

The aged care industry in regional Australia: will it cope with the tsunami to come?

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Abstract: This paper reports on a pilot project to map the aged care industry in the Bathurst region of Central West New South Wales. The purpose of the project is to inform the future efforts of government, community based providers (CBPs) and private agencies in the sustainable development of the aged care industry. Early data suggest that the fragmented industry structure of CBPs, funded through asynchronous, disjointed state and federal funding programs, will be unable to respond to the increased demand for aged care services during the next decade. Initial findings also suggest that market tensions between CBPs and commercial providers will increase as they engage in competitive tendering for federal and state funding, and directly compete for scarce labour in a tight regional labour market. This paper explores these issues through a case study of a regional city (Bathurst), a nearby regional town (Blayney) and a rural village (Wattle Flat). The study draws on: interviews with community based service providers, commercial providers, seniors' organisations, and local, state and federal government agencies; and, focus groups with seniors (aged 60+ years) in each of the localities.

Keywords: Not-for-profits, social services, social capital, social services, governance.

Introduction

Ageing in rural and regional Australia

Demographic change

Among the foreseeable social, environmental and economic challenges faced by Australia, the ageing of our population is the only phenomenon which can be predicted with any degree of accuracy (McIntosh 1998; Productivity Commission 2005). The ageing of the population has emerged as a result of a sustained lower fertility rate since 1965¹, longer life expectancies² and the large cohort of 'baby boomers'³ who are beginning to reach retirement age⁴. It is forecast that by 2021 the number of Australians aged 65 years and over will increase to 18% (4.2 million) (ABS 2006b; AIHW 2002). Based on these projections, in 40 years, one-quarter of the population (or 6.6 million people) could be aged 65 years and over. It is also projected that the number of people aged 80 years and over—the ageing of the aged—will almost double during the next 20 years and triple during the next 50 years (AIHW 2002)⁵. The use of formal aged care increases rapidly after 80 years of age, therefore, population ageing will exert substantial pressure on aged care expenditure and aged care service delivery during the next 20 years (DoHA 2005; Productivity Commission 2005, p.34). In spite of access to residential care facilities, the majority of older Australians will remain in their own homes, with meals programs, home support, respite and allied health services, and social support services substituting for institutionalised care (ALGA 2005; Brown et al. 2005; DoHA 2005, 2007a, 2007b, 2007c, 2007d)⁶.

A lesser known feature of population ageing is occurring at the regional level where non-metropolitan areas have, on average, older age profiles and more rapid rates of growth in numbers of over 65 year olds than metropolitan areas (ABS 2006b; Productivity Commission 2005, p.15). It is predicted that, with the exception of Western Australia, populations based outside metropolitan areas will age more rapidly than city populations (ABS 2006a, 2006b; Intergenerational Report 2002). To date, there is little detailed empirical understanding about ageing in rural and regional Australia and its implications for the community based provision of services.

The expectations of 'baby boomers'

The ageing of the population will put significant pressure on regional communities, and not just for the provision of aged care services (ALGA 2004, 2005). With higher superannuation savings in the near term and with increasing expectations and needs, the consumption potential of older residents will drive an increased demand for goods and services that accommodate their income and lifestyle preferences (DoHA 2005; Gittins 2004; Kelly et al. 2002). We are witnessing this already in the Central West region with the 'tree-change' migration of older Australians to the inland cities of Bathurst, Orange and Mudgee. Changing expectations are also evident in the data collected in this study from community based service providers (not-for-profits, NFPs), which identify an increasing expectation of quality, speed and range of their services. For example, managers of hostels have identified resident demands for internet access in their rooms and customised air-conditioning.

Managers of nursing homes have also identified the expectations of their residents' families, for single room/private facility accommodation for their over 80s family member. These expectations cannot be met in older style residential facilities designed, for example, around four-bed wards. Consistent with a consumer society, consumption patterns and expectations of service, aged care services are changing in rural and regional Australia. It is not just a matter of finding a statistical match between the demographics of ageing and service availability, but also developing an understanding of the changing clientele and their different expectations of consumption and lifestyle in the context of the capacity of current service providers to meet those expectations.

Methodology

This research attempts to stimulate awareness of the challenges posed by population ageing in non-metropolitan Australia as the first step in gaining a foundational understanding of the larger economic, social and environmental problems of maintaining sustainable regional communities. As such, it employs an exploratory method by offering a case study, which maps aged care services and ageing issues in a regional city, a rural town and a rural village. The city is Bathurst in the Central West of New South Wales with a population of 37,000, and two of its satellite communities, the rural town of Blayney population 4,000 and the rural village of Wattle Flat population 214, both being approximately 30 kilometres from the major regional centre of Bathurst. Given the marked variations in composition and migration between this region's city, towns and rural villages, the fieldwork locations were selected to target issues of spatial inequity, which are foundational to an understanding of rural and regional life.

