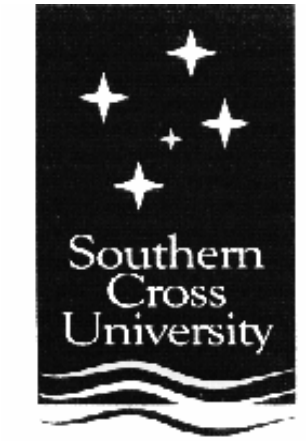

THE UNIVERSITY OF NEW SOUTH WALES

School of Rural Health

Aged Services Learning and Research Collaboration.
(ASLaRC)

Submission
To
House of Representatives
Standing Committee
On
Ageing

Aged
Services
Learning
and
Research
Collaboration.

THE UNIVERSITY OF NEW SOUTH WALES

School of Rural Health
Faculty of Medicine

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Monday 19th May, 2003

Dr Andrew Southcott MP
Chairman
House of Representatives
Standing Committee on Ageing
Parliament House
Canberra, ACT. 2606

Dear Sir

The attached documentation presents the submissions of several organisations concerned with providing for Coffs Harbour's increasing aged population.

There is clear evidence of an explosion in the aged population in an environment not able to care for them.

Coffs Harbour is not unique in this. Many other coastal regions have, or will have, the same problems.

What is unique is that Coffs Harbour has a large, effective, network of providers able and willing to address the problems and to develop solutions which can be exported to other regions.

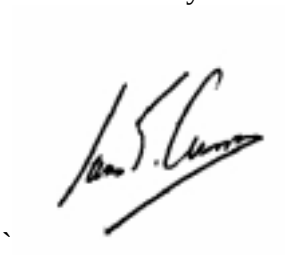
Two universities (University of NSW and Southern Cross University), TAFE, Council, major developers, private and public hospitals, home care services and others all

co-operate with each other now and are very willing to embark on action research programmes to address the varied problems we all perceive.

The two Universities have set up an entity (ASLaRC) specifically to meet this need.

ASLaRC will be presenting its case to the Minister for Ageing for seed funding (in the order of $500,000 p.a.) for three years to develop specific and general solutions. Any assistance from your Committee would be most welcome

Yours faithfully



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1. Introduction
2. The population
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6. Technological Innovations
7. Research Priorities

Chapter 1

INTRODUCTION

The University of New South Wales (UNSW) has set up a campus of its School of Rural Health in Coffs Harbour. It already has medical students placed and will expand over the next few years.

The Southern Cross University (SCU) has a large, well established presence at the Coffs Harbour Education Campus (CHEC). That University has a School of Nursing and Health Care Practice, a Department of Exercise Science and Sports Movement, an Institute for Action Research, a Department of Psychology, a School of Business and a Department of Information Technology. The Campus includes a TAFE College, a Senior School and an Innovations Centre.

The town itself offers, in a largely rural setting, a Base Hospital, an active Division of General Practice, domiciliary services, nursing homes, hostels and the usual compliment of voluntary and ancillary services. The City Council is most supportive of Educational activities and has provided a site for the Medical School Building.

There is general agreement that the anticipated large influx of "sea change" retirees will over stretch existing services.

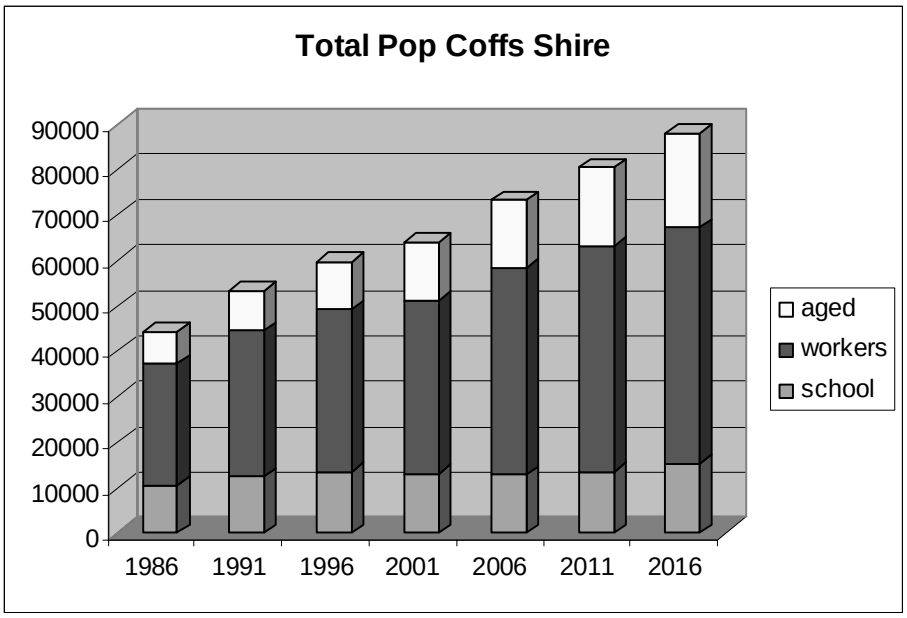
The happy co-incidence of all the above elements, all with good communication channels, has prompted the two Universities to propose an Aged Services Learning and Research Collaboration (ASLaRC). Its function is not to duplicate biomedical research into ageing but to examine practical ways to maximise the delivery of services to the ageing population, firstly in the region, but ultimately to the ageing population in general.

The two campuses already have the elements in place to tailor courses at all levels to meet the challenges identified by ASLaRC.

Chapter 2

THE POPULATION

The population of Coffs Harbour is not typical of NSW, or indeed of most of Australia. Despite a perception of greying it maintains a higher proportion of younger, working age (albeit unemployed) adults and maintains its fair share of school aged children. The dramatic greying of Tasmania and South Australia is not reflected here.



Nevertheless the official population projections (Mid North Coast Board) give rise to some doubts. The cohort of school age children seems to rise without good reason and the historical exodus of 15-25 year olds is reversed in the projections for the next 15 years.

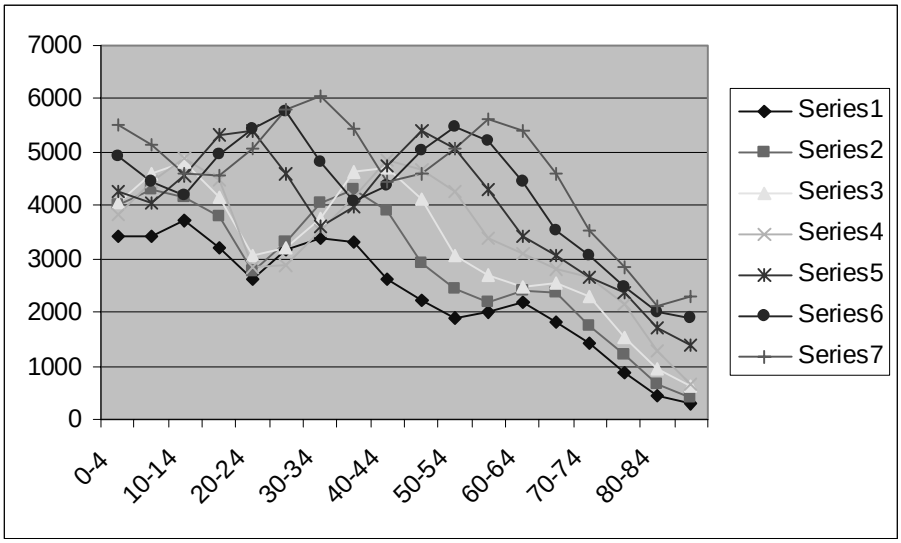
We do not believe that the figures for 2006-2016 apply to the 15-30 year age groups – unless a major expansion of educational and job opportunities emerges.

The figures for 60+ almost certainly are conservative.

What is clear is that older Australians are leaving the cities for "sea change" lifestyles and that Coffs Harbour is experiencing a dramatic immigration. Developers anticipate 2-3000 new retirees within 5 years.

The problem is that these people have paid their rates and taxes elsewhere to develop the infrastructure (care services, nursing homes, senior citizens centres etc.) and arrive here on rate rebates and other discounts. The major task is how to reallocate resources away from the cities.

Population trends for Coffs Shire



Note the divergence between historical data (1986-2001, series 1-4 and projection 2006-2016, series 5-7)

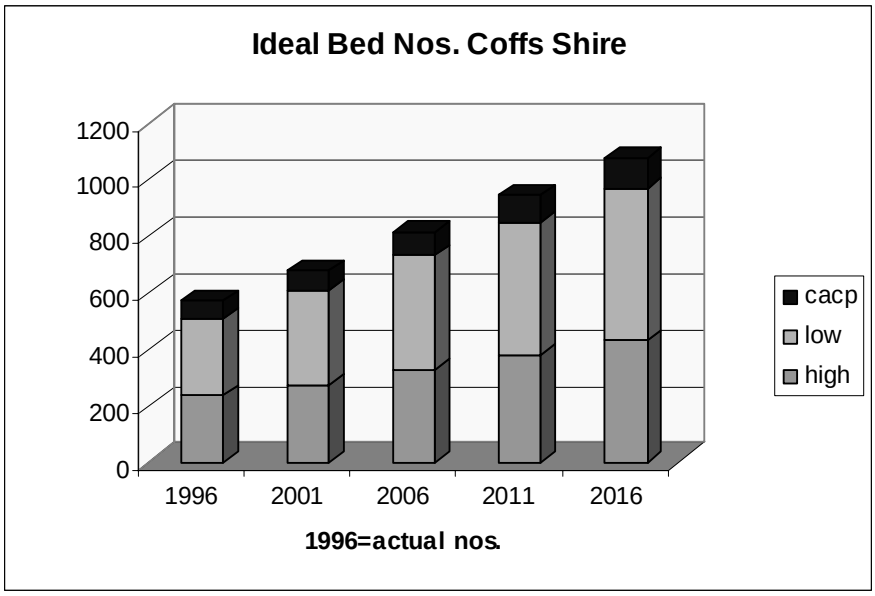
Residential accommodation

Institutional accommodation numbers are already well behind planning ratios.

