Chapter 4
Conclusions

The needs of the older population and the aged care industry are complex. The conclusions of this study that need to be pursued will have to be actioned or implemented with the involvement of all stakeholders. This must involve older people with a co-operative partnership approach of local government, rural communities and aged and disabled service providers, together with funders of services, both private and public, at the State and Commonwealth government levels.

This thesis takes a broad, community-based view of the needs of older people and suggests that community ownership and participation is essential if future service provision is to succeed. A continued over-emphasis on ownership of services and levels of government responsibility is identified as one of the major barriers to an effective delivery of aged care services and to allowing rural communities to reach the full potential of meeting the needs of the older population.

Developing older people friendly communities

Because of the changing population mix, most rural communities have focused on the loss of younger people from their communities in search of education and employment in regional and urban centres and have sought to increase employment opportunities to retain the younger sections of the community (Access Economics Pty. Ltd 2001:23). The reality is that rural communities will continue to age or 'grey' and that this group will become predominant. Most older people now prefer to retire and stay in their own local community, and there is increasing unemployment in the older 50+ workforce.

Rural communities are seen as safer communities for older people, more tolerant and accommodating of people with a disability and generally have access to community services, facilities, recreational and lifestyle opportunities (Gattuso & Goddard 1999). These services and facilities are identified as major attractions to older people and areas where older people spend their income. Some rural communities have identified the value of tourism to their community and have adopted strategies to attract tourists. Older people themselves are also identified as a significant tourist group.

Older people and aged care as an industry and employer: Future directions

The aged care and disability service provider organisations are already a significant industry and employer within rural communities. The health services, in particular, have an important role in providing services to older people, and the general practitioner and the local hospital are seen to be of central importance to older people and rural communities.

There is a wide and diverse range of services and service providers from local government, community not-for-profit, corporate for-profit and not-for-profit, churches, government agencies providing community services, stand-alone hostels and nursing homes, and retirement villages. As a result, there is a high degree of fragmentation in service delivery and sometimes uncertainty or disputes about responsibility. There is co-ordination among service providers through mechanisms such as local at-risk groups. This approach is meant to ensure that agencies jointly assess clients and determine their needs. The regional office of the Department of Ageing and Disability facilitates these types of approaches. There are other good examples of co-ordination and co-operation, both within communities and across the region, including the local regional grouping of the Aged and Community Services Association of NSW.

There are, however, continual concerns about the viability of a whole range of these services because of the fragmentation of ownership and management. Increasingly higher standards of care requirements, including accreditation, the reliance on capped public funding and rapidly changing care trends, are presenting difficult challenges for the aged care industry. It is clear that 'ageing in place', an emphasis on providing services to older people in their homes and the clear preference of older people to remain in their own homes and be provided with services, will require changes in the nature and structure of aged care service providers to ensure their viability.

It is becoming increasingly obvious that many services on their own may not be viable. There needs to be increasing integration of service provision to ensure that viability. Unfortunately, this issue is often seen and debated in the context of ownership, rather than what is best for individuals and the community in terms of service provision. There needs to be a bigger emphasis on integration of services and the use of funder/purchaser split models rather than on ownership and control of services.

Unfortunately, the earlier approach to the multi-purpose centre concept and the move to area health services in rural New South Wales was based on centralised control and the removal of community involvement in local health services. Subsequently, this approach has not significantly changed and is unlikely to do so until such time as NSW Health can see itself in a funder/purchaser role rather than directly providing and controlling all services.

In fact, other New South Wales government agencies such as the Department of Community Services and the Department of Ageing and Disability are increasingly moving in the direction of a funder/purchaser role and withdrawing from direct service provision in favour of contracting service provision. This approach provides the opportunity for specific service providers, such as aged or disability providers, to broaden their role and become community care providers, receiving funding from a number of government agencies, both state and commonwealth to provide the full range of integrated services to a client. This would avoid the current fragmented approach involving both multiple providers and funders. This direction, if also adopted by NSW Health, offers the best opportunity to provide integrated care and to ensure the viability of local services and service providers.

As mentioned in this study, there is no one solution to the best way to deliver aged, disability and health services to rural communities and hence a range of options and models are proposed. In fact, diversity in delivery models should be encouraged particularly as it will provide the opportunity to compare and evaluate those models.

Rural communities, local government, and aged and disability providers should consider the following options and models for development locally:

- Rural communities should consider entering into partnership with a preferred aged/disability care provider to deliver professional aged care advice and/or manage and develop a range of care services within the community.

- Communities should consider a range of options in terms of a partnership with a preferred aged care provider including not-for-profit aged care providers, disability services providers or local government management, with aged/disability providers delivering expertise and advice.

- Particularly where the aged care services and facility in a rural community are of similar or greater scale than the local health services, that they should also seek to manage the local health services (hospital and community services) on

behalf of the Area Health Service through a contracted purchaser/provider arrangement.

A number of recommendations from the recent Sinclair Report (Sinclair 2000) are relevant to this study and should be pursued by local communities. The particular recommendations relevant to this study are:

55. ... ongoing community consultative process be conducted in association with AHS planning of the changes ...

56. That residential aged care providers in conjunction with Aged Care Association be encouraged to work with the AHSs to meet the needs of aged care, sub-acute and primary health care services in rural communities.