The structure of the aged care industry: fragmentation, duplication and frustration

We estimate that the aged care industry in the regional city of Bathurst alone, is worth in excess of \$20 million dollars to the local economy, employing approximately 450 people and calling upon more than 400 volunteers⁷. We estimate that 98% of the labour force is female, predominantly casual and permanent part-time. The aged care industry is therefore a significant contributor to the regional economy and community development, although its 'welfare' and 'pink collar' tags, reinforced by a large volunteer workforce, distort perceptions of its actual significance.

The Australian aged care system depends on, and is characterised by, a mix of types of provision and the need for a high degree of cooperation between service providers and the community (Brown et al. 2004, p.2). The industry in the Bathurst region is no exception⁸. We estimate that 75% of aged care services in the region are delivered by a mixture of CBPs, (including church and national charity groups), the majority governed by local volunteer management committees. While one might assume that responsiveness to clients' needs would be guaranteed in the number, range and differentiation in provider types, aged care clients reported that there is a fundamental mismatch between the clients' needs for life-long decisions in a stable, long-term service delivery framework and the current piecemeal and fragmented structures. It is described by clients and service providers alike as a "maze" and a "real mystery package" in which there is no long-term certainty of service from the client's perspective and no guarantee of organisational survival for the CBP. Government departmental "silos", segmented by jurisdiction, buy the provision of services to a range of client groups on a contract basis in accordance with their preferred policy priorities. Providers, being contracted to the government purchaser are held accountable to the purchaser, not to their clients, as they competitively tender against each other and commercial operators for federal and state funding across a bewildering range of complex programmes.

This supply-side service delivery framework (Hughes 2006, p.7) is identified by all regional CBPs in our study as the source of their major operational problems. Firstly, most of our not-for-profit organisations reported that funding is never guaranteed beyond the current financial year, with funding variations tied to new initiatives and programmes which providers report are quite serendipitous from government. The amount of funding from the raft of government departments, the timing of its provision and the conditions under which it is to be spent are considered by not-for-profit providers to be "totally unpredictable". It is understandable that only 10% of CBPs who were interviewed, have formal strategic planning in place. This is consistent with the identification by Brown et al. (2005) of the lack of strategic planning, generally, in human services. When asked if they anticipated an increased demand for their services during the next 10 years, there is unanimous agreement from providers. However, only three community-based organisations in the current study produce

comprehensive strategic plans. The common response is that CBPs feel hamstrung by their short-term funding cycle. Given the 'tsunami' of 'baby boomers' and the undoubted increased demand for their services, it is of concern that the current supply-side service delivery framework with short-range funding does not permit providers to strategically manage their resources and develop their organisations. It was notable that commercial providers are far more sensitive to market trends and that strategic planning is a focus for their managements. The managers of two private providers spoke the language of "business and markets" and clearly identify the market niches which they wish to capture.

A second operational problem with the supply-side service delivery framework, which all the not-for-profit organisations we contacted reported, is an excessive reporting burden. One CBP identifies that it mandatorily reports annually to five government providers on their respective programme allocations and develops a five-strand annual budget. A common theme from not-for-profit providers is that the reporting burden is exacerbated by the increasingly complex tendering process for government funding "packages". With increasing competition coming from commercial service providers who draw upon their professional financial and resource management skills, the CBPs are finding increased amounts of their time involved in bureaucratic tendering processes in order to effectively compete for contracts, a process which it is felt, diverts resources away from service delivery. Private providers identify the strategic planning expertise of their head office (always located outside the region) as a competitive advantage for their business.

A third operational problem which CBPs identify is linked to the 'fit' between their mission of community service and their commitment and strong sense of obligation to ensure the equitable provision of services in the surrounding rural area. The inefficient and ineffective industry structure overlays what are already significant challenges to service delivery in rural and regional areas (AIHW 1998). The distances that separate rural populations, such as the village of Wattle Flat (30 km from the City of Bathurst), from their service providers who are based in their nearest regional town, is well documented (Gibson et al. 2000) and recognised as a significant issue for CBPs, given the high costs in the delivery of care to rural areas (AIHW 2002). Three factors are at work here. Firstly, the spatial issue means that the provider incurs additional travelling costs (motor vehicle and labour costs) to

reach clients in surrounding rural villages and on rural properties. Secondly, the older age demographic in the surrounding rural area means that while there is a strong community need for aged care services to support residents to remain as part of their village communities, services must be delivered on an individual and customised basis, which incurs additional costs. Thirdly, providers experience great difficulties in recruiting labour (both medical professionals and semi-skilled home care support workers) to service their rural clients. It is common practice to recruit and train the client's neighbours to provide services, where appropriate.