Project numbers for present trends are

			YEAR (actual places)	2001	2006	2011	2016
BEDS	high care	40/1000	=	235	277	325	378	430
	low care	50/1000	=	342	346	406	472	538
	CACP	10/1000	=	88	69	81	94	108

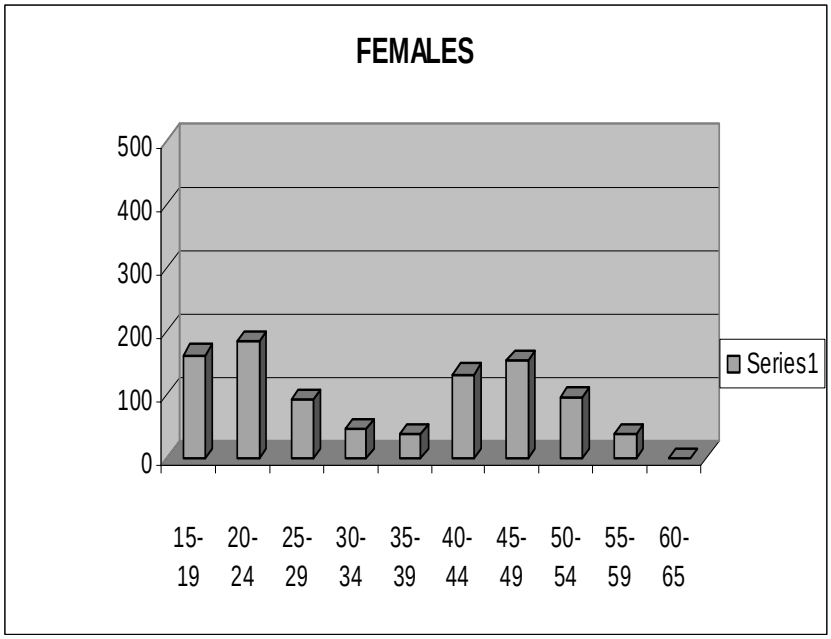
In the following graph ACTUAL beds are shown as 1996 and PLANNED (approved) beds as 2001. 2006-2016 are the projected requirements to meet the standard.



This clearly shows that the region is already well behind in provision of beds and community places and that it is not likely to catch up in the foreseeable future..

As to the labour force the **figures show a continuing exodus of 25-30 year olds but interestingly a hump of 40-50 year old females in search of work**. That may prove, short term, to be a source of carers, given suitable training.

Female Job Seekers



Chapter 3

EXISTING RESOURCES

The aged are intensive users of health resources. However the vast majority (80%) live out their lives in their own home environment without recourse to residential accommodation/care. The home environment results in far lower costs to the public purse, even when substantial levels of support are provided.

3.1 GENERAL PRACTITIONERS

GPs are central to the care of the aged. The situation here is marginal. Many surgeries have their books closed and new entrants to the town have difficulty accessing a family doctor. The day-to-day demands for surgery services have made home visiting almost extinct. **Certainly to travel any distance to a home, nursing home or hostel visit for the Medicare rebate is quite uneconomic**. The constant cry from established practices is for more young practitioners. They are not appearing and the established GPs are ageing themselves.

3.2 SPECIALISTS

One of the perceived benefits of starting a medical school here was the possibility of attracting more specialists. There are severe deficits in oncology, ENT, dermatology, orthopaedics, medicine, psychiatry, and geriatrics. Waiting times and waiting lists are ballooning. **A large number of residents travel elsewhere for specialist care. This is a significant burden on the aged.**

Publications from the Australian Medical Workforce Advisory Committee (AMWAC 1988.7) set out the problems of a regional medical workforce. The following snapshot of Coffs Harbour is based on their recommendations.

Summary of medical workforce in Coffs Harbour catchment. (65,000)

Recommended levels			"Optimum"	Actual	Shortfall
10,000-30,000					
GP	1:	1,500	43.3	28	15.3
general surgeons	1:	11,500	5.7	2.7	3.0
anaesthetists	1:	6,000	10.8	5	5.8
20,000-60,000					
obst & gynae.	1:	12,500	5.2	3	2.2
paediatrics	1:	20,000	3.3	2	1.3
psychiatry	1:	12,500	5.2	0.5	4.7
orthopaedics	1:	14,000	4.6	2	2.6
geriatrics	1:	106,000	0.6	0.5	0.1
pathology	1:	50,000	1.3	2	-0.7
50,000-80,000					
ENT	1:	40,000	1.6	1	0.6
dermatology	1:	90,000	0.7	0	0.7
rehab medicine	1:	133,000	0.5	0	0.5
neurology	1:	106,000	0.6	1	-0.4
thoracic medicine	1:	98,000	0.7	0	0.7
Not fully specified					
general physician				2	
cardiology	1:	40,000	1.6	1	
Based on catchment population of		65,000		**Net shortfall**	36.4

3.3 NURSING WORK FORCE.

There is a strong anecdotal case that there is an acute shortage of nurses, at all levels. Precise figures are not immediately available and elucidation of this situation is a priority. ASLaRC has already commenced this work.

3.4 ACUTE HOSPITAL BEDS

Coffs Harbour Base Hospital has 154 general beds, 30 mental health beds and 24 rehabilitation beds. Admission of aged people in crisis is difficult to arrange and early, often inappropriate discharge, is common. Discharge planning is well done where it is done but in many instances it is sadly lacking. Waiting lists for

common procedures, not necessarily unique to the aged, such as cataract, colonoscopy, hip replacement etc. are perceived as long. (officially 3.8 months for patients “ready for care”)

The perception is that the hospital fails to cater for current requirements and has no hope of coping with anticipated population increases.

3.5 MENTAL HEALTH SERVICES

Psychogeriatric services and other mental health services are poor.

3.6 OUTPATIENT SERVICES

There are few outpatient clinics at the hospital. Patients are referred to the appropriate specialists at their rooms.

3.7 TRANSITIONAL BEDS

Such beds are intended to free up acute hospital beds while an aged patient awaits placement**. There are none.**

3.8 NURSING HOME BEDS (High Band)

At the current planing ratio of 40 beds per 1000 population over the age of 70 Coffs Harbour should have 277 high band beds. It has 235, and all of these are not yet operational. Accommodation standards vary from barely adequate to overly generous.

3.9 HOSTEL BEDS (Low Band)

The ratio here is 50/1000. This yields a desirable number of 346. The actual number is 303(+39 not yet operational). The standard is more uniform but one large facility is outdated and will soon have to be replaced..

3.10 RESPITE CARE

There is huge, largely unmet, demand for respite care both in the patients own home and in institutions.

3.11 DAY CARE

The one day care facility is grossly overloaded.

3.12 DAY HOSPITAL

This is not to be confused with day care. The function of a day hospital is not to occupy or amuse, but to offer a full range of investigative and therapeutic services without using in-patient beds. Cancer care, renal services, rehabilitation services and day surgery are in place on this basis.

3.13 SELF CARE (SHELTERED)HOUSING

This is not subject to planning guidelines or government subsidy. Market forces apply. Units are available in the religious/charitable and private sectors.

3.14 HOME CARE

This is demonstrably the most cost effective mode of caring for the aged. It has many elements and is far from fully developed, balanced or managed. There is much confusion as to who funds or takes responsibility.

3.14.1 HOME NURSING

Nurses have traditionally borne the brunt of home care of the elderly. Numerically they are the highest proportion of professionals in the system and remain critical to standards of care. In Coffs Harbour services are provided by both public and private services. Co-ordination and management of their effort is a problem. Funding sources are complex and budgeting time consuming and frustrating.

13.14.2 HOME HELP

This service began as provision of housemaid type assistance and has grown to a much more proactive home care provision. Demand exceeds supply.

13.14.3 ALLIED DOMICILLIARY SERVICES

Physiotherapy, Occupational therapy, Podiatry, Speech pathology, Social Work and the like all need to be delivered in the home environment, perhaps more so than in institutions.

13.14.4 MEALS ON WHEELS

This is very often the entry point to home care services. It provides a major element in delaying or preventing admissions to institutions. It also, by default, provides a valuable monitoring and early warning system.

13.15 COMMUNITY TRANSPORT

Coffs Harbour has a poor public transport service. By the standards of Sydney/Wollongong/Newcastle it is very expensive. Senior citizens discounts are not available.

If full use is to be made of home services, day care, day hospital and other services in an effort to keep the aged in their own homes then transport between the various elements is critical.

The existing community transport organisation has 4 buses (22 seats each) but only 20 hours/week of paid driver time. The rest is provided by an ever diminishing pool of ageing volunteers.

Chapter 4

GAPS IN SERVICES

The first task of ASLArc will be to properly define these gaps. For the present the perceptions are merely those of a small group and are certainly subject to correction.

There is an urgent lack of solutions to crisis situations in aged care. Hospital beds are not available, respite beds are fully booked and a comprehensive set of home services is impossible to arrange out of hours/weekends etc. Transitional beds would go a long way to meeting this need.

While the region is clearly well behind planning ratios for long stay beds that is not necessarily a bad thing. Beds are an expensive option. There is clear evidence that home care (aging in place) is a very viable alternative. It is an area in which research is pressing. While the cost to the community (i.e. government) is demonstrably lower much of the cost remains with the user and their family. The users themselves very clearly prefer to stay in their own homes, even at the trade off of lesser services.

Many medical practices in the region have closed books and accept no new patients. All the doctors complain of unduly heavy demands on their services yet cannot attract or retain new practitioners in the town. **There is a patently obvious shortage of medical specialists.** While the Medical School may address the problem at some future time the need is now.

Home care services are funded from and provided by a variety of sources, public and private. Accessing these services is difficult for the uninitiated and frustrating for the professionals. All the providers feel over stretched and unable to properly meet demand.

There is a good Aged Care Assessment Team based on the Hospital. However its role is constrained and its resources limited. Ideally it should control discharge planning and home care services as well as its gate keeping role in residential care.

There is no equity in community transport. Over-60s can travel all day for $1.20 between Wollongong, Sydney and Newcastle but not in this region. Public transport is provided be a private company which clearly cannot provide this level of subsidy.

We have only begun to scratch the surface of technology applications for the aged. Despite popular opinion the elderly are well able to user computer and internet services. The whole gamut of electronic service delivery lies before us. Banking, shopping, security, entertainment, information, audio-visual communication and medical triage are just a few of the areas that come to mind.

