evidence to the contrary (Best 1999:2; Humphreys 1996:13–14; Strasser & Bryant 1999:1).

The lack of a strategic focus on the needs of an ageing population is the result of a number of factors. These include a concentration on the ownership and control of services instead of how best they can be delivered, and a concentration on concepts of integrated care and efficiency performance above measures of fairness and effectiveness. This is particularly the case in small rural communities that are ageing at higher proportions than that projected for the Australian population as a whole. These approaches reflect a centralised corporate management, which often has a focus on efficiency above effectiveness, and on operational issues above future strategy and direction.

This study confirms that older people are living independently in the community, mostly in their own homes, and intend to retire locally in those homes. They would prefer to receive services at home rather than be admitted to a nursing home or hostel. Next to staying at home, the preferred choice is self-care units. A significant proportion do not access services and, when they do, it is the local doctor and the local hospital who they identify as the main points of contact, re-inforcing the central importance of these services to rural communities.

This study also suggests that government and rural communities should see the ageing of the population as a positive opportunity to maintain and increase populations in rural communities. This can be achieved by focusing on the value of older people, becoming older people friendly communities and targeting older people in a variety of ways to ensure their retention and to perhaps increase the population through attracting older people to smaller rural communities.

There is a range of options for how health and aged care services could be delivered in the future with greater co-operation and involvement of, in particular, not-for-profit aged and disability providers. Options include partnerships, joint ventures and amalgamations, as suggested by Ireland (2001), while Koff (1998) proposes co-opted services and integrated systems, the latter also being supported by Alexy and Belcher (1997). Internationally, there are examples of models of care that would be adaptable to the Australian context, such as the On Lok model of San Francisco (Bodenheimer 1999) and the models being developed in Oregon and elsewhere in the USA (Concannon 1995; Robert Wood Johnson Foundation 1994; Roberts 1991) as well as the 'ServiceHouse' concept from Sweden (Asplund 1994).

The research suggests that aged and disability care providers should consider broadening their role and focus into becoming both housing and community service providers. This broader role would allow the delivery and support of a wide range of community services to ensure their future viability, providing better integration of services and strengthening local employment (ACA 2000; Yeatman 1996). This suggests potential for innovative residential aged care development on local hospital sites to, in effect, provide a mini retirement village concept and develop existing housing stock to provide a greater range of housing options.

Older people and rural communities

In this study the term 'rural community' is used widely and is meant to suggest that this includes the general community, local government, chambers of commerce/development boards, and health and aged/disability care providers.

The older population in New South Wales numbers some 1,049,652 people, or 16.8% of people aged 60 years and over. Forty-two per cent of that group, or 439,671, live in regional New South Wales. In the New England region in 1996, older people over the age of 65 represented some 12.4% of the population, compared to 12.6% for New South Wales. By the year 2006, this percentage in New England is expected to increase to 14.9%. In individual communities this percentage will range from 10.2% to 28% of the population in 2006, compared to 14.92% for New England and 13.36% for New South Wales (Wooster et al. 1998).

These projections present both challenges and opportunities for rural communities, care providers and government as well as individuals and families who choose to live and retire in rural communities. The major challenge is how to deliver an appropriate range of services to small rural communities with declining populations. The opportunity is the potential to demonstrate integrated models of care that are innovative and reflect community and personal care needs ahead of organisational and functional responsibilities for service delivery.

This study identifies the major issues facing an ageing population and draws on national and state research data and projections. A household survey over eight local government areas will attempt to identify regional and rural trends and intentions of older people and to contrast those with the state and national trends. The household survey covers a range of issues that include demographic detail, personal household/finance detail, disability levels, retirement and accommodation intentions, as well as service utilisation issues.

Interviews with aged care providers and local government will also attempt to identify and confirm issues, directions and opportunities for rural communities experiencing an increasing population of older people. Conclusions will hopefully be drawn from the research to present options and models for the future direction of care for older people and identify possible opportunities for communities to benefit positively from the increasing proportion of older people.

Rural health and aged care in Australia: The older population in context

In the International Year of Older Persons (1999) and the NSW Healthy Ageing Framework the following themes were developed (NSW Department of Ageing & Disability 1999):

- older people are entitled (if they so wish) to continue in paid employment without discrimination
- learning is a lifelong process open to older people
- older people's wellbeing and health (joy) includes emotional wellbeing and relationships with others, including family and community ties
- all older people, whether healthy or frail, are entitled to be valued and treated with respect (dignity)
- older people are entitled to live their own lives, and to maintain independence and autonomy as they age.

The development of a National Strategy for an Ageing Australia is the Commonwealth Government's response to the 1999 International Year of Older Persons. Included in the terms of reference were the objectives to:

- promote and inform a consideration by the Australian community of the likely impacts of, and possible responses to, population ageing
- consider the impacts of, and potential policy responses to, ageing under four major themes:
  - independence and self provision
  - world class care
  - healthy ageing
  - attitude, lifestyle and community support. (Bishop 1999:1–2)

The Organisation for Economic and Cooperative Development (OECD) (Bishop 1999) identifies the following among seven principles for population ageing reforms:

i. Public pensions, taxation and social transfer programs should be reformed to remove financial incentives to early retirement and disincentives to later retirement.

ii. Job opportunities should be available to older workers who should be equipped with the necessary skills and competencies in this respect.

iii. A move to fiscal consolidation and debt reduction could mean a phased reduction in public pensions and increased contributions.

iv. As a consequence, retirement incomes should be more mixed in their source to provide risk diversification, a sharing of the burden, and more flexibility to individuals over retirement decisions.

v. Health care expenditure should have a greater focus on cost effectiveness, directed to reducing physical dependence and provide explicit policies for providing care to frail older people.

In summary, the background paper of The National Ageing Strategy (1999:vi) suggests that we need to ensure policies that '... maximise the capacity of older people to participate and contribute, through better health, better retirement incomes and more flexible employment and caring arrangements'.

This statement is made in the context that ageing should be about increasing our economic wellbeing and not viewed as an impending burden. The background paper describes health and ageing as big business and a very important part of our economy. The Prime Minister is quoted in the Background Paper (1999:vi–vii) as saying that he had asked the Ministerial Reference Group responsible for the National Strategy to:

> focus on four themes. Firstly, helping Australians to be independent and to provide for their later years through employment, life long learning and financial security. Secondly, delivering quality health care through new approaches to service delivery, coordinated care and independent living. Thirdly, improve attitudes to older people and ageing, lifestyle issues such as personal safety, housing, transport, recreation and community support. And fourthly, encouraging healthy ageing and the role of general practitioners in maintaining the well being of older people.