57. As part of the healthy ageing goal, NSW Health and rural AHSs facilitate and support the development of appropriate supported accommodation for older people.

63. That pilot projects and subsequent evaluation be undertaken on co-locating general practitioners, the community pharmacy and other human services within the premises of small rural health facilities.

65. That, where appropriate, existing not for profit hostels be supported and encouraged to provide residential high aged care services or establish multi-sited aged care facilities; and

66. That NSW Health creates an opportunity for closer collaboration with the not for profit aged care sector through the alternative models for service delivery as outlined in sections 4.4.3 and 4.4.4 of this (Sinclair) Report.

67. That a contractual framework for service contracts between not for profit service providers and AHSs in small towns be developed by NSW Health; and

68. That AHSs be encouraged to lease health owned space and equipment to private health practitioners, other service providers and Government Access Centres or like services.

69. That a Co-ordinated Care Trial involving the health, aged care and transport sectors be established in a geographic catchment area and two small rural towns be selected as pilot sites.

84. That all MPSs and other public health facilities, which have designated aged care beds, that provide residential aged care, and meet Commonwealth certification and accreditation standards be approved as residential aged care providers under the Commonwealth Aged Care Act 1997.

Rural communities, with an increasing older population, a well defined geographic area, a local general practitioner(s) and health and aged care services, has a greater potential to deliver experimental, innovative and integrated care models more easily and effectively than larger urban centres. They should seek to develop such programs in furtherance of achieving more effective care services and become more widely known as an 'older people friendly community'.

Recent changes to the Medicare Benefits Scheme (MBS) have introduced 21 new items to allow for the greater involvement of the general practitioner in working with other health professionals to provide health assessments, care planning and case conferencing. This gives the potential to introduce a PACE/On Lok model of care (Bodenheimer 1999) or variant into a small rural community.

On Lok Senior Health Services (meaning 'peaceful, happy abode') were created in 1971 in San Francisco's Chinatown, integrating acute and long term care. The Service obtained pooled capitated Medicare and Medicaid financing and uses these funds to provide integrated care services to older people with virtually no federal or state restrictions. On Lok has a volunteer Board of Directors that includes community residents, physicians and professionals with technical and fund raising skills.

Subsequently, programs have been established based on the On Lok model called Program For All Inclusive Care for the Elderly (PACE). PACE sites are run by a variety of non-profit organisations and are designed for frail elderly and disabled people who need intensive long term care and are not for all elderly persons. The care delivered extends to meals and home services as well as assessment and treatment over a range of settings. The participants were described on average as 80 years old, had 7.8 medical conditions, had impairments interfering with the performance of two to three activities of daily living, 39% lived alone, 42% had dementia, and more than half were incontinent. Applications of this model are now increasingly possible in Australia and should be pursued as a pilot scheme and research project by rural communities.

Rural communities, in association with local general practitioners and aged and health care providers, should consider establishing a scheme that enrols all older people in a preventative program. Such a program would provide regular medical assessment, dietary, exercise and lifestyle advice and opportunities to participate in activities with the object of maintaining good health and reducing the use of services and facilities.

This study identified a high frequency of use of general practitioner services by the older people who responded to the household survey. As indicated previously, changes to the Medicare schedule provided additional item numbers for general practice screening and consultation with other caregivers. A British study by Fletcher and Bullpit (1994:18) canvasses the benefits of a series of screening programs and concludes that earlier studies demonstrated improvement in detection of a range of problems. In examining the results of five trials, the study suggests a lack of consistent results. However, those trials suggest that:

> the screened group had fewer days in hospital but were more often referred to other agencies, and screening was not associated with a reduction in subsequent medical problems. The screened group showed a 24% reduction in bed days in hospital, a 19% reduction in hospital admissions and most important a 40% reduction in mortality in the first three years.
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> The authors conclude that this particular study was important as it looked at the expenditure on salaries for the screening personnel, office costs, increased use of home help, modifications to the home and increased cost of pensions of those that stayed alive and compared these with financial gains reductions of days in hospital, days in nursing homes and a reduction the use of the emergency services. The financial savings were large and remarkable.

Other trials mentioned by the authors suggested a reduction in deaths in urban areas but unaffected rates in rural areas and, while there were fewer days in institutional care, more patients attended day hospitals and were admitted to hospital. A meta-analysis of six trials failed to confirm a benefit from screening in terms of mortality but demonstrated a benefit for home assessment by living at home one year later as opposed to dying or living in an institution. Similarly, hostel admissions were reduced in this group.

Government should consider developing a proposal to pool all commonwealth and state funding for the broad range of aged care services to a single rural community and combine all service providers in a PACE style organisation to provide a pilot researched model of integrated care. Health insurance funds should be encouraged to participate and enrol their local members in this proposed scheme.

Research (Dansky et al. 1998; Goldacre & Himsworth 1999; Fennel & Flood 1998; AIHW 1998) suggests a legitimate and widespread use of hospital beds by the aged in rural communities. Without that use many small hospitals would not be viable and this study also confirms the central importance of the local hospital in the minds of older people as a provider of services. This study also confirms a

central role for the general practitioner and the local hospital in the care of the aged. It clearly demonstrates that the community sees all levels of government as having a significant role in aged care, together with the general practitioner, the hospital and community health, and the inter-dependency of them all should be obvious. This also suggests that greater partnerships between communities, all levels of government and health, disability and human service providers are appropriate.