All interviewees identified the expectation of government that the aged, in rural areas, would need to relocate themselves to their regional centres to access medical and support services. This has significant implications for the sustainability of rural communities if a generational spread cannot be maintained. For the reasons identified above, the provision of services to rural communities is not a commercially attractive proposition for private providers who "cherry-pick" lucrative contracts in the higher population density areas of the regional city and town. Issues of spatial equity and aged care service delivery are likely to become even more prominent during the next two decades (Brown et al. 2004, p.2).

The 'glue' of social capital

Given that the current industry structure is not conducive to the effective and efficient delivery of services, how then do CBPs manage to meet the demands and expectations of the aged? Social capital (Lui and Besser 2003; Stone 2001) (the network of mutual obligations) is the 'glue' that holds the Bathurst regional aged care industry together. All CBP interviewees identify the strength of informal, local networks between providers as a means of "making the system work". For example, it was common for volunteers from a transport or meals service CBP to informally notify the district nursing service or medical professionals if they perceive a significant deterioration in their client's condition. All CBP interviewees also identify the significance of social capital in their direct relationship with their clients. The socialisation/personal interaction aspect of their service is just as important as the functional service delivery. For example, most CBPs offer recreational and entertainment opportunities to their clients in addition to their specific service function.

Significantly, this pilot project identifies that any analysis of service provision and age-friendly infrastructure must incorporate an

understanding of the integral role that CBPs play, not only in functional service delivery, but also in the generation of social capital, which is at the heart of community development and sustainable rural and regional communities. The fragmented industry structure is partly re-integrated through the shared sense of community obligation and the strong bonds of social capital generated by CBP workers and their clients. The statistics are unequivocal. There will be a significant increase in demand for services during the next 20 years, which will put even greater strains on an already fragmented and inefficient industry structure (ABS 2006a, 2006b; DoHA 2005, 2007a, 2007b, 2007c, 2007d). Under such increased strains it is unlikely that social capital alone will be able to keep the current industry structure functioning.

Community based service providers and the market

Ultimately the community needs reform to the way in which aged care services are delivered. We are already witnessing the emergence of a market in aged care services in the Central West region and the consequent competitive pressures under which regional CBPs now operate. The tensions between CBPs and commercial providers will continue to increase. Commercial providers report that they are strategically targeting segments of the regional market which are deemed to offer the greatest returns. CBPs report that they find it difficult to compete for labour in an already tight regional labour market, given the higher wages and career opportunities that commercial operators are offering. This is consistent with the Federal Department of Health and Ageing identifying community care workforce development as a priority area in its 2007–2008 budget (DoHA 2007c).

These existing tensions can only be exacerbated by the current trend to accelerate the introduction and spread of market-based, consumer-centred systems and individualised funding arrangements across a range of services and programs. Individualised funding allocations are already in use in several jurisdictions in aged care (Hughes 2006). In Victoria, Tasmania, Queensland and South Australia, state governments have been experimenting with overseas models (United Kingdom, United States and Canada) that to varying degrees, assign a direct payment to the client who is then free, often through an intermediary broker, to purchase services directly from providers (Hughes 2006). With such changes on the horizon, it is timely to ask what configuration of CBPs, commercial providers

and government is likely to produce the best outcomes for the aged in the Bathurst region.

A pathway forward

An alternative industry structure for the delivery of regional aged care services

The Federal Department of Health and Ageing acknowledges the need to develop better models of care planning and delivery. To date it has sought to achieve this through quality assurance measures within the existing service delivery model (DoHA 2007b). We suggest that such an approach has limited efficacy, given the massive problems of the overall industry structure. On an international level, efficient and effective service delivery models for aged care are being developed (Gupta and Harding 2007) using microsimulation models.

This pilot study would like to suggest investigation of another approach. We propose that the regional model adopted for natural resource management (NRM) in Australia has potential for the provision of aged care services in rural and regional Australia. The aged care industry and the NRM and landcare sector have much in common: complexities of dual federal and state funding and the need to move to a regional systems approach to facilitate a more strategic approach to government funding and service delivery; the uncertainty for CBPs, their clients and the community about outcomes and processes; a diversity of stakeholder values; excessive reporting to government agencies; the need to combine regional planning and local engagement given the CBP nature of service delivery and the heavy reliance on volunteer labour; and the need for strong, professional governance, moving away from a plethora of volunteer management committees of individual providers. We are suggesting that these synergies are sufficient to explore the application of the NRM regional model to aged care service delivery in rural and regional Australia.