The background paper (1999:vii) suggests beginning:

> a cultural change that focuses on those less tangible but nonetheless vital elements of a civil society — *a recognition of the experience, wisdom and ongoing contribution of older Australians ... that old age is to be enjoyed and not endured.*

At the 1997 World Congress of Gerontology the participants published a message for world leaders that, in part, stated:

> To more effectively address the challenges posed by this massive global demographic change, we call for a fundamental shift from the traditional narrow perception of individual and population ageing. In almost all policy statements, writings and research findings 'the old', however defined, are distinguished from the 'non-old'. Such arbitrary categorisation overlooks the universality of ageing and the continuous evolution of the experience of ageing in a rapidly changing world. While the main focus in gerontology has been on the later stages of human life we stress the importance of lifelong individual development to achieve successful ageing. (Andrews 1998:3)

The declaration message (Andrews 1998:4) goes on to suggest that:

- Services should encourage and support older persons in maintaining an active and participatory life-style and encourage them to take the lead in pursuing the improvement and maintenance of their own health and wellbeing.
- There is a need to recognise the integral role of the family and other forms of informal social support of older persons.
- Maintenance of individuals in their chosen environment must be the primary objective of care programs for older persons.

The demography of older people

The population of Australia is ageing and the proportion and number of older people is expected to rise substantially. The ageing of the Australian population has been occurring since the early 1970s and the trend is expected to continue for at least the next 50 years. The Australian Institute of Health and Welfare (AIHW 1998:64–65) suggests that:

- Population increases projected for the period 1976 to 2016 are significantly higher for the older population than for the overall population, with rates of increase highest among the very old (ABS).
- Twenty years ago, 9% of the population (1.3 million) were aged 65 years and over.
- By 1996 this had increased to 12% (2.2 million).

- By 2016 it is projected to increase to 16% (3.5 million people).
- In 1976 one in six older people was aged 80 and over.
- By 1996 one in five older people was aged 80 and over.
- By 2016 it is projected that one in four older people will be aged 80 and over.

According to the NSW Department of Ageing and Disability (2000):

- Seventeen per cent of the population is currently aged 60 years or more (1.05 million people).
- By 2021 older people are expected to represent over 24% of the population (more than 1.8 million people).
- By 2041 the number of older people is expected to rise to 2.3 million and represents nearly 30% of the population.
- Forty-two per cent of those over 60 in New South Wales live in Regional New South Wales (439,671 people).
- Eleven point eight per cent (123,800) of people 60 and older are employed in full or part time employment.
- Fifty-five per cent or 572,176 of people 60 and older receive a full or part Commonwealth aged pension.

There were 174,975 people living in the New England region of New South Wales at the 1996 Census and people aged 65 years and over constituted 12.53% of the total population. This compares with 12.74% of people 65 and over as a percentage of the total New South Wales population, as shown in Table 1.1.

It is important to note that this increase in the older population has occurred at a time when the total population of the New England area decreased by 6,170 or 3.4% in the same period.

In the Australian context the population is now ageing quite fast and for the 65 and older population it is anticipated that the proportion will increase from 12% in 1997 to about 18% in 2021 and around 26% in 2051 (Bishop 1999:8). It is noteworthy that a number of the smaller rural communities in the New England region have already reached or are rapidly approaching the 2021 projections.

Table 1.1: Percentage of people aged 65 and over in selected local government areas

Local government area	People over 65 years %	Number	Inter-census growth* %
Barraba	18.8	428	15.0
Bingara	18.62	391	17.4
Manilla	16.76	527	18.6
Quirindi	15.26	743	5.09
Tenterfield	15.15	989	13.5
Glen Innes (Severn)	15.02	1,354	7.2
Inverell	14.77	2,200	6.12
Guyra	13.62	580	11.96
Walcha	13.32	427	7.2
Gunnedah	12.76	1,636	12.05
Nundle	12.74	170	16.4
Tamworth/Parry	12.53	5,870	10.88

*Percentage increase in the number of people 65 and older between 1991 and 1996.
Source: Adapted from New England Area Health Service Demographic Profile 1999.

In Australia, the highest annual rates of growth for the 65 and over age group will occur between 2011 and 2021 when the peak of the baby boom generation (born from the mid 1940s to early 1960s) will enter it. There will also be substantial increases in the number of people aged 85 years or more as a proportion of population, from 1.2% in 1997 to up to 4.8% in 2051 (Bishop 1999:8).

The Robert Wood Johnson Foundation (1994:198) describes a similar situation in the United States of America:

> America's rural communities today contain the Nation's highest concentrations of elderly people. Given the aging of the U.S. population and the migration of young people out of rural communities, this concentration will intensify during the next decade. The elderly make up about 15 percent of the rural population, compared with 12 percent in urban areas. In many rural communities, as many as 25 percent of residents are elderly.

The population age-sex pyramids of this region reflect the significant changes occurring particularly in small rural communities where '... the traditional kind of pyramid with a broad base and tapering top, the world population structure is

evolving into a V-shaped kind of pyramid. The world is literally being turned upside down demographically' (Myers 1997:66).

Health and life expectancy

According to the AIHW (1998:65), gains in life expectancy since the 1960s have been concentrated among the middle-aged and older population and mortality at older ages has fallen dramatically in Australia and in other developed countries. Recent analyses have shown that mortality rates for the very old (80–89 years and 90–99 years) have been declining in a number of developed countries since the 1950s and that rate of decline has been increasing in recent years (Vaupel 1997). Australia's men and women aged 65 years now have around the sixth highest life expectancy in the world, following countries such as Japan, France, Hong Kong and Switzerland. The increase in life expectancy is due to marked declines in mortality among older adults since the 1960s (AIHW 1998).

The majority of older Australians living in the community rank their health as either good, very good or excellent. Just over one third who rated their health as fair or poor were more likely to be in the older proportion of that age group (AIHW 1998:65).

In terms of the planning of future services, it is important to remember that those rating their health as 'fair' or 'poor' are more likely to be from low income or low education levels and from those who are overweight, inactive and smoke. In future generations, with increasing affluence, education and an appreciation of the importance of lifestyle, those who report fair to poor health, and have greater utilisation of services, may be a diminishing group.

It is often said that the increasing older population will present an economic burden to society in general. However, Schulz (1997:82) responds to this assertion by stating that many of the statistics presented in population ageing discussion are worthless in assessing the economic impact of an ageing population and that 'demographic analysis without economic analysis is a kind of voodoo demographics'.

The NSW Department of Ageing and Disability shows that on average men now live to 75 years and women to 81 years. Women who were 65 in 1996 can expect to live another 19.6 years and men 15.8 years. Because women live longer than men, there are 75 men for every 100 women aged 65 and over, and 40 men for every 100 women over the age of 85. There are only 4,345 Indigenous people aged 60 years and over in New South Wales, representing 4% of the Indigenous

population, and only .4% of the total number of people aged 60 and over (NSW Department of Ageing & Disability 1999).