It is true that hospital beds are not necessarily the most desirable form of residential care for older persons and may not meet commonwealth accreditation standards. However, faced with a choice of relocation away from family and friends, it is suggested that most would have selected the hospital admission. The fact that some facilities have not been upgraded to meet standards is also a reflection on the almost complete lack of capital funding provided to rural health services, a finding reflected in the recommendations of the Sinclair Report (2000).

In addition to other recommendations in this study, there are other more immediate solutions to this dilemma. Fennell and Flood (1998), in the American context, emphasise that the traditional definitions and roles of hospitals and nursing homes no longer apply, that hospitals are increasingly supplying more long term care and nursing homes have been providing care for more acute and sub-acute patients. The following quotation from that research is important in the context of Australian rural communities:

> Within rural areas, the hospital-LTC (long term care) link is particularly complex. In most rural areas hospital beds can be used as "swing-beds", that is, a bed can be used to provide either acute or long-term care. Since 1982, small (fewer than fifty beds) rural hospitals have been eligible to participate in the National Swing-Bed program, in which Medicare reimburses the incremental cost of providing long term care in an acute care bed instead of a nursing home. In 1987, eligibility for swing-bed participation was extended to rural hospitals with 55–99 beds, and current estimates for swing-bed participation is over 60 percent of rural hospitals. (Fennell & Flood 1998:427)

Aged care beds have been delineated in New South Wales rural hospitals since the 1980s and therefore have always been funded as such through hospital budgets. The American swing-bed variant is a further option for formally recognising this reality on a national scale and provides a viable alternative for securing the long term use of hospital beds for the local aged care population.

Rural communities should consider lobbying the Commonwealth government to give consideration to a national swing-bed program to maintain the viability of small rural hospitals and to ensure equity of access to aged care accommodation for older people in their own communities.

The development of low cost assisted housing and self-care units on hospital and aged care campuses, together with the redevelopment of existing housing stock for these purposes by residential aged care providers, is consistent with the preferences by older people for that type of care over hostel and institutional care. It is also consistent with suggested policy directional moves for disability and aged care providers in Australia and with international trends identified in the literature.

Diversifying roles of aged and disability care providers

Many existing aged and disability care providers developed in response to community needs to provide specific services to local communities and have subsequently grown and developed to meet changing needs. There has also been increasing control and influence by government through policy development and increased dependence on public funding. In the past, residents of retirement villages may have entered these complexes in their late 50s and early 60s,whereas today, residents of retirement villages, nursing homes and hostels are all more likely to be in their late 70s and 80s on entry. This dramatic change reflects the better health, wellbeing and independence of older people and also an increasing trend to care for older persons in their own homes and/or the community.

While the increasing proportion of the older population may well sustain the existing forms of aged care for some time into the future, it cannot safely be assumed that these same facilities and services will be sufficient to sustain existing organisations, particularly smaller, stand-alone, single facility providers.

There is potential through partnerships, joint ventures, mergers and service integration for facilities and organisations to respond to this challenge. However, another approach is for aged and disability service providers to diversify and expand their roles and the range of services that they provide. Aged and disability service providers need to consider becoming community service providers. If we examine the current roles and activities of these providers, we see that in addition to providing aged and disability services, they deliver a wider range of services and have the necessary skills and expertise to support services to the wider community.

Given the high degree of co-morbidities among older people, including mental illness (Fennell & Flood 1998:428), there is the potential to also consider ageing and disability services providing a range of community mental health services and not just to the older or disabled group. Aged and disability services are currently larger providers of housing than the public sector housing authorities and have the full range of expertise to be a provider of affordable public housing. Many provide home maintenance, gardening, transport and catering services, either directly to residents and clients or by providing employment to clients in these areas. Many provide education and training services to their staff and/or clients and some are registered training organisations. Many have well developed management and financial systems 'in house' to support a broader and diversified role than do other small voluntary and not-for-profit providers of community services.

Aged Care Australia (ACA 2000) suggests that community groups 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'. Yeatman (1996:xi) suggests that there is 'an argument for bringing of community and residential care for people who are frail and aged into strategic alliance with the disability sector'. This does not suggest that the services need merge but that there is potential for both aged and disability services to provide services to both groups across the traditional boundaries between the two.

Currently, commonwealth and state government agencies are calling for expressions of interest that directly allow aged and disability providers to consider developing a broader community role. Some examples of these include:

- Commonwealth Department of Health and Aged Care — Commonwealth Regional Health Services Program: $42.8 million over four years for voluntary, private, not-for-profit and incorporated bodies including nursing homes and hostels, local government etc. that propose service planning and/or service delivery projects that make a difference to health needs of small (5,000 or less population) rural communities.

- NSW Department of Community Services — expressions of interest for auspicing youth refuges and adolescent and family counsellor service and Aboriginal foster carer support service.

- NSW Department of Ageing and Disability — expressions of interest to provide a home modification brokerage service, a dementia advisory service and an adult learning and support service system.

- NSW Department of Housing — expressions of interest in providing low cost community housing.

The above discussion suggests strong potential for aged and disability service providers to both develop into community service providers, sustain their future viability and create opportunities for employment and increased services in smaller rural communities where services have increasingly been lost through the general retraction of the public sector.