Chapter 5

EDUCATIONAL and RESEARCH OPPORTUNITIES

This is the major strength ASLaRC. All of the elements are already virtually on the one site.

The Health Campus (essentially the Base Hospital and the Mid North Coast Board services) is situated close to the Education Campus (which incudes the SCU, TAFE, the Senior College and the Innovation Centre) and the Medical School building will be between the two with easy access to both. Happily relationships among the elements are cordial and communication is easy. The City Council remains a major player having provided the sites for the Education Campus and the Medical School. Education/ academic activity is seen as a major future direction for the City.

One of the guiding principles of ASLaRC will be to conduct research in the local area which will have State and National applications and also be amenable to practical solutions. The inbuilt links to two Universities, TAFE, School, Hospital, residential accommodation, home care, Council, medical practices and Community organisations places it in an almost unique position to achieve its aims.

ASLaRC has the present ability to influence courses in the final years of school, in TAFE level 3 nursing caring and administration courses, in the Schools of Nursing, Human Services and Information Science at SCU and in the School of Rural Health. Students from all these elements are to be seen as contributing to the research projects. Academically the Institute can sponsor students for further diplomas and degrees in all the disciplines. For example Certificates and Diplomas in Administration, Masters by Instruction or Research in Nursing, Social Sciences, Psychology and Computing, right through to PhD and MD levels.

The major justification for the School of Rural Health is to attract quality medical personnel back into regional centres. The additional carrot of academic excellence will complement that aim.

Chapter 6

TECHNOLOGICAL DEVELOPMENTS.

Despite the perceptions of the young the elderly and not computer illiterate. Internet and computer courses are very popular where they have been offered. The application of information technology and the whole question of man/machine interface is a fertile field for research and education. **The Myer Foundation papers identified this as a major area for research.**

SCU has on this campus a School of Information Technology (one of its major strengths) and the Campus also supports an Innovation Centre to provide commercial input to its endeavours. Both are well aware of ASLaRC's activities and greatly supportive.

The whole gamut of electronic service delivery lies before us. Banking, shopping, security, entertainment, information, audio-visual communication and medical triage are just a few of the areas that come to mind.

Examples for potential activity in the home are:-

Banking. Now that Banks no longer seem to want real customers electronic banking seems the future for us all. Ways of helping aged and disabled customers access their banking need to be developed.

Shopping. E-shopping is with us. Can we implement it?

Security. A wide variety of security systems can be offered in home via the internet. Intrusion, accident and fire alarms come to mind.

Information. Library services, hobby and community information can be provided

Entertainment. Music, books, games and group activities are already available.

Audio-visual. The net can now sustain two way TV conversations. The potential to keep in touch with family, friends and services is great.

Remote control. More and more devices can be controlled over the net. The potential is there to check security, fires, stoves, electric blankets, lights etc by remote to ensure that all is well at the end of the day.

Medical triage. There is already much activity in e-medicine. The potential is for the net to provide access to triage services to relieve anxiety and identify risk.

Many other areas also have a great need for technology**. Nursing home administration lags well behind in IT applications.** Community transport projects could benefit from computer dispatch systems.

The use of computers for such endeavours as maintenance of waiting lists, tracking of resource allocation and budget control are all in their infancy.

Chapter 7

RESEARCH PRIORITIES

In many ways the priorities of ASLaRC will be constrained by the availability of funding and research staff.

The intention is to provide a matrix of opportunity and work towards completing individual projects within it on an opportunistic basis.

Projects which appeal immediately are:-

To construct a computer model of the region's population and services for the aged so that all agencies can access current, accurate information and we can have the ability to test a variety of solutions. While the local figures will not apply elsewhere the mathematical model should be fully exportable to other regions.

To research the problems of recruiting, training and retaining staff in aged care and to address the problems of professional pride and confidence in such an environment.

To introduce computer prescribing and medication tracking in residential accommodation for the aged. This will be fully exportable. **This project is nearly complete.**

There is a clear need to address the issues of non-cancer dying in our community. It is badly done and much in need of research.

Community transport for the aged is poorly supported outside the Wollongong – Sydney – Newcastle nexus.

The One-Stop-Shop. Is there some way users and providers can access all services from a single agency, such as the Aged Care Assessment Team, on a seven day basis? Can the major services be managed as a coherent unit?

AGED CARE SERVICES – COWPER (May, 2003)

INTRODUCTION:
Life expectancy continues to increase. In Vic life expectancy has risen by 1.3 years for women and 1.8 years for men in the last five years (attachment 1). Our ongoing ageing together with the prospect with increased movement of older people to the economically deprived electorate Cowper makes for interesting times.

DEMOGRAPHY (attachment 2)
Sets out population projections for LGA's of Coffs Harbour, Bellingen and Nambucca as per 2001 ABS statistics with projections to 2006, 2011 and 2016.
Yamba and Maclean are not included as they form part of the Northern Rivers Area.

AGED PLACES AND COMMUNITY AGED CARE PACKAGES (CACPs) NUMBERS AND RATIOS are as set out in (attachment 3).
They include some recently approved but not yet completed facilities.
Last year it was announced that 6,000 CACPs would be progressively added to the National total over the next four budgets to help increase the desired CACP ratio from 10 to 18 per thousand over 70 over a four year period.
Current allocation of CACPs for Coffs Harbour is 120 places representing a current ratio of 16 per thousand over 70.
There are currently more than 40 on waiting lists for CACPs which are of several month's duration. The hours of service allocation are sometimes shorter than desirable.
Ten high level care (EACH) packages are shortly to be allocated for the whole MNCHS.

ACUTE HOSPITAL SERVICES:
Average patient length of stay in the Medical Ward of Coffs Harbour Health Campus is about four days with more than 90% average occupancy indicating a system under strain. The Private hospital faces similar pressures. There are no dedicated step down beds. Older patients who may need residential placement are sometimes transferred to Bellingen or Macksville Hospital while awaiting a permanent place. This is disruptive for them and their families who may have difficulty .in visiting. Respite services are often inappropriately used for convalescent care or for those awaiting placement which again is not their proper function.

ACUTE HOSPITAL/COMMUNITY INTERFACE:
Increasing pressures on hospital beds lead to tendency to discharge home quickly from both wards and emergency departments. An aged care discharge planner as well as an emergency dept liaison worker and co-ordinated discharge team is needed. The ACTIP (Aged Care Transitional Intervention Program) provides 8 weeks follow-up from nurses and therapists for people discharged home to a marginal situation but while it is an excellent service its admission criteria limit its utility. Community based services may take time to be set in place post-discharge. Community Nurse follow-up is usually limited to a two-week period. Home services for younger people post-discharge are extremely limited. Hospital in the Home type services eg IV therapy are in need of

development. A "Pathways to Home" program with more resourced and integrated post-acute discharge services are sorely needed.

AGED CARE ASSESSMENT:
The Coffs Harbour Assessment Team (ACAT) carries out 45 assessments per week having more than doubled its assessment numbers in the last four years with an assessment rate now more than twice the State average. (attachment 4)
There is a need for 2-4 Geriatric Assessment Beds at Coffs Harbour Health Campus to compliment community assessment services.

DEMENTIA AND PSYCHOGERIATRIC SERVICES:
There are now more 1,000 people with dementia in the LGAs of Coffs Harbour, Bellingen and Nambucca.
Five years ago there was very little in dedicated resources beyond a counsellor and support groups auspiced by the Alzheimers Assoc.
While services remain inadequate there are now 10 dementia carer support packages, 69 High band, 8 Low band dementia specific places in secure areas in Coffs Harbour, and 16 high band and 17 low band dementia specific places in the Nambucca Valley with the likelihood of more being developed in the near future.
Specially now that medications of benefit are available there is great need for resources to facilitate diagnosis of early dementia such as the CADaMS (Cognitive and Dementia Management Support) clinic which dot Victoria. We have no dedicated psychogeriatric assessment beds to assist the care of people with BPSD (Behaviour and Psychological symptoms of dementia). According to Professor Henry Brodarty in recent MJA Article (attachment 5) 1,650 beds are needed nationally which equate to 8 beds locally for people with severe behavioural problems in need of a specialised unit.
The CADE (Confused and Disturbed Elderly) unit at Wingham is too far away to be of practical help to us and has little patient turnover.
A psychogeriatrician now visits here twice monthly which needs to be enhanced but is an improvement on the previous situation.
The Alzheimers Assoc no longer funds a local counselling/case management service but instead is negotiating for an area wide advisory/advocacy and education position.
There is considerable need for enhanced dementia outreach and case management to help patients and their carers through this devastating illness.
A dementia specific day centre is badly need in Coffs Harbour as the only day centre currently services a mix of people with dementia, developmental disabilities, and mentally competent people which is not the optimum mix.
Enhanced education of carers and community and residential care providers of people with dementia is a priority.
Dementia services need to be co-ordinated as per the last largely un-implemented State Dementia Plan.

PALLIATIVE CARE:
Needs increased resources to enable around-the-clock care at home. More support services would make it possible for more people with terminal cancer and end stage neurological disorders to be cared for at home.

A Hospice providing respite, symptom management and terminal care remains a high priority need for this rapidly growing area.

RESPITE CARE:

Residential and in-house Respite have been in extremely short supply in this area abetted by the misuse of respite for convalescence or awaiting permanent placement.

Some facilities have refused to take people with dementia for respite as more resources are need for their care.

It is to be hoped that the opening of several new respite places at the Masonic Aged Care Facility in Coffs Harbour will improve the local situation.

REAHABILITATION:

The opening of the 24 bed Rehabilitation Unit at Coffs Harbour Health Campus together with the commencement of the Medical Specialist in Rehabilitation Medicine with Allied Health Professional and Nursing Staff assistance has greatly improved the local situation.

Community and outpatient (day therapy) rehabilitation services need to be enhanced.

YOUNGER PEOPLE WITH DISABILITIES:

It believes that younger disabled in this area is above the State average. Consideration needs to be given to the feasibility of respite and residential facilities for young people with disabilities requiring this type of care as admission to Aged Care facilities as at present is inappropriate.

ABORIGINAL COMMUNITY:

More extensive liaison with Aboriginal Community and hospital workers together with the allocation of Aboriginal specific CACPs is leading to greater interaction between Aboriginal and Aged Care Services.