Schulz (1997:82) argues that ageing of populations 'is primarily a product of economic growth and concurrent fertility decline and that this is a force for good'. He stresses that 'the old world of many children, short life spans and little time for leisure and recreation is disappearing, and in its place there will be a new world of fewer children, longer life spans and a more relaxed retirement'.

In considering the potential impact of the older population and the opportunities that population ageing presents, it is worthwhile reflecting on how significant those changes have already been and how dramatic they will be in the future. Mulley (1997:1160) notes that:

- In Greco-Roman times average life expectancy was 20 years.
- By the year 1000 it had risen to about 30 years.
- By the mid-19th century an American could expect to live for 39 years.
- By 1911 the figure was 46 and in 1930 it was 55.1.
- Over the past 100 years the proportion of Britons over 65 has risen from 5% to 16%.
- From 1991–2031 in Britain there will be a 48% increase in those aged 75–84 and a 138% increase in the over 85s.

Today, few would consider the age group 65–74 to be old and that term is now reserved for those over 75, and those over 85 are considered to be of advanced age. The profound change in population structure has more to do with public health measures, and improved perinatal care, than the intervention of drugs, surgery or medical technology. The 'greying of nations' is largely the result of a reduction in premature deaths.

Facts and myths about older people and ageing

The NSW Department of Ageing and Disability (2000) reports that:

- *Despite the perception that older people need looking after*, the majority of seniors live independently and require no assistance with daily tasks. Only 130,890 older people live in residential care facilities, with 95.7% of people 60 years and older living in the community.

- Older people with a disability and living in the community are more likely to receive assistance from a spouse or partner than from formal community services.

- Dementias affect less than 1% of people aged 60–64 and less than 3% of people aged 70–74. The incidence of these conditions increases significantly in people over 85 years.

- Among those aged 60 years and over living in the community, 19.1% percent report needing help with home maintenance, 13.1% with home help, and 10.6% with transport.

- Older people are living longer and at the same time enjoying more years without severe handicap.

The perception that older people are lonely, do not socialise and cannot learn is not supported by the facts that reveal:

- Most retired people are socially engaged and maintain active, independent lives.

- Older people are more likely to participate in activities such as gardening, going to movies, the theatre and concerts, and visiting art galleries and museums.

- In New South Wales, seniors spend $895 million on domestic travel each year, take longer holidays than the general population and 75% of the people over 60 travelled in the last year, with visiting friends and relatives and general pleasure being roughly equal reasons for that travel.

Health and disability

As reported previously (AIHW 1998:67), the majority of older Australians rate their own health as 'good', 'very good' or 'excellent'. Research also suggests that older people in developed countries, such as Australia, are living longer and enjoying more years without severe handicap. The association between age and self-rated health status within the older age group is illustrated by the fact that only 9% of the 65–69 age group rated their health as 'poor' compared to 17% of the 85–89 age group (ACA 2000). Data also show that the major causes of death are diseases of the circulatory system, followed by neoplasms, then the respiratory system, with deaths due to circulatory system decreasing over time and neoplasms increasing.

The NSW Department of Ageing and Disability presents the following facts:

- The most common health problems among older Australians are arthritis, vision and hearing problems, high blood pressure, heart disease and varicose veins.

- In terms of chronic illness, older men are more likely to experience deafness and heart disease. Older women are more likely to have arthritis, hypertension and varicose veins.

- Dementia affects around 6% of people aged 65 and over and by age 85, one in four people is at risk of developing dementia.

- Injuries from falls are a major reason for hospitalisation of older people, particularly for those aged 85 and over. American research suggests that physical frailty affects more than 3.25 million Americans, most over 65 years of age. Frailty is the leading cause of falls and results in 250,000 hip fractures per year.

- Six per cent of people aged 65 and over living in the community experienced at least one of the most common mental disorders during the 12 months prior to a 1997 survey.

- Approximately one in ten people aged 70 and over living in the community may suffer from depression.

- Medication use is more common among people aged 65 and over than any other age group.

International evidence suggests that increases in disability began in the late 1960s and 1970s at a time when mortality rates at older ages began to decline significantly. The increases were confined to the less severe end of the disability spectrum. Studies also suggest that there is no evidence of an expansion of morbidity based on more severe measures of disability prevalence. More recent evidence suggests that disability prevalence rates among older people may be starting to decline and we may be observing the start of compression of morbidity in low mortality populations (Mathers & Robine 1997:51).

A British study by Brundy and Bowling (1997:107) suggests that 'most people aged 65 and over are able to perform all tasks of daily living unaided'. Its key findings were that:

> decreasing levels of physical functioning are associated with poor mental health and problems with feet, muscles and joints; that there is no association between changes in the level of physical functioning and social network support and the use of a range of health service professionals. Few of the United Kingdom population studied use preventive or rehabilitation services.

This study also cites the Framingham study (Jette & Branch 1981:1202). This study reveals that 'older people were less disabled and impaired than commonly supposed' (Jette & Branch 1981:1211). A further national population survey cited in this study 'showed that the loss of independence was a central concern in relation to ageing'.

While disability levels have increased since the 1970s when mortality rates at older ages began to decline, the increases were at the less severe end of the disability spectrum. In addition, this was also the beginning of increased medical attention to secondary prevention, greater awareness of chronic conditions, greater contact with the health system and greater awareness through screening programs. All of the factors may be contributing to both higher reporting and increased modification of behaviour (Mathers & Robine 1997:51–55).

In three surveys conducted by the ABS since 1981 (AIHW 1998:25), disability and handicap rates have remained relatively stable. Of the 18% of the total population estimated to have a handicap, 36% were aged 65 years and older. Of the almost 48% of all older people who had a handicap, 17% reported a profound or severe handicap, with 71% aged 80 years and over having a handicap and 41% a profound or severe handicap (AIHW 1998:21).

More than 70% of people with a disability reported that it was primarily due to a physical condition, with sensory ability at 18% and intellectual, mental and psychiatric conditions accounting for the remaining 12%. The AIHW (1998:21) emphasises that these figures do not take into account prevalence as they count each person once for the main disabling condition.

Research also suggests that disability prevalence rises with age, differs in social groups and by location. It is also reported that there has been a decline in chronic disability in older Americans and that over a seven year period, the probability of someone aged 85 or over remaining free from disabilities increased by nearly 30% (Mulley 1997:1160).

In a recent American study it is reported that the burden of disability in the last years of life was reduced during 1986 to 1993 in the oldest men and in all

women, indicating that the decline (in America) in hospital and nursing home use is partly due to better health (Cooper, Youlian, McGee & Cao 2000:512). The study reported national data that showed a surprisingly large percentage of the oldest old managed without daily assistance and were physically robust. The study suggests that:

- The overall quality of life in the last years of life is improving at a greater rate in the oldest-old than in the younger-old.
- Those dying at the oldest ages generally had more disability but spent less time in hospital prior to death than those dying at younger ages.
- Medicare payments in the last years of life decreased with age.
- The very old and frail elderly use long term care more often than expensive acute care.