Aged and disability service providers should consider a staged move into public housing by delivering services such as group homes, refuges and respite care. This can be achieved through developing specific facilities and by recycling building stock that is no longer suitable for aged care and by more flexible and varied use of existing building stock. Aged care and disability providers should consider the potential to become public housing providers and managers on behalf of government agencies.

Aged care and disability service providers should also consider providing privately supported care accommodation for older people and auspicing, managing and delivering a broader range of community, education, training and transport services on behalf of government agencies.

Strengthening small rural communities by linking health services, aged care and residential services in an older people friendly community

In many small rural communities the local hospital is centrally located together with integrated community health and co-located HACC services, and substantial co-located hostel or nursing homes run by voluntary community organisations are also on site. Many rural hospitals have substantial land not being used that could accommodate a range of services and accommodate a variety of residential settings for the aged and disabled.

This presents a whole range of opportunities to rural communities and their local or preferred aged/disability provider. The opportunity is to link together these service streams and provide a range of affordable housing options on site that can maximise the use of kitchens, day care and health services.

The second preferred choice of housing identified in the household survey was self-care units. Hospital sites would be ideal sites to develop those facilities and provide group or cluster housing and supported care accommodation. Options could also be provided for family units that allowed close access to handicapped or disabled in adjacent self-care units. Where sufficient land is not available, the feasibility of acquiring adjacent residences to achieve similar objectives should be explored.

The objectives of this approach are to maximise and make more effective the use of the existing core services and to make rural communities more attractive to retirees. It also has the potential to make the development of services by aged and disability services in these towns more attractive as they do not have to develop an entire new site and can use much of the existing infrastructure. Importantly, as identified in this study, older people seem to prefer a range of aged care accommodation ahead of that currently being constructed as hostel accommodation.

This model can be developed as a collaborative partnership with other providers on site or in that community, or an arrangement could be negotiated where the aged or disability service provider is contracted to manage and provide the health services and to develop the residential facilities. If the aged or disability service provider is external to the community, they may also have the capacity to attract and bring clients as new residents to that community.

Carers

A significant proportion of respondents to the household survey indicated that they cared for themselves (individually or by spouse/partner) and the next significant group of carers were family members followed by a range of agencies as the principle carers. At least one respondent saw the caring role as being a lifetime experience with little prospect of retirement from that role.

It is suggested that carers often feel unsupported and lack an understanding of the health care issues they confront and that service providers concentrate on delivering services to the recipient of care without sufficient thought to the needs of the carer. Research (Askham 1998) suggests that support to carers should be needs led rather than service led and that support could range from training/preparation to providing skills, respite, equipment, emotional support, help with care tasks and relaxation services.

Education and training

There are two main aspects to consider in respect to education and training. The first is the importance of education and training to older people themselves, and the second is the importance of education and training to those employed in the aged and disability care sectors.

While in the past retirement was a short life episode, ageing is now regarded as a life stage spanning 20 to 25 years or perhaps a quarter of an individual's lifetime. Therefore, older people need to have access to continuing education to allow them to continue to pursue their hobbies and life interests and to participate fully in commerce, employment and community affairs.

Importantly, the Adelaide Declaration on Ageing (Andrews 1998:4) suggests that:

- The general public of all ages should be educated to dispel prevalent negative beliefs, myths and stereotypes of ageing.
- Ageing persons should themselves be empowered to ensure their capacity for self-help and independence and enable them to make informed choices about all aspects of life.
- The role of older people as educators in the community should be taken into account and a respect for wisdom and experience restored.
- Appropriate education and training should be ensured for both formal and informal caregivers to deal effectively and positively with issues associated with ageing. At all levels, and across disciplines, formal education should incorporate an appreciation of similarities and differences among people of different ages.

There are a number of education service providers who have the potential together with rural communities to target the ongoing education interests and needs of the older person. These include TAFE, universities, Third Age universities, adult education and training organisations. Some aged and disability care providers also have education and training capacity to offer education.

The education and training needs of those employed in the aged care and disability industry are significant in the New England region and are already being addressed through TAFE, the University of New England (UNE), UNE Partnerships in association with the Aged and Community Care Services Association (NSW) and the Australian Nursing Homes and Extended Care

Association (NSW), and other training companies. Some aged care providers are also registered training organisations in their own right.

The regional grouping of the Aged and Community Services Association also provides extensive in-service education in association with its members and a number of providers participate in the training of nurses in association with the School of Health, UNE. UNE also has a specific aged care-gerontology focus amongst its education and research programs. There is an obvious commitment to training and education within the aged care industry in the New England region and this is positively reflected in the quality of care being provided. The Australian College of Health Service Executives (ACHSE) has recently launched an aged care manager continuing professional development initiative for aged cae managers called Aged Care Learning and Networking (AcLan), and the Rural Futures Institute of the University of New England is working on retirement issues for rural dwellers, particularly retired farmers and the potential of technology for older people. Some of the research and reports on education and training suggest that:

- All educators and practitioners working in the area of ageing should be trained to have an understanding of research methodologies and be skilled in critical assessment and application of research findings.

- Negative views of ageing suggest that geriatric medicine as a career is unrewarding, frustrating, and dull (Mulley 1997) and this is despite the fact that general practitioners' workload is increasingly provided to an older population and that the aged care assessment process (ACAT) is highly regarded.