Regionalisation is the result of government or industry forming 'administrative regions to improve management efficiency and delivery' (Jennings and Moore 2000, p.178). Decision-making may remain centralised or also be devolved to regional managers. Regionalism relies on community members to initiate and develop regional arrangements, often relying on multiparty arrangements and planning. Regional planning and management empowers the community. Such empowerment is aided by regional based, government-community partnerships. The NRM regional model's potential is highlighted through its 'capacity to devolve decision-making and resource allocation to appropriate

scales, to tap into and build on deep local knowledge and connection to place, and to work across issues and industry [providers] in an integrated way' (Campbell 2006, p.3). A strong argument for the regional model is that decisions about how resources should be allocated, used and managed are best made at the level that most closely represents the people affected by those decisions (Ribot 2002).

The 13 Catchment Management Authorities (CMAs) that have been established across New South Wales under the NRM regional model have a board and staff, and are directly responsible to a State Minister. The success of a CMA is based on its ability to set a clear agenda for action with community support. Fundamental to this is the setting and acceptance of catchment standards and targets. Public engagement and participation is needed to fulfil statutory requirements, to ensure public acceptability of decision-making, and to enhance chances for successful ownership and implementation of catchment action plans and investment strategies by members of the public (Ross et al. 2002). As with NRM, it is hard to disaggregate issues in the aged care area and just focus on one aspect at a time. Problems cannot be considered independently of other social, economic, commercial, legal, policy and institutional dimensions. As with NRM, successful planning and provision of aged care services in Australia depends upon engaging a wider range of stakeholders. For example, seniors do not think of single issues such as transport to hospital. They think of the more holistic issue of having access to health services. The regional model has also produced an investment in regional capacity building as the involvement in the NRM processes has substantially enhanced the skills, knowledge and capabilities of community representatives engaged in the planning and implementation activities (Paton et al. 2004). In fact, it was also found that the government officers, at commonwealth and state level, learned as much as their regional partners. Historically NRM and its governance in Australia had suffered from an *ad hoc* approach and an inability to adequately learn from past experiences (Dovers and Wild Rivers 2003). The creation of CMAs and having a focus on engaging community members for the boards represented a significant challenge in regions suffering from public participation burnout and cynicism arising from continued restructuring of NRM administration. The barriers faced by regional NRM bodies are similar to those faced by the aged care services identified in this study and by other authors (Allan and Curtis 2003; Campbell

2006; Paton et al. 2004) and include the items shown in Table 1.

Other issues with the regional model arise whenever there is the drawing of boundaries. CMAs are largely bounded by the watersheds of major river systems thus ignore social networks. The strength of identifying and acknowledging social catchments, as would be the case in applying this model to aged care, is that they are centred on their own central places, communities, comprising people they already know and work with in other groupings (Brunkhorst et al. 2004). Dissatisfaction and often competition between existing communities can occur where boundaries split communities that share relationships, concerns and similar land use.

Conclusion

The pilot project suggests that we need a radically new configuration of service delivery if aged care services in the Central West region of New South Wales are to effectively cope with the additional demands for service, which we know are inevitable during the next 20 years. The current industry structure is held together by the goodwill of social capital which will wilt in the face of: increasing market competition between CBPs and commercial providers, and between CBPs themselves as they competitively tender against each other for government funding; the demanding expectations of service from 'baby boomers'; the imperative of professional governance to ensure compliance with an increasing raft of government regulation and accountability (industrial relations, workplace health and safety, fiduciary responsibilities of operating budgets in the millions of dollars; health regulations); and the changing face of volunteering in Australia. We are suggesting that the NRM regional model is worth exploring as a way forward to securing industry restructuring and cultural change in the aged care industry before the tsunami of 'baby boomers' arrives.

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Endnotes:

¹The ageing of Australia's 'baby boom' cohort, with lower mortality rates than previous generations and smaller cohorts following as fertility declined, accentuates the impact of an ageing population. In the past century, the proportion of the population aged over 65 has risen from just 4% to nearly 12.5%. By 2042, about 24.5% of Australia's population is expected to be aged over 65 (Australian Government Treasury 2002:4).

²Australia's death rate fell from 8.5 per thousand in 1971 to 6.9 per thousand in 1991 and around 6.7 per thousand in 2001. The decline in mortality rates across all age groups is expected to continue for the next four decades. Although women have a

higher life expectancy than men, men's mortality rates have fallen faster than those of women (Australian Government Treasury 2002:4).