This study suggests that changes in health and the natural history of disease processes may be occurring concurrently and that the findings counter arguments for rationing care to elderly persons with chronic illness and bolstering arguments for supportive care. The study concludes that if the reported favourable trends continue and extend to all age groups it could portend slower rates of growth in national health expenditures in the future as well. This view is supported by a British study (Goldacre & Himsworth 1999:1338) which indicates that:

> data undermine the proposition that health care in elderly people should be restricted because they have 'used up' their entitlement; the data show that generally they have deferred drawings on their notional hospital 'account' until their final years of life. Elderly people are heavy users of hospital services, but this is largely because most people now die in old age.

Health and rural and remote location

According to the Australian Institute of Health and Welfare, Australia's rural and remote populations have poorer health than their metropolitan counterparts with respect to several health outcomes, have higher mortality rates and lower life expectancy (AIHW 1998:vi-vii). Figures reveal the following picture:

- Rural females can expect to live 80.8 years, only 0.4 years less than females living in 'capital cities'.
- Males living in the rural zone can expect to live 74.7 years, compared to those living in 'capital cities' that can expect to live 75.6 years.

- Male and female death rates for those living in 'capital cities' were 6% lower than for those living in 'large rural centres' and 20% lower than for those living in ' remote centres'.

- Hospitalisation rates for falls in people aged 65 years or more show higher rates in rural and remote zones.

The report (AIHW 1998:vi–vii) also emphasises that indicators of socio-economic wellbeing all show increasing socio-economic disadvantage with increasing distance from a major urban centre. This disadvantage is also reflected in access to health resources through the difficulty of distance, time, cost, transport, availability, shortages and uneven distribution of health facilities and health professionals.

As a consequence of the above, people living in rural and remote zones need to travel greater distances to receive hospital treatment and, therefore, acute hospitals have a broader role in rural and remote zones compared with those in metropolitan zones. This is particularly the case in those communities where no residential aged care facilities are available. In general terms, the report (AIHW 1998:viii) shows that:

- The supply of general practitioners and retail pharmacists falls sharply in rural and remote zones.

- 'Capital cities' have 30% more hostel accommodation for the aged than rural zones and three times more hostel places per capita than 'remote centres'.

- Medicare data indicate that people living in rural and remote zones are using fewer services than those living in metropolitan zones.

- Overall hospitalisation rates are highest for those living in remote zones.

Findings are supported by international data that indicate that health care services and resources for older people in rural areas can be highly variable and lack integration. The international data also comment on poor health status of rural dwellers and that lack of transport is also an inhibiting factor in access to health services (Klein, Kimberly, Fish, Sinkus & Jensen 1997:885). Research also indicates that the issues surrounding the delivery of health care are complex and often services are studied in isolation despite the fact that service delivery is multi–faceted (Dansky, Brannon, Shea, Vasey & Dirini 1998:320).

In the United States of America the Robert Wood Johnson Foundation (1994:198) describes a similar situation to that found in Australia:

> Old age and chronic illness go hand-in-hand, and many rural elderly need health and social services that are beyond the capacity of the community to provide. In particular, home care and assisted-living housing arrangements are almost non-existent in rural areas. Many rural elderly must relocate to obtain such services, or they are placed in nursing homes unnecessarily. At the same time, many rural communities have excess bed capacity in their acute care hospitals. Overall, the service mix is inappropriate and inefficient. Not only are services compromised, but these inefficiencies also lead to marginal fiscal viability among providers that might be deployed to meet the needs of the rural elderly.

Disability and handicap

'Disability' refers to limitations in functional abilities and 'handicap' refers to health related limitations in more complex tasks such as self-care, mobility and communication (AIHW 1998:21). Disability is specifically addressed in this thesis not only because of the importance of this group and the fact that the group is also ageing but, importantly, because of the similarity in service delivery and expertise within services and needs of this group and the general aged population. The increasing ageing of this group of disabled, and their carers who are also ageing, diminishes the distinctions in care needs between older people and the disabled and increases the potential of the existing distinctive and separate aged and disability providers delivering services across both groups. These similarities are important in the potential they suggest for future models of care delivery, which are explored more fully in chapter four.

In the final report of the review of the Commonwealth State Disability Agreement (CSDA) (Yeatman 1996:xi, 18, 30), it is argued that disability services are like no other service sector in the range of needs involved and the kind of system challenge they pose. However, the report also argues that there are grounds for bringing the aged care program in its community care aspects into strategic alliances with disability services. Among the disabilities population are older people whose frailty has come with age and those whose disabilities were acquired when young but are compounded with the frailties of age. The report concludes that the ageing of the population may 'grey' the picture of disability-related needs to some degree. It also suggests that the similarities in values of aged and disability programs with regards to rights, personhood and the importance of independent lifestyles in community settings provide the

opportunity to better utilise overlapping services such as the Home and Community Care Program and the Commonwealth Rehabilitation Service.

The report (Yeatman 1996:15) goes on to suggest that the disability movement ethos is not peculiar but is 'a widely shared set of expectations about how services should be designed and delivered'. It suggests that in the next ten years there may be reasons 'to rethink how current policy approaches divide up the population and its needs'. The report (Yeatman 1996:15) comments that:

> there is a high degree of convergence in the values (in disability/and aged care policy/programs) of residential or accommodation services. It is not clear that it will make sense over the longer term to break up these two areas of services into those that belong to 'disability', and those which belong to 'aged care'. Moreover, the current trend is likely to increase the number of people across both disability and aged care who are supported to continue to live at home rather than to go into some form of residential care.

The report goes on to emphasise that another similarity of these services is the central importance of carers and volunteers to the wellbeing of older persons with or without disability. Aged Care Australia, in its draft housing policy discussion paper, also suggests that it is as important as the public sector in providing affordable public housing (ACA 2000:1). Equally, disability services have a housing role as well as a training and employment role.

It is important to emphasise here that the above report, and certainly this thesis, is not suggesting that services to the aged and disabled should be merged. However, it is evident that both disability and aged care providers have the range of services, skills and expertise to deliver both aged care and disability services. Importantly, in the context of small rural communities, they have the potential to provide a range of services to a growing segment of those communities in the broadest context of health care, aged disability services, housing and employment.

The Final Report of the Review of the CSDA (Yeatman 1996:100) goes on to suggest partnership programs for disability services including aged care, mental health and education. Importantly, it suggests that:

> the complexity of this service area is probably unique. What other service area demands the same capacity to work across a relatively large number of distinct program areas as well as many provider organisations of different sizes and types? Disability services require a strategic public management approach oriented to outcomes. This is one which can no longer presuppose a discretely bounded public

sector. Rather it is one which enters into a strategically orientated degree of experimentation as to which mix of governments, markets, community and professionalism produces the best results for the area in question.