- There is concern about adequate support, supervision and training of volunteers (NSW Department of Ageing & Disability 2000).

- Nursing staff and allied health staff need to be trained to think in cross contextual terms about functional disability regardless of whether this disability arises out of the frailties of old age or some other impairment (Yeatman 1996).

- How can therapists be trained not to place too much reliance on technology or equipment and be encouraged to see that the most important aspects of therapy are their goodwill, intelligence and capacities (Yeatman 1996)?

The future viability of services in rural communities is said to depend on the participation of communities in identifying needs and developing solutions, and this requires community development skills, capacity building and an understanding of research and planning methodologies. The delayering of management levels and the centralisation of management, particularly in government agencies, have meant that many of theses skills have been lost to communities, voluntary organisations and local facilities of government agencies.

It is understood that NCOSS is currently looking at competencies in this area for health funded NGOs but there is a need for a broader opportunity for community members, employees and managers of voluntary, not-for-profit and government local agencies to gain these skills.

Financing

Most aged care services delivered to older people are funded directly or indirectly through public funding, with a more recent contribution from the recipient or family. Some providers deliver services on a payment basis to people who do not qualify or are awaiting assessment for home services or accommodation. There is potential to extend theses services to the well old through supported care models in either purpose-built accommodation, existing modified personal housing, self-care units, group homes, etc.

While older people are pensioners, their income does have a discretionary element or they may be prepared to convert all or part of their equity, as now occurs for hostel accommodation, to receive a guaranteed level of accommodation or services in the community.

Given that aged and disability care providers already provide a range of home care services (meals, lawn mowing, cleaning), they might consider the business opportunities these present in delivering to the general population, either directly or through training, or perhaps accrediting individuals offering these services as contractors. The potential of developing these services through utilising the skills of the older unemployed or disabled needs to be considered, as does the potential for providers to act as a broker of these services for older people.

An Occasional Paper (ACIL 1999:44) on the economic implications of Australia's ageing population adequately summarises a wide range of economic issues and concludes that 'aged care will be affordable over the next fifty years ... and that ... casual observers probably under-estimate the economic contribution of the aged'.

Implementation

The successful implementation of these recommendations will require a long term strategy that utilises the collective expertise and resources of the community, local government, local business development boards/chambers of commerce together with aged/disability care providers and the local health services.

It would be important for each community to identify its existing potential and resources, identify gaps, and determine partners and best solutions. They will need to systematically work to ensure the needs of their rapidly ageing communities are met, identifying opportunities to retain and increase their older population and ensure that as a group they are an equal and important contributor to those communities.

Implications of findings for policy, practice and suggested models of care

In considering the implications of the findings of this study for policy and practice we are reminded that the intention of public policy can be subverted in its implementation (Minichiello & Walker 1996:6). It is also clear that ageing is seen in problematic terms and that approaches to addressing those problems are implemented in such a way that is not only specific to the problem but is achieved without the involvement, and often contrary to the expressed preferences, of older people (Achenbaum 1996:145; Myers 1996:3; Minichiello & Walker 1996:5).

The literature also reminds us that the roles of existing service structures no longer reflect accurately the services provided and that the differences in those roles and structures are disappearing and merging (Fennell & Flood 1998:424; Hindle 2000:3–8; Yeatman 1996:xi). At the same time, the aged care industry is only beginning to recognise the challenges it faces and, understandably is attempting to address those challenges where recognised within the context of existing organisational structures, funding and physical facilities (Cook 2001; Ireland 2001; Isaacs 2001).

There is evidence in current public policy in Australia and in the research literature in Australia and internationally that the issues of ageing need to be addressed in the broadest sense and from the perspective of older people (Andrews 1998:3; Bishop 1991:1–2)). In the context of rural communities, particularly those outside the major regional centres, there is the added difficulty of not having the population to sustain a full range of health, aged, disability and community services locally. Those services that are available are mostly at the direction and control of centralised and distant government agencies or

corporatised private and not-for-profit providers. Rural communities also have to generally contend with declining population and services and, hence, an increased difficulty in attracting and retaining adequate numbers of trained professional staff.

At the same time, those same communities have a proud history of progress and innovation and participation (Kahssay & Oakley 1999:12), particularly in the establishment of local hospitals, aged care hostels and other community services. This community involvement and participation demonstrates community values and effective social capital, as described by Mooney and Aldrich (2001:161–165) and Baum (2000:4). Therefore, there is the potential for these same communities to come together with government and providers to develop innovative models that are described here as *community care models* that incorporate the full range of care services and facilities. Where the scale of the community is not large enough to support all services locally, it is suggested here that a variant of the model be called a *virtual aged care service.* This variant of the community care model would have as a focus the community itself as the 'facility(s) and services' to be modified and adapted to provide a range of services locally, using, where possible, local housing and institutions and support of those facilities and services to be provided at both a local and distant level through the use of technology.

The organisation of such a model would require a partnership between government agencies as funders, a provider(s) and the community (Alexy & Belcher 1997:148). It would provide for an integrated local management and a delivery of a range of services to both those in the community requiring personal care and general services, as well as a willingness to offer those services commercially to the 'well' community (Kahssay & Oakley 1999:133). It is proposed that such a model would develop employment and training opportunities locally as much for the older population wishing to continue working as it might also provide for a younger workforce, in much the same way as already occurs with some disability service providers. The model would not necessarily be health, illness or aged/disability orientated, but would have a broader vision that builds on the social capacity of the community to support the broader agenda of housing, education, social, cultural and leisure pursuits through both employment and volunteerism.