ETHNIC COMMUNITIES:

It is anticipated that the training and utilisation of personal care support workers from amount the local Seik community will lead to more appropriate care for their older disabled who are sometimes reluctant to utilise mainstream services.

TRANSPORT:

Lack of adequate public transport is well recognised as a major problem for older people.

Some older people with dementia and other disabilities endeavour to continue to drive which represents a major potential hazard, especially on the Pacific Highway.

DENTAL:

Simple measures such as adequate fluoridation of the water supply would produce a vast improvement in local dental health including that of older people.

HEALTH AND AGEING:

Primary and secondary prevention of excess weight, high blood pressure, diabetes, and reduction of smoking and alcohol excess would greatly reduce the burden of heart and chronic respiratory disease, stroke and complications of diabetes, thereby reducing the period of disability and disability prior to death.

SPECIALISED UNITS AND CLINICS:

Stroke Units co-ordinating all aspects of Stroke care greatly improve outcomes.

Specialist clinics, eg for falls prevention and continence management improve quality of life and delay the need for residential placement.

FUTURE DIRECTIONS:

Tele-monitoring, especially for at risk people living alone in remote situations in the community is one application of technology of a huge future potential benefit.

EDUCATION AND RESEARCH:
Provision of enhanced community, residential and health care facilities is of diminished value without the expertise at all levels to provide high quality care.
There is enormous need for a high quality educational resource centre such as the proposed Coffs Harbour Aged Services learning and research collaboration (ASLaRC).

Dr John O'Callaghan
GERIATRICIAN
5/5/2003

770 DEMOGRAPHIC DATA COFFS HARBOUR, BELLINGEN, NAMBUCCA

	Population Health	A.B.S.	01	
COFFS HARBOUR	**2001**	**2006**	**2011**	**2016**
>70	6818	8005	9298	10572
>85	969	1356	1867	2226
BELLINGEN				
>70	1481	1585	1787	2040
>85	208	238	318	369
NAMBUCCA				
>70	2733	3073	3485	3926
>85	359	437	623	759
TOTAL				
>70	11039	12660	14570	16538
>85	1536	2025	2807	3354

RESIDENTIAL RATIOS

COFFS HARBOUR

COFFS HARBOUR:

ESTIMATED >70 POPULATION:
2003 = 7300
2006 = 8005
2011 = 9298
2016 = 10572
CURRENT NO OF PLACES: **REQUIREMENTS:**

	Years:	2003	2006	2011
High Band 114		**292**	**320**	**372**
(40/1000 > 70)			**Shortfall =**	
		3	**31**	**83**
Low Band				
(50/1000 > 70)				
- 331 (+24 respite)		**365**	**400**	**465**
		Shortfall		
		34	**69**	**134**

RESIDENTIAL RATIOS

BELLINGEN

A.B.S. ESTIMATED > 70 POPULATION:
2003 = 1520
2006 = 1585
2011 = 1787
2016 = 2040

CURRENT NO OF PLACES:	**REQUIREMENTS:**			
	YEARS =	**2003**	**2006**	**2011**
High Band Bellorana = 30		**60**	**63**	**71**
Dorrigo MPS = 10				
(40/1000 > 70)	**Shortfall =**	**20**	**23**	**31**
Total = 40				
Low Band Bellorana = 63		**76**	**79**	**89**
Dorrigo MPS = 11				
Total = 74				
(50/1000 >70)	**Shortfall =**	**2**	**5**	**15**

RESIDENTIAL RATIOS:

NAMBUCCA

A.B.S. ESTIMATED > 70 POPULATION:
2003 = 2850
2006 = 3073
2011 = 3485
2016 = 3926

CURRENT NO OF PLACES:	**REQUIREMENTS:**		
YEARS:	**2003**	**2011**	**2016**
High Band 81	**115**	**123**	**134**
(40/1000 > 70)		**Shortfall**	
	34	**42**	**58**
Low Band 111			
(50/1000 >70)	**143**	**154**	**174**
	Shortfall		
	32	**43**	**63**

MAY 2003 – CACP ALLOCATION

COFFS HARBOUR –

COPS	**90**			
SERVICE FOR SENIORS	**30**			
TOTAL =	**120**	**ESTIMATED**		
ESTIMATED RATIO				
		> 70 POPULATION 2003		
		7300		**16/100 > 70**
BELLINGEN – Bellorana	**30**	**1520**		**20/1000 > 70**
NAMBUCCA – Uniting Care		**25**	**2860**	**9/1000**
> 70				
ABORIGINAL HEALTH	**30**			
TOTAL AREA		**175**		
	+ ABORIGINAL HEALTH	**30**	**11680**	
15/1000 > 70				

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Astoria Developments Pty Ltd

6 May 2003

Dr Andrew Southcott MP
Chairman
House of Representatives
Standing Committee of the Aged
Parliament House
CANBERRA ACT 2600

Dear Dr Southcott

We became aware of the potential for a Retirement Village through the information provided by Coffs Harbour Futures. Through that initial approach and the information made available not only did the Company begin to look closely at the feasibility of such a development we were able to focus on the acquisition of the Lisarow Gardens RV which became available at the same time.

Following that acquisition we began to look at Coffs Harbour as a potential development opportunity for a RV. Significantly Coffs Harbour offers a real opportunity to develop a fully integrated RV within a new residential community. Increasingly we were seeing that the approach to develop the RV within and as part of the community would gain acceptance from our target market.

As a result of the discussions between potential Aged Care Operators several issues arose which were not previously considered by Astoria. When we were introduced to Jim Curran we became aware that unless Government is aware of our plans they have no way of providing the trained people we need to operate the RV successfully.

Our business model for a successful RV incorporates the development of a separate Aged Care Facility which would be owned and operated by a specialist provider. The entire RV development would be operated by in such a way that where there is an opportunity for cross servicing these would be identified and implemented.

General agreement has been reached between Astoria & Ramsay Health Aged Care Division for the development and operation of the Aged Care Facility.

Our involvement with Government not only will allow us to identify our future requirements it will also ensure that we are part of the solution. Had we not been involved with “Futures” and Government it is unlikely that we would be traveling the path that we have embarked on.

Geoff Smith

ST AUGUSTINE'S CATHOLIC COMMUNITY

12 Gordon St (PO Box 2450) Coffs Harbour NSW 2450
ABN 28 947 720 072

Phone 02 6652 5714

Fax 02 6651 2897

"Our Hearts are restless until they rest in you, O Lord"
St Augustine

Dr Andrew Southcott MP
Member for Boothby
Chairman
House of Representatives Standing Committee on Ageing

Dear Dr Southcott

Below are background notes relating to your Committees inquiry. Our organisation will be represented at the community forum to be held in Coffs Harbour on 19 May 2003.

Notes for submission to
the House of Representatives Standing Committee on Ageing

Care

There is a lack of specific psycho-geriatric facilities to care for residents with dementia who are not safe to care for in standard aged care facilities. Presently people requiring this specialised care are taken from their local community to either Newcastle or Sydney.

GPs are sometimes unwilling to comply with Aged Care Standards and documentation requirements. It is difficult to find a GP for residents who do not have a local history.

In older facilities there is difficulty in providing the facilities that the next generation will expect such as computer facilities, fine dining, increased privacy.

RCS

Excessive documentation requirements to validate processes requiring up to 28 hours to take history, conduct assessments and to develop a care plan.

Funding for each category is insufficient to cover the increasing costs of care and services required to maintain standards. It is certainly insufficient for small to medium organisations to refurbish or rebuild ageing facilities.

Funding does not increase to cover increases in wages meaning that wage increases lead to reduced staffing levels and inevitably care.

RCS validation process is too 'inspectorial' leading to an attitude of a need for excessive documentation instead of better documentation to support claims. Validators expect to see three items of evidence to support each area of the RCS.

Changing resident profiles especially in high care facilities is not well reflected in the RCS tool and therefore inadequately funded. High care facilities are increasingly becoming palliative and dementia care units but this is not recognised in the funding arrangements.

Challenge of reducing life expectancy of residents means increased turnover leading to increased stress on staff and increased documentation workloads.

Staffing

There is a well known crisis due to the shortage of RNs, ENs, and trained carers throughout Australia which is particularly experienced in rural areas. While the Government is attempting to address this issue for the public health sector there is no action in aged care and sometimes our carers are poached back to the public health system.

There is a wage disparity between acute care and aged care which is draining skilled staff from the aged sector.

There is an extreme shortage of skilled and experienced aged carers particularly with specialisation such as dementia, continence and gerontic nursing.

There is a shortage of allied professionals such as podiatrists, OTs, dieticians, physiotherapists etc in rural areas available for use in aged facilities.

There are insufficient skilled managers in aged care facilities. Usually the manager is a nurse with little or no management education or preparation to run a small to medium business. This can quickly lead to burnout from over stress, further reducing the number of skilled clinical carers. Management skills are not being provided to undergraduate nurses even though this is now a significant part of their role due to legislative requirements.

There is a need for a strategy to attract younger people to the profession and provide them with an effective career path. Continuing to attract only older carers leads to OH&S risks associated with fitness for the job.

Legislative Requirements

Increasing paperwork is taking care staff away from core roles. This includes, duplication of State and Commonwealth health regulations and auditing in high care, need to write daily notes in high care, increasing regulation regarding food safety, medication restrictions in hostels under the Poisons Act, inability for ENs to provide medication in aged care facilities.

High cost to the facility in applying for accreditation both in terms of fees and preparation time. As this comes from general running costs it effectively reduces the funds available for care.

General

There is increasing difficulty in running small stand alone facilities in rural areas without infrastructure necessary to carry out the care and administrative requirements of the Aged Care industry. Pressure from funding shortfall and increased legislative imposition is leading to significant stress on operators and in some cases the decision to get out of the industry. Care traditions that have been established in a community may be lost to the absorption into larger centralised organisations. Solutions to rural problems need to be found in order to ensure that our elderly are cared for with dignity within their local community.

Yours sincerely

Tim Allsopp
Chief Executive Officer
12 May 2003

13 May 2003

Health & Aged Care Issues

Gaps exist in the following areas:

Psycho-geriatric Centre

High needs area for people suffering from acute conditions, currently living inappropriately in residential care.