Housing and residential care

The AIHW Report (1999:1) provides the following details on residential aged care:

- As at 30 June 1998, there were 3,015 residential aged care facilities in Australia providing a total of 139,917 places — an average of 46 places per facility.
- In terms of size, 40% of facilities had 21 to 40 places, 28% had 41 to 60 places and 4% had more than 100 places. Twenty per cent had 20 or fewer places.
- Overall, about 2% of occupied place days were used for respite places.
- Almost half of those resident in residential aged care facilities at 30 June 1998 were aged 85 and over.
- The majority of residents were female (72%). Female residents were older than male residents; over half the female residents were 85 years or older, compared with 34% of male residents.
- The vast majority of residents received a pension, 9% were self funded retirees.
- Only 7% of residents had been in care for less than three months, 20% for between three months and one year, 53% for one to five years and 20% for five years or more.
- Fifty-eight per cent of residents fell into high care categories (RCS 1 to 4), 42% into low care categories (RCS 5 to 8).
- There were few differences between male and female residents in relation to dependency.
- The trend to increasing high care levels will continue, given the decreased availability of residential aged care beds in relation to the increasing ageing proportion of the community.

- Provision for residential aged care varied across types of geographic regions. Metropolitan areas had the highest level of provision at 89.9 places per 1,000 aged 70 and over.

- Rural zones had 81.7 places per 1,000 aged over 70.

The *Report on the Review of Aged Care Services in New England Area Health Service* (Wooster, Minton & Hawkins 1998:8–9) suggests that currently there is an oversupply of nursing home beds and an undersupply of hostel beds and Community Aged Care Packages (CACPs) in the New England region. The residential beds and community services are not evenly distributed across the region and there is anectdotal evidence that demand exceeds supply.

The restructuring of services for older people is addressed in an AIHW aged care series publication (Liu 1996:1–4, 19, 22, 33) which indicates that services for older people have already undergone significant changes in Australia in the last decade. This follows the publication of a number of reports, a process of reform and the implementation of a strategy, which has amongst its core elements:

- Reduce the nursing home supply from 60 to 40 beds per 1,000 and re-allocate the savings to community based services (CACPs).

- Increase the hostel supply from 33 in 1985 to 50 per 1,000 people aged 70 and over.

- Expand community care.

- Expand the multi-disciplinary assessment teams to determine eligibility for all nursing home and hostel admissions.

- Introduce new funding strategies in order to provide incentives to nursing homes and hostels to care for more dependent persons.

The report suggests that the planned changes to residential care delivery, as outlined above, may be inadequate and would not provide sufficient nursing home type care in the period from 2006 to 2016. In terms of planning the type, location and mix of accommodation in rural communities, the above report makes some important statements, which can be summarised as follows:

- Living alone before entering a nursing home is associated with a very long expected length of stay, about eight months longer than those who lived with a

spouse only, and nine months longer than those who lived with their children's families.

- Residents who previously lived with non-family members have the longest expected length of stay — fully 75 days longer than those who lived alone.

- This suggests that co-residents who are not family members provide less support for frail aged people in the community than family members and that they may contribute to the admission of their frail co-residents to a nursing home.

- Apart from those who lived with their parents prior to admission, residents who lived with their spouses and others, or with their children and children's families prior to nursing home admission are likely to experience very short-term periods of care.

- Those who lived alone or with non-family members prior to admission are more likely to fall into long stay categories once admitted.

- Many older people in non-metropolitan regions, particularly rural and remote areas, stay in acute hospitals for an extended period as nursing home type patients.

- The implementation of both diagnosis related funding in acute hospitals and multi purpose centres is likely to impact on the utilisation patterns of older people in rural areas.

The report also suggests that older people prefer to remain in an independent living environment where possible. In terms of nursing home admissions, people living in a house or flat have the shortest length of stay at admission, while those living in independent units have the second shortest length of stay.

The report concludes that there appears to be a marked association between the expected length of stay at admission and prior housing tenure (Liu 1996:42):

> The closer the nature of the housing tenure to that of the nursing home, the longer is the residents' subsequent stay in a nursing home. The more different the nature of the housing to that of the nursing home, (i.e. the more independent), the shorter is the residents' stay in the nursing home.

Research reported in the 1999 Department of Ageing and Disability Research Report (Parmenter & Stancliffe 1999:4) reveals that people with disability living

in semi-independent accommodation enjoy more choice and have greater community participation, and the cost of semi-independent living was significantly less per person than group home accommodation.

Residents living in semi-independent facilities were also assessed as enjoying better outcomes on several important lifestyle and satisfaction indicators than counterparts in group homes. Again, these findings have important implications for rural communities, disability and aged care providers in planning future service delivery (Gattuso & Goddard 1999:6).

Other research cited in the Department of Ageing and Disability publication suggests that ageing people with an intellectual disability living in rural communities enjoy a more supportive and participatory life than those in city locations. The rural location was perceived to be safer by consumers and carers and care management was less fragmented. Ageing people with an intellectual disability felt members of rural communities were generally more knowledgeable and understanding of disability (Gattuso & Goddard 1999:6).

Aged Care Australia, a representative industry body of State Aged Care Associations, has developed a draft discussion paper on housing policy (ACA 2000:1) which highlights the significant role of church, charitable and community aged care services in the provision of housing for older people. It also emphasises the importance of housing on the current and future needs of older Australians, particularly in the context of 'ageing in place' and on 'linking tailored care and support services to older people and their carers wherever they live.'

The Housing Policy discussion document of Aged Care Australia (2000) discusses a number of important issues about older people and housing that are important in the context of this thesis and are summarised as follows:

- The aged care sector provided accommodation for 111,501 older people throughout Australia in nursing homes, hostels and independent living units in 1996, compared to 105,500 people aged 65+ who were accommodated in public housing in 1994.

- The focus on the care dimensions of residential aged care has tended to detract attention from the role of the aged care sector as a housing provider.

- An estimated 250,000 frail older people throughout Australia have low incomes and are living in insecure accommodation (boarding or renting) of whom an estimated 140,000 have an expressed need for support.

- Residential aged care services provide housing and care as integrated services to frail older people. However, the emphasis on 'ageing in place' and on tailoring services to meet the individual care needs of older people, wherever they choose to live, mean that housing and care services must now be seen as separate but linked elements of aged care service provision.

- The promotion of 'ageing in place' will present new challenges to both the community and residential providers of aged care services and should stimulate a wider diversity of accommodation options, by housing and care providers, than has been the case in the past.

- Responding to the diverse needs of older people and facilitating 'ageing in place' will require innovative approaches to the provision of accommodation and care services.

- Community groups and aged care providers are well placed to develop innovative accommodation and linked care services which are responsive to the diverse needs and lifestyles of the older people in their local communities.