³Baby boomers' are the large cohort of Australian residents born during 1946–1961 in the aftermath of World War II.

⁴The 'baby boomers' will begin to reach 65 years of age from 2011 onwards, resulting in a sharp increase in the proportion of the population aged 65 plus during the subsequent 20 years to approximately 4.2 million.

⁵By 2020, 500,000 Australians will be aged 86 years and over (AIWH 2002:2). Based on recent trends, men born in 2042 are projected to live to 82.5 years, an average of 5.3 years longer than those born in 2002. Women born in 2042 are projected to live to 87.5, 4.9 years longer on average (Australian Government Treasury 2002:4).

⁶The 2007-2008 Federal Department of Health and Ageing identifies that most Australians prefer to grow older in their own homes. The Department's Ageing Budget makes significant provision for community care packages, both low level (for example, help with household activities and personal care) and high level (which may involve complex nursing). The greatest growth is in high-level care at home. In previous decades many of these seniors would have taken up institutional residence.

⁷The figure is based on interviews with 20 providers in Bathurst. The exact worth to the local economy is not possible to determine in that private providers are reluctant to release budget and wages figures. Given the strong trend towards part-time and casual work, many of the employees may well work for more than one employer. Similarly, volunteer numbers have been aggregated, however, volunteers may offer their services to more than one organisation.

⁸The Bathurst/Blayney/Wattle Flat aged care service providers are: two community nursing services (NFPs) which cover the Bathurst city area and Blayney township; a district nurse, servicing the outlying area of Wattle Flat and other small villages; a small State Government public MPS hospital with outpatient aged care services; the Meals on Wheels (NFP) meal production facility, preparing hot meals for volunteer delivery in Bathurst city and frozen meals for delivery to distributor organisations across two thirds of New South Wales (NFP); two community based home care providers (NFPs) funded through a bevy of state and federal programmatic modules and "packages", won through a competitive tendering process. Their coverage and clientele overlap with the State Department of Ageing, Disability and Home Care's (DADHC) Home Care Service. Services range from cleaning, personal care, shopping and volunteer visitor programmes. (The Federal Department of Veterans Affairs also provides these services in the Bathurst regional area, with client assessment and service co-ordinated from South Australia.); a day respite care centre (NFP) recurrently funded through state and federal funding; two community transport organisations (NFPs) (buses and motor vehicles driven by volunteers), which facilitate eligible frail aged access to medical services, shopping facilities and social activities within the region, and to Sydney if required (funded through two federal

departments and one state department); the team of medical professionals known as the Aged Care Assessment Team (ACAT) operating out of a local church-run private hospital, acting as the gateway for assessment and access to services (a role won through a tendering process); one nursing home (church owned and managed, high care) with associated hostel and independent living units; one nursing home (community based organisation, NFP, high care) with associated hostel facilities; two hostels (charity owned and managed, low care) and associated retirement villages with privately owned units; a retirement village of 36 one bedroom units offering low cost accommodation with a high proportion of retired rural village residents (community based NFP in partnership with a church); three charity based welfare agencies such as the Salvation Army and St Vincent de Paul offering financial support with essential services, crisis accommodation, the supplementation of clothing and food, and volunteer home visits. Estimates are that 10–15% of their clients are 60+ years; a commercially owned and operated hostel (head office control operating from outside the region); two commercial home nursing services (based outside the region); three commercial home care services (based in Sydney and operating through local co-ordinators), and; one commercial nursing home (head office control operating from outside the region).

Table 1. Synergies between the delivery of NRM and aged care

Fragmentation (multiple sources)	Information exists but where to find it is an issue. Inconsistent messages from mixed sources creating confusion and a lack of trust.
Overwhelming volume of information	Difficult to find time and resources to search, filter and manage the information available to them from the multiple websites and organisations.
Relevance to regional scale and issue	Generic or broad information is difficult to scale down to a particular geographical area and not necessarily addresses regional needs.
Accessibility	Format of information, the like or dislike of web searching, preference for face-to-face communication.
Information sharing	Not shared enough between regions or between national organisations or on a regional to national scale.
Two-way flow of information	Regional bodies feel that their information needs are not heard or valued at a state or national level.
Excessive reporting frameworks	Reporting remains exceedingly complex and time consuming and continues to focus heavily on activities but little time for evaluation and reflection.
Lack of forward funding commitments	Government financial commitment can be contentious and erratic and there is little confidence that governments will commit to widespread longer-term funding.