Their conditions often affecting other residents and causing disruption throughout the facilities. Security and safety of the residents is a concern in dealing with these residents.

Staffing is another concern. Staffs do not possess the required qualifications in dealing with people suffering from this type of disorder.

It appears this problem is certainly not restricted to the Mid North Coast, which means there is opportunity to develop a specialised unit in our region, which could attract residents from outer regions.

Satellite Rural Aged Care and Industry Centre

Such a centre would embrace transport requirements, (shopping), integrated social needs (hairdressing), counselling, remedial therapies (massages), allied health services (GP) and meals.

The personnel used for this centre need to be appropriately trained and qualified from the surrounding district.

The needs that exist in our rural and remote areas include:

People who elect to stay in their own home or farm, but requite medical, nursing and carer assistance.

People who desire to remain at home or farm, but for some of the time reside in a style of an aged care, potentially viable “polyclinic”, providing medical, nursing and hostel style accommodation, located in each small country town where demand exists, such that the resident can remain as close to his/her family as possible.

Presently aged people are forced to move to aged care facilities where vacancies exist. This can mean they may have to travel long distances, which makes communication with their families almost impossible.

Aged care in rural communities is inadequate by any standard. Are they the “lost generation”. Proper care for the rural aged will help to stem and could even reverse the outflow of monetary and medical resources from country areas. This concept could lead towards reducing “the great divide between the city and the bush” as quoted in the analytical newsletter’ The primary report (NSWFA news release 22/03/01).

This is one of a number of measures essential to creating a “u” turn in the bush.

The Satellite Multi-function Aged Care and Industry Centre could operate as a major focus point for the community to:

- Access health out reach services (GP and allied health services)
- Guide and support older people who wish to remain at home
- Guide and support those older people who need to move to aged care facilities
- Provide social and leisure activities directed to healthy ageing

Coffs Harbour Education Campus

NEW SOUTH WALES DEPARTMENT OF EDUCATION AND TRAINING

TAFE NSW

COFFS HARBOUR SENIOR COLLEGE

Warren A Grimshaw, AM
Executive Director

6 May 2003

Dr Andrew Southcott MP
Chairman
House of Representatives
Standing Committee on the Aged
Parliament House
CANBERRA ACT 2600

Dear Dr Southcott

AGED SERVICES – COFFS HARBOUR EDUCATION CAMPUS

The Coffs Harbour Education Campus is a partnership between Southern Cross University (SCU), the North Coast Institute of TAFE (NCI) and the NSW Department of Education and Training (DET). The partnership is a unique one in that each of the sectors maintains their own integrity and quality of programs, and at the same time provides opportunities for students to move easily between the educational levels. The Campus, which was established in 1995, provides an ideal environment for collaboration between the sectors. This collaboration further enhances the opportunity to promote the social and economic development of the region, especially as each of the partners is committed to this objective.

The need for strategic action in the development of research capacity to support the development of coherent policies in Aged Services throughout this region and beyond has been a priority of the partners for some years. In 2001, following the provision of funding from the NSW Department of State and Regional Development, the Coffs Harbour City Council, CHEC, and community organisations in the city, a consultancy was commissioned to establish the viability of an Institute of Aged Services Research.

This work took account and built on the Strategic Plan for Aged Services for the Cowper electorate. This was also taken up by the Coffs Harbour Future Development Corporation and the City Council and new funding was provided to support the implementation of the recommendations of the Strategic Plan. This demonstrates clearly the strong support in the community for this development.

> The Commonwealth government's decision, in partnership with the University of NSW, to establish a rural health school in Coffs Harbour, provided the opportunity for the universities to join forces to promote the concept of the Aged Services Learning and Research Collaboration (ASLaRC). This offers enormous potential in the development of policy and research profile in aged services. This partnership will also embrace and build upon the strengths of the NCI at Coffs Harbour, and indeed the Coffs Harbour Senior College. The initiative, therefore, has the strong support of four major educational providers. I am not aware that this could be matched anywhere in Australia.
>
> The demographics of Coffs Harbour indicate significant population growth in the period to 2016, particularly in the 65+ age group. This is an ideal focus for research in this area which will lead to a better understanding of the needs of the aged, both at the regional, national and international levels. The support of the community is assured through the Coffs Harbour City Council, private and public hospital systems, the Coffs Harbour Future Development Corporation and the community itself. The research leadership provided by SCU and the UNSW will galvanise the community into a coherent approach in support of this initiative and indeed provide an incubator that will lead to national and international recognition.

The Campus Executive and the Board of Governors of CHEC is committed to support this initiative through the education providers on campus. Creative solutions will result from this environment and provide opportunities to meet the needs of a variety of occupations which are emerging, and will emerge, as we better understand the needs of the aging in the 21st Century.

As Executive Director of CHEC, I strongly support this initiative and will commit the resources of the Campus to the achievement of the goals of the proposed research institute. All that is needed is funding support from the federal government to bring this vision into reality.

I look forward to meeting the House of Representatives Standing Committee.

Yours sincerely

Warren Grimshaw
Executive Director
MID NORTH COAST

COMMUNITY CARE OPTIONS

INC.

P.O. Box 1382 **Coffs Harbour 2450**

Tel. (02) 6651 4343 Fax (02) 6651 4362

12 May 2003

The Chairperson
The House of Representatives Standing Committee
On the aged
Parliament House

Dr Andrew Southcott,

I understand that the House of Representatives Standing Committee on the Aged is taking submissions in relation to resources for the aged care sector.

Our organisation provides direct services and support to older people living in the community by way of Community Aged Care Packages (CACP's) and Dementia Respite services. We receive funding from the Commonwealth Department of Health and Ageing, including funding through the National Respite for Carers program. We have also recently submitted an expression of interest to provide Extended Aged Care in the Home (EACH Packages).

It is our experience that people can be best supported within the community when funding and other resources can be accessed in a flexible and seamless way. At present CACP's are funded at a single level, whereas clients' individual needs vary greatly. It is our belief that people could remain in their own homes, supported in a safe and dignified way, although they may require very a high level of support, with the introduction of more flexible models of funding.

If people could access support within the community from the time that they require a very low level of support, until they require nursing home level of care, they could effectively 'age in place' in the community. We therefore support the government's consideration of more flexible funding models and the introduction of such programs as Extended Aged Care in the Home.

However the availability of other support services such as respite, transport and community nursing will also determine the success of such programs. We urge the Standing Committee to consider the levels of funding allocated to such ancillary services, so that the opportunity for other programs to succeed is not undermined. We also urge the Standing Committee to consider packages of support for people with an acquired brain injury, facilities for supporting people with challenging behaviour and acute mental health problems. There is an ongoing lack of rehabilitation support and therapy centres, and a lack of resources for ageing carers of people with disabilities who are also ageing and ageing people with disabilities (joint initiatives between ageing and disability funding providers are required).

Thank you for giving these issues your consideration. We look forward to hearing the outcomes of the Standing Committee meeting.

Yours sincerely,

Nicole Jut

Assistant Manager

7th May, 2003

Dr Andrew Southcott MP

Chairman

House of Representatives Standing Committee on Ageing

Parliament House,
Canberra ACT 2606

Dear Dr Southcott

Re: Coffs Harbour meeting of the House of Representatives Standing Committee on Ageing

The Mid North Coast (NSW) Division of General Practice welcomes the opportunity to present its views on the impact of Ageing on the Coffs Coast to the House of Representatives Standing Committee on Ageing.

Current Situation

The Coffs Harbour LGA has a population of 61,770 people. The city has experienced a population increase of 3298 in the last five years, at a growth rate (7.5%) which is much higher than either the state average (5.5%) or the national average (6%).

At the same time the number of people over 65 years of age living in the Coffs Harbour region has grown by over 15.8% or 3.3% above the NSW State Average. The Mid North Coast along with the Illawarra Statistical District, has

the fastest average annual growth rate in NSW of people over 65 years of age (3.2%) (ABS, Older People, New South Wales, 4108.1,2000).

In addition, higher growth rates for the same age group are recorded for the Nambucca (21.1%) and Bellingen LGA's (17.1%) that fall within the local Base Hospital catchment area have experienced higher growth rates including Bellingen 17.1% and Nambucca 21.1%.

Through the concerted efforts of Regional Economic Development consortia's to attract self funded retirees to the area it is reasonable to expect that the current growth rate for persons aged over 65 years within the Coffs Region will continue if not increase significantly.

Median weekly household income in the area was well below the state average of $800-$999 and the national average of $ 700-$799 with Coffs Harbour LGA showing a range of $500-$599

The area has an average Aboriginal & Torres Strait Islander Population of 3.6%, well above the State average of 1.7%. The largest population bases were recorded in Coffs Harbour LGA (1809), Nambucca (954) and Grafton (884). Australia's largest Regional Punjabi community is located within the Woolgoolga area

How does the Area's Medical Infrastructure and Services match up to demand? The answer is poorly if the following survey of the local medical landscape is anything to go by:-

Public Hospital Services:

Hospitals

Coffs Harbour Health Campus has 202 Gazetted inpatient beds – while the CHHC states that Campus holds 254 total inpatient beds, cubicles, and day treatment spaces. In reality, the operational bed capacity for the hospital is well below the stated bed capacity as a result of under resourcing and nursing shortages.

Other District Hospitals and Facilities within the area include:

Macksville & District Hospital	50 beds
Bellinger River District Hospital	35 beds
Dorrigo Multi Purpose Service	6 beds
Baringa Private Hospital	66 beds (licensed for 80)

Medical Specialist Workforce:

> As a large Regional Centre, Coffs Harbour Area has a relatively low medical specialist workforce in comparison to the neighbouring regional centres of Lismore and Port Macquarie and other regional centres of similar size.

The lack of access to specialist services places a greater burden upon an already disadvantaged community who can ill afford to leave the area to seek appropriate medical treatment. This situation has influenced many GPs to undertake additional procedural medicine and sub-speciality work to compensate for this workforce shortage.

The rapidly expanding aged population places urgent demand for specialist aged care services such as Psychogeriatrician, Gerontologist and Geriatrician services that are not adequately provided for in the local area.