The above document goes on to suggest that housing must be:

- accessible
- affordable
- appropriate to individual needs, lifestyle, etc.
- secure and safe
- integrated within the local community
- well located in relation to social networks and community services
- co-ordinated with linked care and support services
- domestic scale adaptable and diverse.

In addition to accessing normal sources of public housing, the document mentions other financing options, such as shared equity and equity conversion, that could be used as a means to assist older people to make the transition to more appropriate housing.

If one were to add the role and resources of the disability sector providers to that of aged care providers in the context of housing, there is clearly considerable expertise and potential. These industries could develop and diversify in this area, not only for existing clients, but in respect to the well older people, younger people with physical and intellectual disabilities and specific groups needing housing. Such groups would include those needing crisis accommodation, half-

way houses, as well as the range of ordinary people requiring affordable housing and retirement housing.

The mix of these markets has the potential to provide a range of housing to groups of people in a community with good social infrastructure that cannot be duplicated in specific retirement villages or in more urban settings. This approach also offers greater potential for the provider to offer a greater range of like services such as home modification, repairs, maintenance, meals, transport and social activities to its clients and residents and to those living at home in the community. It also has the potential to generate service industry business and employment to support the growth in these services.

Older people and community services

Contemporary acute care practice and policy has seen a rapid increase in shorter stay, day only surgery, and early discharge of all patients from the hospital system. A higher proportion of those people who use hospitals are older people (Dansky et al. 1998:327). An increasingly older and frailer population and changes in family structure have all contributed to a higher demand for home services and an increasing complexity to those services. These changes in service delivery and utilisation reflect the impact of changed government policy described earlier in this study. Importantly, this change in emphasis is supported by research, which demonstrates that home-based services are also the preference of older people (Hafez 1994; Concannon 1995).

There is a diverse range of community care services for people with disabilities, frail older people and carers in New South Wales. These services are funded and delivered by all three levels of government, by disability and aged care providers and a large group of mostly community based, not-for-profit organisations. These providers represent a significant employment group to regional New South Wales, and a considerable focus of community involvement and volunteer effort. The sheer range of service providers represents fragmented service delivery and, as government increasingly focuses on specific needs of the frail aged and disabled, it is likely that the delivery of services will continue to be the responsibility of a range of providers, despite a clear need and support for integrated and co-ordinated care.

This fragmentation of services, due to divided government responsibility, is also compounded by the phenomenon current in Australia's health and community care industry (but certainly not peculiar to it) that places more emphasis and attention on who owns the service or organisation (Hindle 2000:6). This focus is

at the expense of any consideration of how best to deliver services and make them accessible at the local community level.

There is, however, a strong desire and increasing evidence of co-operative effort and co-ordination among and within community providers and residential aged and disability providers. There is potential to strengthen and extend services by aged and disability providers delivering a full range of residential and community services, either directly or in partnership with other community organisations and local government.

Many of these services are now well recognised and established in local communities and include Home Care, the Home and Community Care (HACC) Program, the Disability Services Program and community health services. More recently the development of Community Aged Care Packages (CACPs) and the National Respite Carers Program has been seen. As of December 1997 there were 3,300 HACC projects operating from 4,000 outlets alone (ACA 2000).

These few major service groups represent approximately 100 service providers or branches, offices and community groups across the New England region and again represent the complexity of service delivery. These services cover the whole range of respite, domestic services, meals, transport, day care, and shopping and home modification.

Fortunately, at government level there has been recognition of the need for better co-ordination and integration of service delivery and, in 1998, the Department of Ageing and Disability issued a discussion paper on community care assessment in New South Wales (Department of Ageing & Disability 1998) which provides a framework for comprehensive community assessment and co-ordination of care. The discussion paper specifically outlines two models currently operating as demonstration projects which are appropriate to rural and remote areas. These are the Orange-Carbonne Demonstration Project and the Tamworth Community Care Demonstration Project, together with an Aboriginal and Torres Strait Islander model.

Like residential care services, it is generally felt that there is an under supply and difficulty in access because of location and/or regulation of access to community services compared to demand. This represents opportunities for increased service delivery and employment for rural workers in this service industry. Given the incremental nature of government funding, alternative funding/payment options will need to be developed to turn this potential into reality. *The Final Report of*

the Review of the Commonwealth/State Disability Agreement (Yeatman 1996) suggests that:

- Of the 3.02 million people with disabilities living in households, 1.48 million (49%) reported a need for help with one or more activity associated with everyday living.
- There are 13,500 people with severe and profound handicaps in critical need of accommodation, accommodation support or respite services.
- There are 7,700 severely and profoundly handicapped people with carers aged over 65 years.
- Seven thousand carers of people with severe and profound handicaps say they cannot access respite.
- Up to 70,000 people with severe and profound handicaps may need access to day/recreation activities.

Aged and Community Services of Australia (ACA 2000) suggest that in respect to the HAAC Program:

- Approximately 220,000 people receive HACC services at any time during the year.
- Sixty-nine per cent of HACC clients are female.
- Forty per cent of clients are aged 80 years or more; 19% are under 65 years.
- The difference between HACC clients and residential care clients is that only 6% of HACC clients are aged 90 or more, whereas 19% of hostel residents and 22% of nursing home residents are aged 90 or more.
- Home help, day centre care and home meals are the most frequently provided services and community nursing accounts for the greater share of HACC expenditure (22.5%), while home help accounted for 19% (96/97).

Community Aged Care Packages were introduced in 1992 in response to the growing emphasis on home based care, with concurrent reductions in the overall level of residential provision. A review of aged care packages and community options by Mathew, Evans and Gibson (1997) suggests that they have demonstrated that both highly dependant people and those with complex care needs can be cared for in their own homes and that effective home based

management of people requiring quite intensive levels of care is a feasible alternative to residential care. The report (Mathew, Evans & Gibson 1997:5) indicates:

- At survey, 224 services were providing CACPs to 3,800 clients.
- Most clients were aged 70 and over, with women aged 80 and over constituting the largest group.
- Living alone was the most common type of living arrangement, followed by living with a spouse.
- Most clients had a co-resident or visiting carer.
- The most common type of service provider was 'other community and government'. Stand alone care package providers and hostels were also substantial providers of care package services.
- While usage rates are less than one per 1,000 for the under 75s, there is evidence of higher use among the very old.

Leisure, lifestyle, income and employment

The New South Wales Department of Ageing and Disability (2000) reports that:

- Most retired people are socially engaged and maintain active independent lives.
- A 1997 Seniors Card survey indicated that 75% of members aged 60+ travelled in that year, 61% ate at a club an average of 4.5 times during the year and 75% of respondents drove a motor vehicle.
- The most popular home-based recreation and leisure activities amongst older people are reading, watching television, and listening to radio/music, arts and crafts, and interaction with pets.
- Six per cent of people aged 60+ engaged in sporting activities in 1997. People over the age of 60 spend more time participating in sporting activities than people aged 40–59.
- Australia's 2.97 million seniors spend $895 million on domestic travel each year.