Within this broad model described as the *community virtual aged care service*, there would be potential to adapt the organisation, structure and range of services to meet the varying needs of individual communities (Strasser 1999:10; Best 1999:2). There would be an emphasis on services ahead of facilities and the

potential to source funding across government agencies with reduced concern over which level of government has service responsibility.

A community based *virtual age care service* is worthy of consideration as a pilot scheme in rural communities, particularly where nursing home and hostel beds are not available or are needed for higher category care residents (category 1–4) and to accommodate those in low care category 8 and those not assessed as needing residential care or aged care packages. It is appropriate for those communities where it is not feasible to provide the full range of purpose-built facilities.

Naturally enough, aged care and disability providers often think in terms of the physical facilities that they manage (nursing homes, hostels and retirement villages) and within the confines of the public funding that is provided for those purposes. This all suggests that facilities and services need to be of a certain scale or size to be viable. This focus and responsibility can preclude them from thinking outside the confines of existing services.

However, 'ageing in place' and Aged Care Packages are changing the dimensions of aged care service delivery to become more flexible. The results of this study suggest that an increasing number of older people would, through the use of their discretionary income and the potential of equity conversion, purchase the range of services that an aged care provider already offers such as home care, meals, maintenance, transport, etc.

In particular, given the reluctance of governments to provide additional aged care places, communities, through their preferred aged care or health provider, should consider the establishment of a Virtual Aged Care Service (VACS) within the community. This could include the range of home delivered services developed as a package and provided to those who are assessed and funded to receive aged care as well as those who can afford to pay, and to those who might agree to a full or part equity conversion of assets to fund those services.

In addition to home delivered services, assisted care could also include respite care, sleep-over staff, a house(s) in the community converted as an older people community centre for social, recreational, meal services and day care as well as delivery of care services in a group setting. The wellbeing of residents in their own homes could be monitored using available technology from this house during the day and remotely during the night from an aged care facility in a neighbouring community that has 24-hour residential services. Self-care and

assisted living accommodation could be incorporated into existing modified housing stock within the community.

The Virtual Aged Care Service therefore allows a full range of aged care services to be delivered with professional expertise and standards, with a minimum need for physical infrastructure. It provides the potential for providers to extend their role, size and, hence, future viability, outside the physical dimension of existing facilities and location to become a more comprehensive community service provider. It also allows a greater range of services to be delivered in a small community than would be possible with purpose-built facilities and has the potential to build on the social capacity of a community to assist in the sustainability of services, issues identified as important in this research.

In terms of developing organisational models, Ireland (2001) suggests solutions to the existing residential aged care challenges in rural settings of *networks and alliances*, *co-operatives*, *partnership/joint ventures* and *amalgamations/mergers.* Koff (1998), when arguing that we need to remove the distinction between acute and chronic care to provide a health care system that responds to and meets the needs of people within a continuum, proposes three models of *co-opted services*, *joint ventures* and a *vertically integrated system.* To this group of possible approaches, the researcher would add *consortium* and a *lead agency approach* should be added. These approaches offer governments, community and providers a number of alternatives to develop a workable relationship in an attempt to establish a virtual aged care service. They also represent some of the approaches already in operation in such models as On Lok in San Francisco and other variants supported by the Robert Wood Johnson Foundation as well as approaches in operation in Oregon, USA, and in Sweden (Asplund & Bonita 1994; Coll 1993; Concannon 1995; O'Shea & Costello 1991; Roberts 1991; Robert Wood Johnson Foundation 1994). A schematic presentation of the approaches this model envisages is presented in Figures 4.1 and 4.2.

Fennell and Flood (1998:430–431) describe the key challenges in organisational issues in the delivery of healthcare to older Americans as:

> Challenge 1. To create an appropriate model — and measures that address the levels of analysis in the model — so that we explicitly recognise and factor into our evaluations the true complexity of the organisational levels and interrelated processes involved in producing care and health for the aged.
>
> Challenge 2. To reframe our view of the healthcare delivery system so that we do not limit our evaluation of success to the narrow

organisation-specific piece of the process and do not design our policies to reflect narrow profit-and-loss/firm-based approaches.

Challenge 3. Finally to reconceptualize "outcomes" of care to take into account the reality of care for the significant portion of aged patients whose health problems do not fit the one-disease/acute episode/cure-is-success model of "quality".