The Division 2002/2003 GP found that the need for new specialist services in the area was in the order of priority:

- Endocrinologist
- Respiratory medicine
- Allergist
- Psychiatry - General adult
- Dermatologist
- Psychiatry - Child – Adolescent

Existing services that are not seen to be adequately resourced (in order of priority)

- ENT
- Dermatologist
- Orthopaedic
- Geriatrician

General Practice:

> The Coffs Harbour area was recently reported in the media as having one of the lowest socio-economic living standards within Australia while at the same time recording the lowest bulk billing rates amongst GPs. The full time equivalent GP workforce to

population ratio in the area is 1:2,300, approximately double the acceptable national standard.

Although approximately 50GPs work in the Coffs Harbour LGA, the FTE workforce only equates to 28 GPs. The low FTE workforce may be attributed to a growth in part time workers and the trend for GPs to undertake more sub-specialty work to compensate for the specialist workforce shortage.

The Mid North Coast Division of General Practice 2002-2003 Survey of Division GPs indicated that 84% of GPs are seeing more than 80 patients a week, with 59% seeing more than 121 (an increase of 11% from the previous GP survey) while 51% of GPs are working 5-9 sessions a week, and 42% are working 10-14 sessions a week

As a result of the workforce shortage, many GPs have closed their books to new patients while it is not unusual for patients to experience waiting times of up to 3-4 weeks for an appointment to visit their GP for non-urgent cases. The workforce shortage reinforces the supply and demand equation, making bulk billing an unattractive option for area GPs, particularly in light of the personal sacrifices made to meet high workload expectations. This situation clearly presents a significant barrier to accessing a general practitioner for the growing number of persons over 65 years of age who re-locate to the area.

Similarly, the current GP workforce capacity is struggling to meet the increasing demand placed upon GPs to conduct poorly remunerated after hours patient visits to the growing number of nursing homes and aged care facilities. This workload situation may influence GPs to relocate to an area where their workload may be lighter and better remunerated. Similarly, the workforce crisis is a disincentive for GPs to relocate to the area.

Future Implications:

Within the local area a social catastrophe hovers above the future horizon awaiting the impending collision between the medical demands of an increasingly ageing community with low socio economic living standards and the declining capacity of the local medical workforce to meet this demand.

As the local population continues to age and aged care facilities proliferate within the area, demand from this sector of the community will increasingly compete with the remaining community to access scarce medical resources and services. Competition between aged

care facilities, acute public and private medical services for nursing, general practice and allied health services is very real and will have dire consequences on the future health and well being of the community without appropriate strategic interventions aimed at a coordinated approach to the recruitment and development of the local medical workforce.

Many retirees choose to relocate to the area away from the support of family. While they may enjoy reasonable health upon moving to the area, their health and independence declines with increasing age, placing an increasing burden upon local health care resources. Public Hospitals continue their efforts to reduce public admissions and hospital stays through early discharge and subsequent reliance upon coordinated community care. Without the support of family close by, many of the ageing unwell tend to rely more upon either allied and community services or are forced into aged care facilities.

Unfortunately, the drive to shift care from the hospital to the primary care setting does not appear to be matched by an increase in community and allied health services to appropriately support the notion of integrated primary care. The shift in care to the community translates to an increased workload upon GPs and other Primary Care Services to meet the demands of caring for an ageing population. The workforce pool of adequately skilled and trained providers is simply insufficient to meet the future needs of the ageing population in the area. It is plainly obvious that a more coordinated approach to recruitment of skilled workers from outside the area is required as is the development of a skilled worker base from the local community to ensure services are maintained to meet consumer demand and the provision of medical care across the entire community spectrum is not adversely affected by competition over scare resources.

Fortunately, a number of local organizations have recognized the need to plan for the future needs of the ageing population and have formed consortia's aimed an developing and coordinating a range of services to support and care for the future needs of this section of the community. Coffs Future of the Ageing strategy, while actively seeking to attract self funded retirees to the area, has taken measures to engage a wide range of stakeholders involved in the delivery of services and care to the elderly in the future planning to meet the needs of an ageing population.

The University of NSW Rural Clinical School and Southern Cross University have collaborated to form a consortium with the charter of researching the local workforce needs to care for the Ageing Population in the area and to respond to the identified needs with appropriate recruitment, education and training strategies aimed at developing the local workforce. This important initiative, the Aged Services Learning and Research Collaboration, is supported by the Mid North Coast Division of General Practice, Mid North Coast Area Health Service,

Coffs Harbour City Council, Coffs Future of the Ageing, Baringa Private Hospital and many of the Aged Care facilities within the region.

These local collaborative initiatives are working as beacons to signal the dangers associated with the future care of the elderly in the local area and identify appropriate pathways to navigate through these dangers to find appropriate solutions for the future care and well being of the local community. The Mid North Coast (NSW) Division of

General Practice Ltd., fully supports these initiatives and commends the request for future funding of ASLaRC to the Federal Parliament.

The Mid North Coast (NSW) Division of General Practice Ltd., welcomes the opportunity to appear before the Standing Committee hearing at Coffs Harbour on the 19 May, 2003, to support this submission.

Yours faithfully

Peter Spence
Executive Officer

Community Services and Health Faculty

Response to the Senate Committee Hearing in Coffs Harbour 19th May 2003.

Prepared by

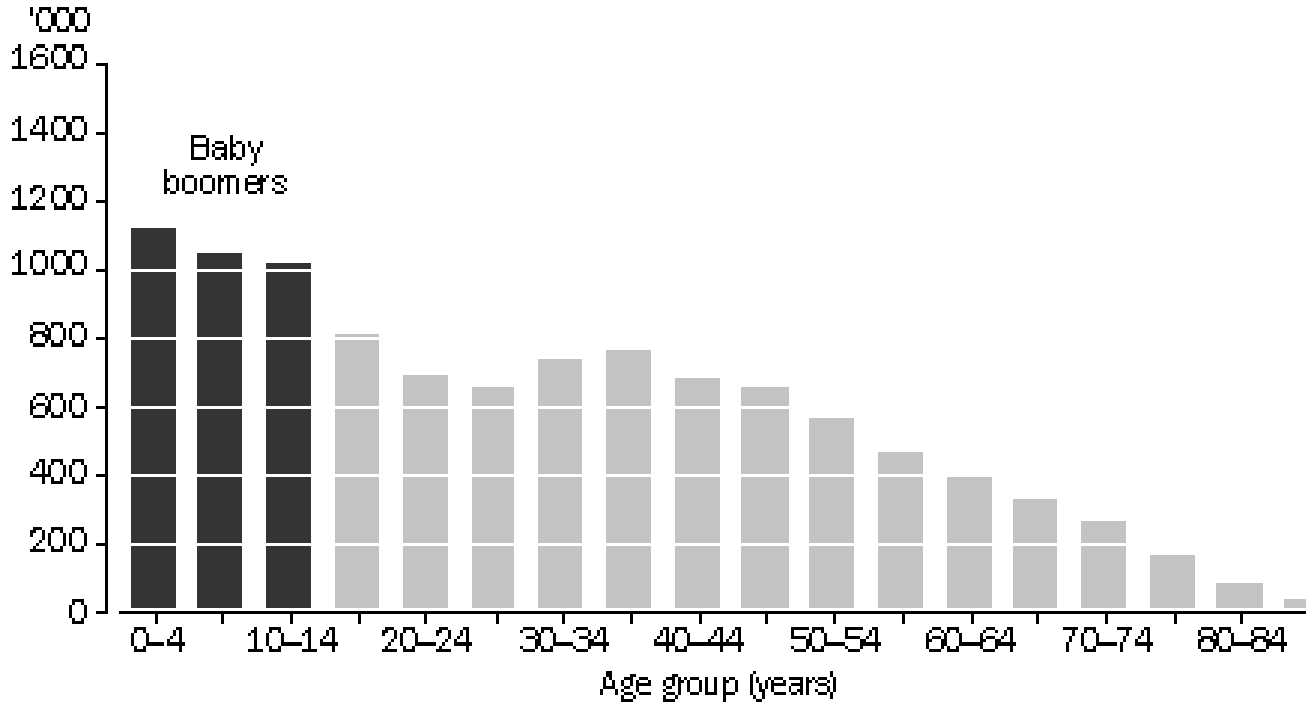
Fran Alexander, Faculty Manager. TAFE NSW- North Coast Institute
Fran.alexander@tafensw.edu.au

North Coast Institute of TAFE, Community Services and Health Faculty response to the Senate Committee Hearing in Coffs Harbour on 19th May 2003.
Prepared by Fran Alexander, Faculty Manager. North Coast Institute of TAFE.
Fran.alexander@tafensw.edu.au

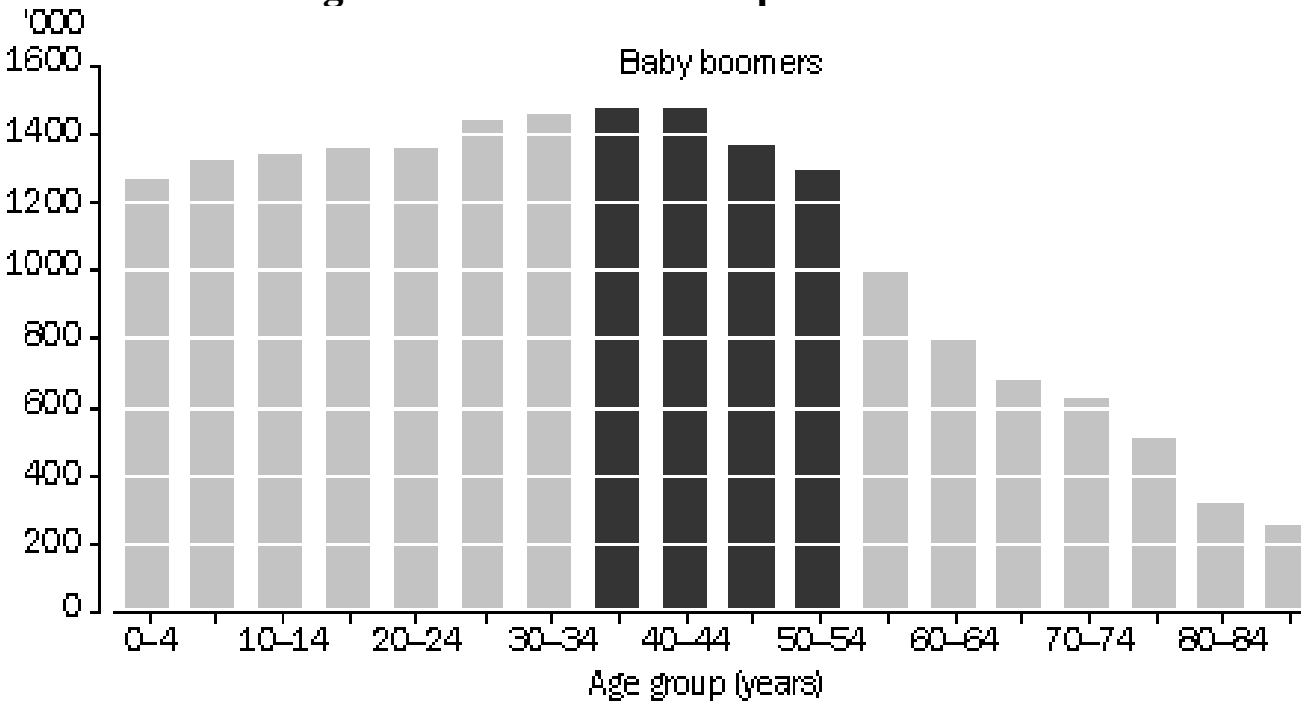
There have been a number of submissions to the Standing Committee on Ageing's Inquiry into long-term strategies to address the ageing of the Australian population over the next 40years. There are many challenges that an increase in the number of older people will bring, among other things great social, demographic and economic challenges. This paper provides one small solution that could have a major impact.