- Older people tend to take longer holidays than the general population and 75% of people aged 60 and over travelled in the last year.

- In a recent survey, 42% of older people said they last travelled for general pleasure and 42% travelled specifically to visit friends and relatives.

- In 1997 there were 29,000 people aged 50+ enrolled in TAFE courses in New South Wales and 47,655 people aged 50+ undertaking Adult and Community Education courses throughout the State.

- Older people have lower disposable income than other age groups, but also have fewer outgoing expenses, providing greater discretionary income. A greater percentage of this income is spent on travelling than in any other market segment.

- Seven per cent of people aged over 65 receive most of their income from employment, 22% from superannuation, etc., and 70% from pensions.

- The group of people who gain most of their income from superannuation is expected to grow while the number of people receiving private income mostly from savings and investments is growing.

- Of all men aged 65 and over and women aged 61 and over, 67.5% receive the Age pension while a further 15.4% receive pensions from the Department of Veterans Affairs.

- Older people, as an age group, have the lowest income of all Australians but are more likely to own a home and other assets.

- Older people who live alone have a higher chance of poverty as they do not have the opportunity to pool income and resources.

It must be remembered that *The National Stragegy for an Ageing Australia* (Bishop 1999) suggests a future with less dependence on pensions and a right for older people to continue to work and not be discriminated against through arbitrary retirement ages. Rural communities generally experience a loss of young people to urban areas in search of employment and in the future these communities may need to look to the older population as a source of employees. The development of older population services and facilities in small rural towns may also provide opportunities for employment of older people.

The NSW Department of Ageing and Disability (2000) indicates that employment issues for older people include:

- By 2020 there will be as many people approaching retirement as there will be people entering the labour market.
- There are 123,800 people in New South Wales who are working and who are aged over 60. The majority (60%) are working full-time, and over two-thirds are men.
- Mature age people tend to be out of work for longer periods of time than other age groups and a person who is made redundant in their 50s could face 30 years of dependence.

From a survey by that Department of unemployed people over 55 it was demonstrated that the main difficulty faced in gaining employment was that employers considered them to be too old. This is despite the fact that research shows that older workers have fewer sick days, fewer accidents and lower turnover rates than younger workers (NSW Department of Ageing and Disability 2000).

Older people as volunteers

In 1995 a national survey revealed that 17.4% of the older population aged 65 and over compared to 20% of people of all ages had undertaken volunteer work in the previous year. Country residents are more likely to volunteer (21%), compared to 12% in Sydney (NSW Department of Ageing and Disability 2000). The survey also shows that:

- Eight point nine per cent of older people do volunteer work with welfare or community organizations.
- Four point one per cent undertook volunteer work with religious organisations and 3.3% with sporting/recreation or hobby groups.
- The most common activities of older volunteers are fundraising (39.6%), management/committee work (34%), food services (26.3%) transportation (19.4%) and befriending (18.2%).
- Three quarters of older volunteers have been volunteering for ten years or more. A Brisbane survey found that 20% of 65–74 year olds had taken up volunteering recently or in retirement.

Volunteering is undertaken to help others as a result of personal/family involvement with an organisation, wanting to do something worthwhile, personal satisfaction, social contact, and learning new skills or putting old ones to good use. Concerns about volunteer work from volunteers include lack of adequate support, supervision and training, worries about legal responsibilities, lack of reimbursement of expenses, and transport difficulties.

Carers

No discussion of older people, ageing and disability would be complete without addressing the central role of carers. The *Older People in New South Wales* fact sheets produced by the NSW Department of Ageing and Disability (2000) reports that:

- There are approximately 800,000 carers in New South Wales, of whom 150,000 (19%) are aged 65 and over.
- Of all older people in New South Wales, 20% are carers.
- Ninety per cent of all primary carers aged 65 and over live with the person they care for and these carers are likely to be caring for a spouse.
- One quarter of all older carers are primary carers, compared with one-fifth of all carers.
- Women are more likely to be carers than men, with 57% of carers and 73% of primary carers in New South Wales being female. Seventy-six per cent of older primary carers are women.
- Of all primary carers, 45% provide care to an older person.
- Half of all carers (50%) are employed. Primary carers are less likely to have paid work (36%) than other carers (54%).
- Seventy-eight per cent of primary carers live with the person they care for and 39% of this group provide, on average, at least 40 hours of care every week.
- Caring is a long term commitment, with 40% of primary carers having been caring for at least ten years.

The National Council on Intellectual Disability (NCID) reported in May 1999 (NCID 1999:11) that:

- There are 450,900 primary carers of Australians with disabilities, with 96,700 of those aged over 65 and 176,200 aged over 55.

- A total of 94,400 primary carers are parents, of which 9,700 are over 65 and 28,700 are aged 45 to 64.

- Again, as with older people, caring is a long term commitment, with 118,700 caring for more than ten years and 59,600 for 25 years or more.

- Over 63,000 of those needing care cannot be left alone for more than a few hours at most.

Yeatman (1996:25) indicates that the Victorian Carers' Project found that 54% of principal carers surveyed reported an unmet need for at least one formal service and that 84% of caregivers were helped by family and friends. This same survey identified four groups on the basis of the relationship to those for whom they care: those caring for a spouse (23%); adult offspring caring for ageing parents (39%); parents caring for handicapped children (20%); and other carers (17%). Key findings of this survey include that spouse carers experiences are likely to be positive, and adult carers, as the largest group, reported negative experience for four out of ten. In this group, parent carers of handicapped children are more likely to have a negative coping experience and almost half of the parents were in the lowest coping index.

Delivering health care to older populations and rural communities

Humphreys (1996:11) rightly encapsulates the issue and the concern of rural communities as follows:

> Many rural communities are currently struggling to maintain their existing populations, let alone to increase in size. The impact of economic restructuring on the rural sector, the rationalisation of public and private services, and the associated process of rural depopulation means that many rural and remote communities are at risk of falling below the critical threshold for maintaining existing health services. These services that might be considered 'at risk' in terms of their ability to maintain existing health care services, like the smaller localities in the rural-urban hierarchy, are likely to require alternative models of health services.

Importantly, he goes on to say that not enough attention has been paid to the ways in which health services are provided to small rural and remote communities. He emphasises the need to take into account the degree of isolation, size and density in determining needs and the ability of rural populations to

sustain a range of health services and that alternative frameworks for the provision and delivery of health services are required.