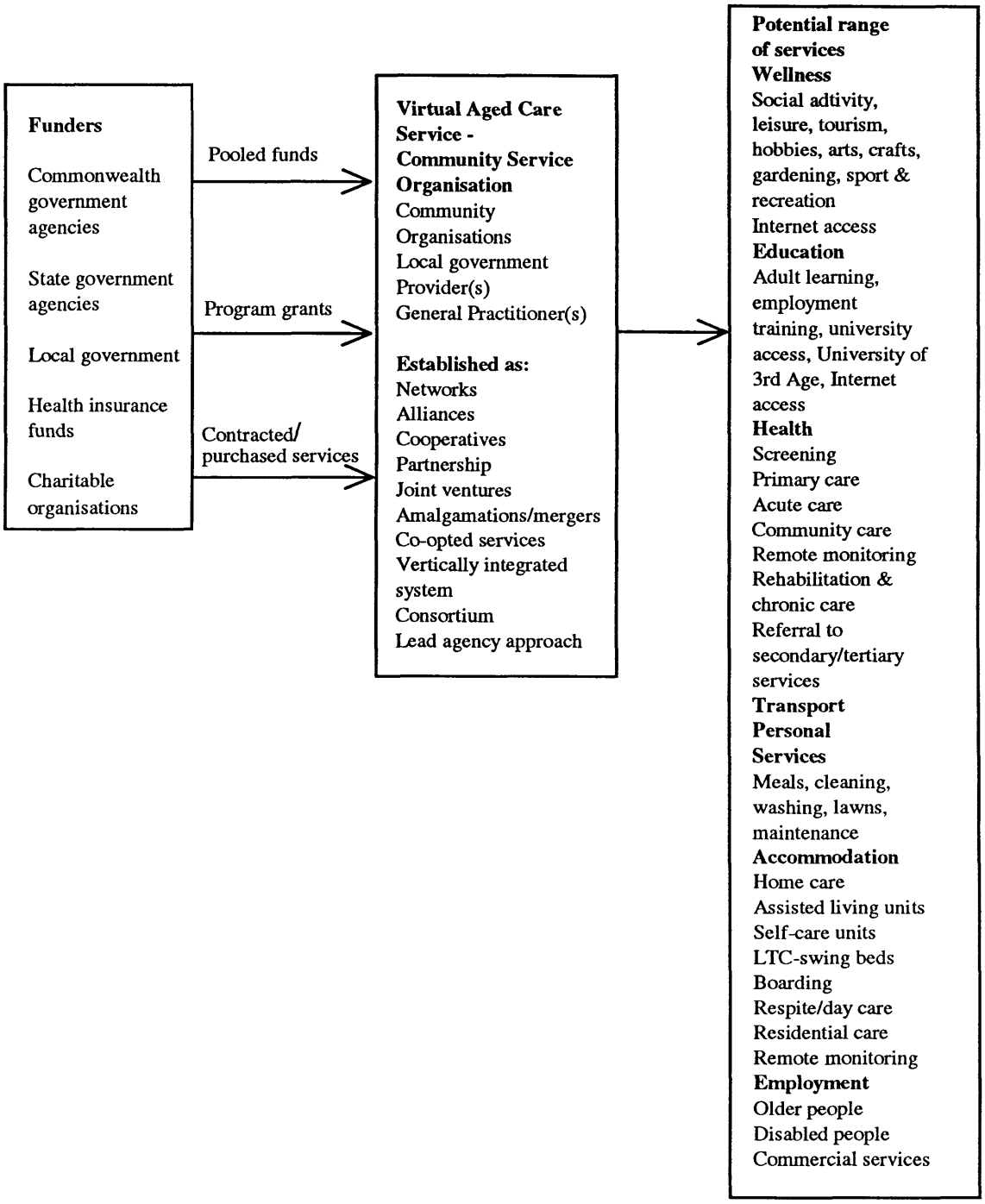

Figure 4.1. Schematic presentation of proposed model of care

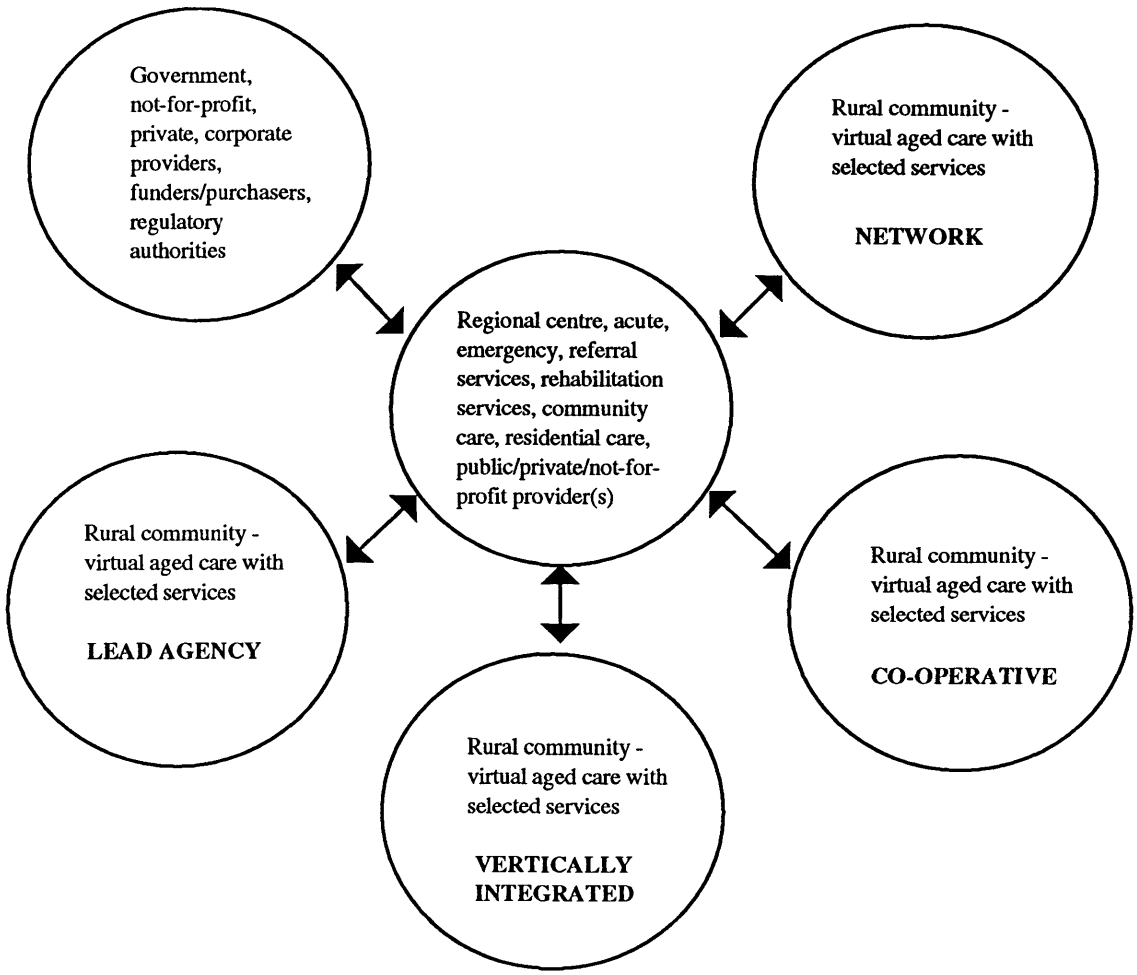

Figure 4.2 Examples of organisational relationships for proposed model of care

In the Australian context, it is appropriate to add a fourth challenge for funders and providers and that is to be less concerned with ownership, control and responsibility and more concerned about moving forward from the existing delivery structures that are no longer appropriate to flexible models that reflect and are designed to meet community needs ahead of funding and organisational issues.

Future research directions

This study examined and reflected on a number of propositions relevant to an ageing population living in rural communities and, in particular, what models of care might be appropriate to meet their needs. These propositions included that the older population is increasing rapidly and will place a disproportionate burden on health and aged care services and that health services to rural communities are in danger of becoming non-viable. The propositions also suggested older people and rural communities are entitled to fair and equitable access to the full range of health and community care services in accordance with the principles of our

universal health care system. The propositions further argued that current organisational structures and delivery systems are no longer appropriate and that solutions, particularly for rural communities, require the active participation of the community, together with providers in the planning, delivery and management of health and community services.

The 'economic burden on health and aged care services' proposition has been disproved by national and international research, although it continues to have currency as an excuse for the perceived stresses and challenges of the health and aged care industry. Fair and equitable access to health and aged care services for rural dwellers is yet to be achieved, although there is now much more recognition of those disparities and of specific programs being introduced to address the issues.

There is an obvious nexus between the declines in rural communities through a loss of commerce, population and services and the inappropriateness of current organisational structures and delivery systems, while acknowledging they are also no longer appropriate across the wider urban, national and international settings. Where there is engagement of communities in the planning, development and operation of health services, it is mostly formalised within the existing organisational structures and delivery systems and is not conducive to moving towards new or innovative paradigms.

As a result, there are a number of directions for further research that can be drawn from this study. These include:

i. A more detailed study of aged care specific preferences of older people for residential accommodation. This study is suggested in that the household survey respondents placed hostel accommodation well below that of nursing home placement. In addition, respondents, after home care, preferred self-care units with services ahead of hostels, yet the current focus on residential aged care, at least in rural areas, still appears to be the construction of hostels.

ii. Admission to residential aged care is now occurring at a later age, with an average age of 85 being common in residential settings. This is likely to result in frailer, more dependent residents with acute care needs. The impact of this change on the role, design and staffing of residential aged care facilities needs further research, particularly given the lead time between

funding and construction of facilities, so that they might adequately respond to the impact of these changes.

iii. Consistent with the above suggested research, the future role of the acute hospital in meeting the acute care needs of older people needs to be re-appraised in the light of the above demographic changes and in respect to the impact of technology on health care generally. Such a study would ideally address attitudes towards access to acute care for older people.

iv. If suggested models of care in this study were adopted, comparative and evaluative research between variants of the model and traditionally organised and delivered services should be undertaken.

v. Research should be undertaken to examine the wisdom and value of the current emphasis in public management on performance measurement and outcomes within existing care paradigms to the almost total exclusion of the use of strategy to shape and determine future public policy and care models. It is proposed that if there were a more balanced emphasis between the two approaches, there would be a greater acceptance of change and adaptation of care models to respond to change.

vi. The change of emphasis of public policy from aged care to ageing and the apparent discrimination against the employment of older workers suggests that the impact of demographic change and the development of a third life stage is not yet understood or impacting on the consciousness of the general population or its institutions. The implication of these developments is worthy of further research to increase understanding of the implications of this significant change.

vii. The inevitable impact of technology on how we deliver care and its potential to deliver care to more rural and remote locations and to allow increased independent living for older people is worthy of continued research and evaluation.

In conclusion, and consistent with the increasingly better educated, politically astute and more experienced older population that is now already in place, there is potential to implement action research and community development approaches to address some of these issues. This might possibly result in sustainable community participatory models of care that reflect the values of a community and engage its social capital.