The following three graphs represent very visibly part of this challenge.

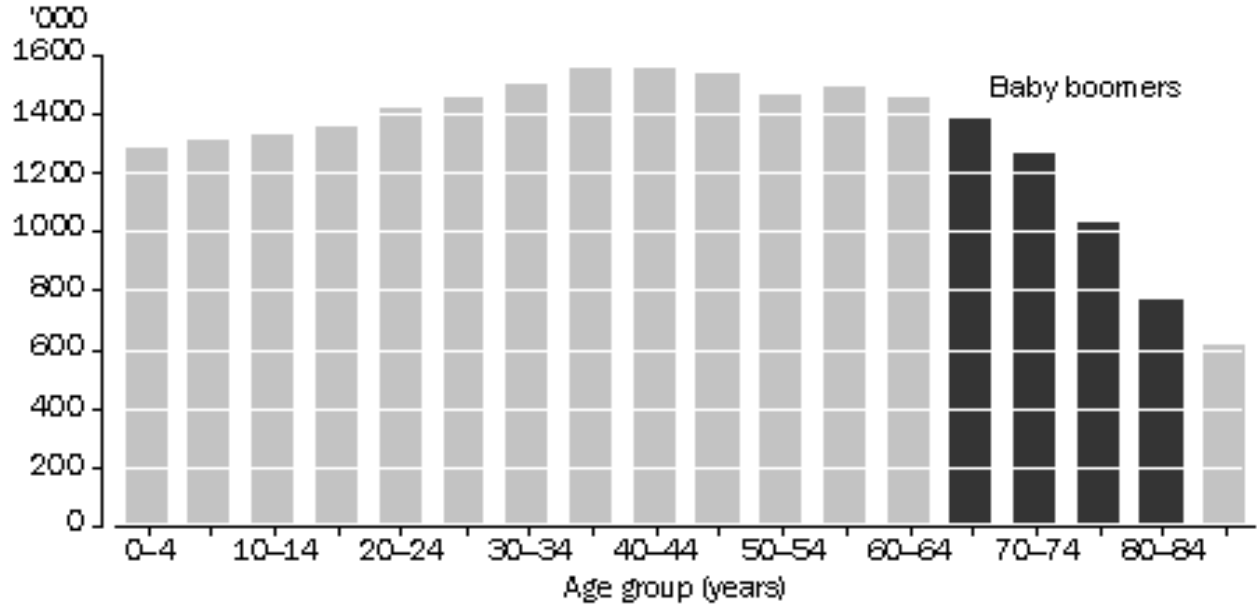
Australia- Age distribution of the population 1961



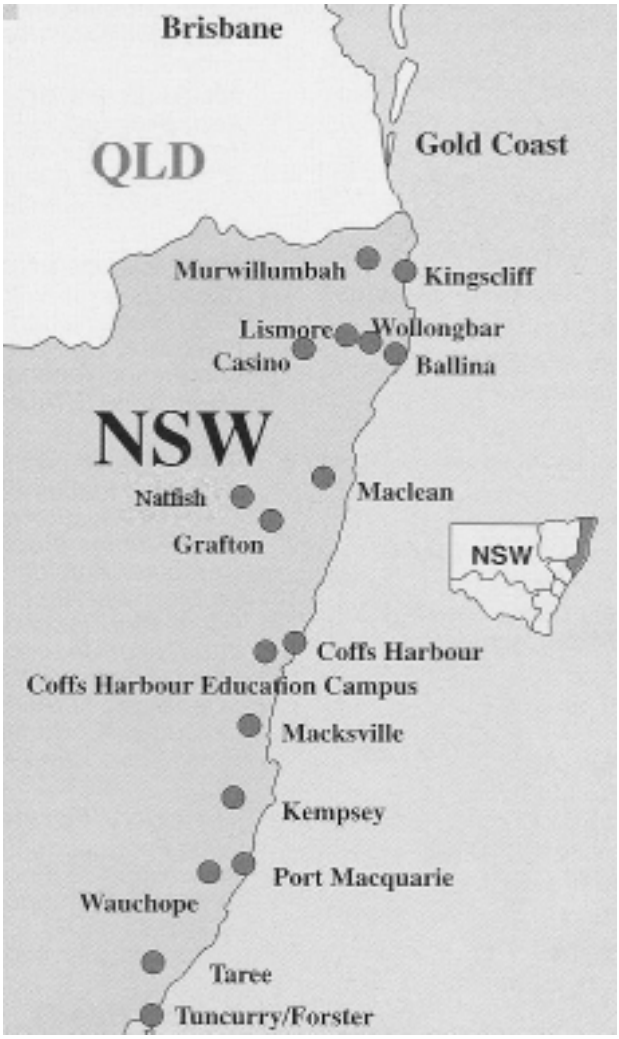
Australia Age Distribution of the Population 2001



Australia- Age Distribution of the population -2031



Source: Demography, 1961; Population Projections
1997 to 2051
(Cat. no. 3222.0).



Even without the impact of the baby boomer/sea change cohort the North Coast is one of the fastest growing regional areas of NSW. TAFE NSW has 17 campuses across the north coast that delivers quality vocational education and training to approximately 39,000 students each year.

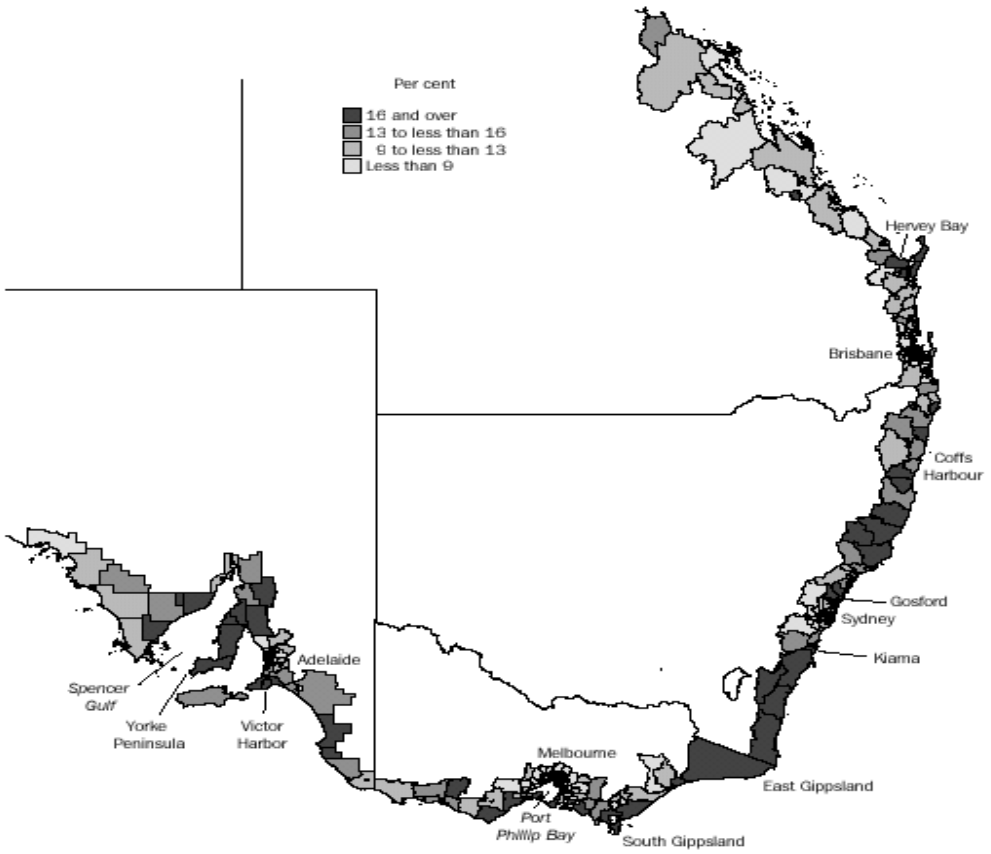
Much of this education and training is for local students for employment in local areas. The most significant growth in industry over the past five to ten years has been in jobs directly related to population growth and the age profile of the population for example, retail, tourism, recreation, health, welfare and other services.

With a projected increase in the number of older people migrating to the north coast and the increase in age and possible frailty of the older baby boomers there is expected to be an increase in the numbers employed in the health and nursing area.
Currently the North coast Institute of TAFE train over 700 Certificate 3, Assistants in Nursing annually. The normal educational pathway for this level of worker is to go on to do a Certificate 4 in Enrolled Nursing and then to University to do a Degree in Social

Science (Nursing). At this stage there is no potential for these 700 students annually to continue to study without leaving the coastal environment. The Enrolled Nurse course is funded by the Department of Health and conducted at TAFE colleges within the state. None of these colleges are on the North Coast, and this is a significant disincentive to people in the area wishing to pursue enrolled nursing training. Negotiations to address this are currently occurring with the NSW Department of Health. Similarly, there is only one university located on the North Coast, Southern Cross University which offers nursing at its Lismore Campus in the extreme North of the region. There is no university at all between Newcastle and Coffs Harbour. So no there are no opportunities in the rapidly growing and aging region between Newcastle and Lismore for Certificate 3 Assistant in Nursing Graduates to pursue further studies.