Humphreys (1996:3) argues for alternative frameworks and delivery models that have the following characteristics:

> *Accessibility*: to ensure that services are actually available at time of need.
>
> *Flexibility*: to respond to diverse health needs, demographic and workforce changes and local circumstances including isolation and the impact of a lack of transport on access.
>
> *An orientation to primary health care and public health*: to address direct causative factors underpinning poor health status.
>
> *Increased consumer participation and community involvement:* to effect real improvements.
>
> *Intesectoral co-ordination and multi-disciplinary collaboration:* to maximise the limited resources to provide health service needs.

The findings of other researchers in the American context are summarised in an article addressing the nursing needs of the rural elderly (Alexy & Belcher 1997:146). This article indicates that rural areas have fewer health care providers, and access to a smaller number and more narrow range of health care services. It also suggests an urban bias in resource allocation and that these factors combined may contribute to the poorer health status found in rural elderly. Again, Mulley (1997:1160) asserts that the unquestioning acceptance of the myth that old age is associated with a poor prognosis is one factor in the exclusion of elderly patients from investigations and new therapies and that negative views of ageing are reflected in the false belief that rehabilitation is ineffective.

This discriminatory approach to the aged was demonstrated in recent years by the New England region of New South Wales, where the Area Health Service determined that long standing role delineated beds in local hospitals in small rural communities were not the funding responsibility of the State and, therefore, not funded. By denying a traditional use of acute beds for aged care services, the viability of the acute facility is put at risk. As a result, given the central economic importance of the local health facility, access to the full range of health services becomes limited and the general economic viability of the community is endangered. This approach, as previously reported, is not supported by the literature (Goldacre & Himsworth 1999:1338; Schulz 1997:82).

Duckett (1999:130) suggests that such projections:

> are usually made as part of politically based destabilising campaigns and should be treated with as much credence as the tobacco industry's assertion about the positive health benefits (and lack of adverse consequences) of smoking over the last 40 years.

Rivlin (1995) asserts that 'age should not be the principal criterion used to gain, or deny, access to medical facilities'. The futility of public policy that attempts to discriminate in service access based on age is clearly demonstrated by Henderson, Goldacre and Griffith (1990:17) in their study:

> People who died at age 85 years and older were less likely to have been admitted to a hospital in the last year of life than persons who died between ages 65 and 84 years. However, elderly patients tend to have longer hospital stays when they are admitted. The duration of hospital stays by the elderly in the last year of life has not changed over time, and has increased by only three days between 1976 and 1985. During this same period, life expectancy after the age of 65 years increased by one year. These findings indicate that the gain in life expectancy after 65 years is not associated with increased duration of hospital stay by the elderly in the last year of life.

The AIHW (1998:viii) states that people living in rural and remote zones have less access to health care based on a number of indicators including health expenditures. The recent New South Wales Auditor General's Reports to Parliament (AG 98/99:322) clearly demonstrate earlier and higher debt ratios of rural health services compared to their metropolitan counterparts.

While the NSW Department of Health report *The NSW Ministerial Advisory Committee on Health Services in Smaller Towns: Report to the NSW Minister for Health* (Sinclair 2000:17) noted that the Resource Distribution Formula is meant to ensure comparable levels of access to health services, it also mentioned the common concerns and perceptions of small rural communities that they are suffering from some degree of funding discrimination. It recommended that a comparative analysis between rural and metropolitan funding be undertaken.

The concerns and perceptions mentioned in the Ministerial Report have been confirmed by the National Rural Health Alliance (2001) in a public call for a fairer share of health funding to rural Australia. The Commonwealth Government's recent Regional Summit had rural health as a major theme and there has been subsequent increased funding to rural health in recent state and commonwealth budgets.

The Sinclair Report argues for a variety of approaches, including better community participation, pilots and better agreement to working together at inter-agency and inter-government level. These approaches are not new and, despite genuine efforts from some quarters, the system is not responsive to the needs of rural communities, and when it is, it is extremely slow. Lander (2001) describes the frustrations experienced in gaining worthwhile change in the establishment of a multi-purpose centre in a rural community in New South Wales.

Dr John Best, in a theme paper he produced for the Regional Australia Summit (1999:1, 2), is critical of capital city-based decision making, the bureaucracy of commonwealth-state relations and the truism that even if politicians change, bureaucrats do not necessarily. While mentioning the multi-purpose concept as one approach to integrated care, he also cautions against a policy framework that 'tries to impose a one solution fits all philosophy'.

Another theme paper developed for the Regional Australia Summit (Strasser & Bryant 1999:4) indicates a sustainable models approach is needed and should be developed community by community. The paper stresses the importance of understanding the different priorities and preferences of people in rural communities and health care providers, which includes for the former the reliance they place on the local hospital and the general practitioner.

In addition to the general practitioner's normal role in a community, the essence of geriatric service structure in Australia has been described by Luk (1998:39) as an:

> elderly patient-general practitioner (GP) centred health care system in which the GP is the case manager of elderly health care while hospitals, geriatricians, geriatric nurses, domestic services and community health teams are active supporters of the GP.

Research from the United Kingdom (McNiece & Majeed 1999:27) suggests that annual contact rates were about 50% higher in elderly patients than in any other age groups. It therefore follows that the general practitioner involvement in the planning and delivery of aged care services is essential.

In addition to the central role of the general practitioner, Strasser and Bryant (1999:10) conclude that a sustainable rural health service depends on community participation and ownership, which should include the business sector, a situation from which the New South Wales health system has rapidly departed since 1996. However, it is a position to which it could rapidly return if it was able to see itself

as a funder/purchaser of services rather than an owner/funder and operator of services as it is currently.

Again, Alexy and Belcher (1997:148) suggest implementing an integrated delivery system within the rural setting and their definition of that system provides an important context in which rural communities might consider how best they may like to see their health and aged care services develop:

> an integrated delivery system is a 'network of organisations that delivers a co-ordinated continuum of services to a specific population and is fiscally and clinically accountable for the health status of that population' ... The integrated system is consumer orientated and capable of delivering a continuum of care through community based outreach efforts which makes health care services more accessible to consumers. Integrated systems demonstrate commitment to the wellness of a defined community by developing collaborative relationships and co-sponsoring projects with other healthcare agencies/providers.

In an article by Fennell and Flood (1998:424), researching how best to deliver health care to older Americans, it is suggested that while it used to be simple to determine where care was given, for example, surgery in a hospital, primary care in a clinic or doctor's surgery and aged care in a nursing home, this is no longer the case. They argue that those clear boundaries of care location have 'faded out of focus and the sectors of care have melded into one another'. Similarly, the authors suggest that the definitions of care can no longer be made on the basis of the care setting as hospitals are increasingly supplying more long term care related services and nursing homes have been providing care for more acute and sub-acute patients. They suggest that we must take into account the real fact of physical and mental comorbidity with the real probability of a mental health diagnosis. Attention should focus on models of care based on the episode of care across multiple organisational settings and move away from narrow organisation-specific process approaches.