This has significant challenges for our Aboriginal population. Because of strong family ties, these populations are even less likely to want to leave the area to continue their studies or careers in areas geographically isolated from their families.There is a significant number of Aboriginal and Torres Strait Islander people on the North Coast with the largest population centred in Kempsey. There are also significant populations in the local government areas of Coffs Harbour, Taree, Tweed and Lismore**.** To cater for these populations the North Coast Institute has one TAFE's largest Aboriginal education programs. 6.5% of the Institute's enrolments are Aboriginal and Torres Strait Islander which is nearly double the TAFE NSW average of 3.4%. With a global shortage of nurses, above average projected increases of frail aged and no career path available locally for nursing students, there is a looming crisis in the North Coast region for care for the frail aged.

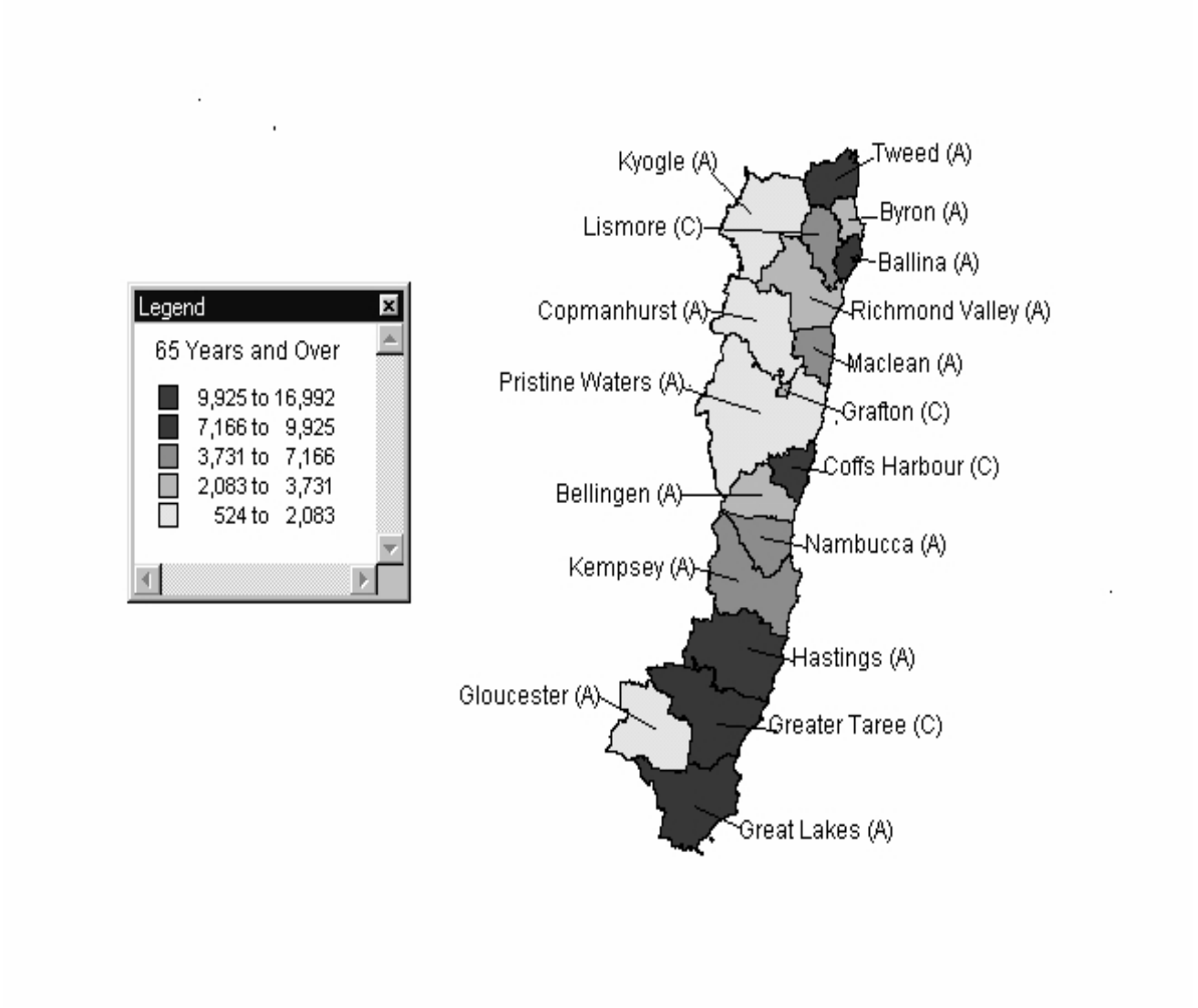
Proportion of People aged 65 and over in SLA's in 2000



Baby boomers, like the ageing cohort before it, tend to migrate to the coastal strip for retirement. Altogether 170 SLAs are projected to have one-quarter or more of their population aged 65 years and over in 2019. This presents challenges for many regions, particularly the north coast region in terms of meeting the needs of the rapidly growing older population. This internal migration of older people to the coastal areas is the primary factor associated with regional ageing in Australia. Population projections show that by 2019, around 18% of Australia's population is likely to be aged 65 years and over, compared with the current level of around 12%. Much of this increase is expected to migrate to the north coast region.

Between 1996 and 2001, the population of the NSW North Coast region grew by 7.7%, compared with a growth rate of 6.5% for the whole of NSW.
This is the second highest growth rate in the State behind the Sydney metropolitan area. This growth is expected to continue or even increase.

North Coast Region by Local Government area. Persons aged 65 and older.



The need for a North Coast regional solution

It is good to see the Federal Government seeking strategies to deal with this national challenge. However, there are challenges that are pertinent to regional areas that require regional solutions.

One of these solutions currently being explored with the NSW Department of Health is the introduction and funding of the Certificate 4 in Nursing (Enrolled Nurse) course with its attendant articulation pathways into University.

A further solution would be an arrangement whereby dedicated student places in the region could be allocated for university nursing bridging programs that build on the TAFE qualifications and include work based training. TAFE has already negotiated bridging courses from the Enrolled Nurse course into the Degree in Social Science (Nursing) with a number of universities.

Dedicated funding as proposed above would support curriculum pathways and innovative partnerships linking TAFE, universities with health and aged care service facilities to provide cost-effective nursing programs. These arrangements would assist local students to have a career pathway and stay in the region to contribute to the social and economic sustainability of the region and its rapidly growing and ageing population.

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Transport Issues for Older People in Coffs Harbour*.*

Mainstream Public Transport services in the area are generally inadequate, with restricted hours, routes and timetables. Evening and weekend services are virtually non existent, as are services from outlying areas. Timetables and routes do not allow for passengers to connect with either rail or air services.

An additional major concern in accessing those transport services which are available is the high cost involved. For example a local pensioner (concession) return fare between Woolgoolga and Coffs Harbour is $9.60. However in order, for example, to access services at the Coffs Harbour Health Campus it is necessary for a passenger from Woolgoolga to use a different bus from the City Centre to the Campus, involving an additional fare of $2.80 return. For patients requiring ongoing treatments this cost ($12.60) soon becomes a near impossible impost.

These costs should be compared to the $1.10 unlimited all day senior concession available in metropolitan areas.

Community Transport.

Provides specialized transport for frailer aged people, and people with disabilities.

Transport is provided for a range of purposes, but from outlying areas tends to be mainly 'health related', while door to door assisted shopping, day care, and some social/recreational transport is also provided.

The service currently operates four wheelchair accessible mini buses, with passenger capacity of between 8 and 21 passengers, and is largely dependent on a pool of ageing volunteer drivers. There is a desperate need for properly trained, younger, fit, paid drivers to be employed in order for the service to operate more efficiently and effectively. It is interesting to note that similar services which operate in metropolitan areas are not expected to utilize volunteer bus drivers, and are funded for paid bus drivers as a matter of course.

The ability to get out and about, and to access necessary services, is critical to maintaining the independence of older people within their own homes and there is a need for transport to be available to support 'ordinary' activities such as shopping, library, social, church attendance etc.

The Coffs Harbour community transport service has not properly advertised its availability since 1993, because of its continuing inability to cope with demand.

The service has never been able to meet clearly identified existing needs in the area. Despite increases in grant funding and in the amount of transport provided the service estimates that it is currently only providing transport for approximately 25% of people who might be considered eligible, and that current clients are only receiving a limited service, ie an average of just 15 outings per client, per annum!

The 'anticipated influx of retirees' will greatly exacerbate an

already extremely difficult situation

Administrative issues:
A major concern of the community transport service is the ever increasing administrative burden which is placed upon it by the various funding bodies.

The service accepts the need to be accountable, but believes that the level of accountability is seriously impacting upon its ability to actually provide transport

The service receives grant funding from several different programs, each with its own set of guidelines and administrative procedures. There are eligibility anomalies and funding inconsistencies which are difficult for service staff and more especially for passengers/ clients to understand.

There is an ever increasing 'welfare' aspect to service provision, where services are required to 'assess' and case manage 'clients' rather than to provide transport for passengers. This is extremely time consuming and costly and has decreased the ability of the service to actually provide transport

In rural areas older people often continue to drive when they would prefer not to, because they see no other option. The cost of driving, as well as some physical limitations, are concerns. There is a need to ensure that acceptable alternatives are available and easily accessible. Road safety concerns need also to be considered in the context of the need for improved public transport availability.

Equity:
Passengers use community transport because mainstream services are unable to meet their needs. If they could use the regular bus service they would, as it is much more readily available, and is

easy to access. When passengers use mainstream services they are able to utilize at least a half fare concession, (or in metropolitan areas the $1.10 per day seniors concession).

However when people either live in a rural area where transport is unavailable, or they are physically unable to access ordinary public transport their need for transport is increasingly is being seen as a welfare issue.

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