COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Reference: Long-term strategies to address the ageing of the Australian population over the next 40 years

MONDAY, 24 FEBRUARY 2003

CENTRAL COAST

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Monday, 24 February 2003

Members: Dr Southcott *(Chair)*, Ms Hall (*Deputy Chair*), Ms Corcoran, Ms Ellis, Ms Gambaro, Mr Hartsuyker, Mr Hunt, Mrs May, Mr Mossfield and Mr Tony Smith

Members in attendance: Ms Corcoran, Ms Ellis, Ms Hall, Mr Hartsuyker, Mr Mossfield and Dr Southcott

Terms of reference for the inquiry:

Long-term strategies to address ageing of the Australian population over the next 40 years.

WITNESSES

Committee met at 9.00 a.m.

CHAIR—Good morning and welcome. I declare open this public hearing of the House of Representatives Standing Committee on Ageing as part of our inquiry into long-term strategies for ageing. Today we will hear from Central Coast Health, Wyong Shire Council, the Central Coast Division of General Practice and Aged and Community Services Australia. Professor Irene Stein, who was scheduled to attend today's hearing, is unable to attend and extends her apologies to the committee.

It is clear that the ageing of Australia's population will have a profound impact on Australia in terms of social, economic and political activity. Areas such as the New South Wales Central Coast have become hot spots for a range of ageing issues, with older people flocking to the area. This afternoon the committee will hear more about regional and local issues from invitees at a community forum to be held at the Norah Head Legacy Hostel.

[9.02 a.m.]

BLACKWELL, Mr Jon Denis, Chief Executive Officer, Central Coast Health

CHAIR—I welcome the representative from Central Coast Health to today's public hearing. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Mr Blackwell, would you like to make an opening statement before I invite members to proceed with questions?

Mr Blackwell—I have a presentation to make. Would you like me to go through that?

CHAIR—Yes, please.

A PowerPoint presentation was then given—

Mr Blackwell—In your introduction, you mentioned the issue of ageing across Australia and on the Central Coast. I will run through some stats and some reasons for why we decided to have a quality ageing strategy here on the coast. Let us look at the population trends. The map on the right is the map of the Central Coast. We have two shires, Gosford and Wyong. You are in Wyong at the moment. You can see the freeway and the railway running through there. Obviously we think it is a distinct geographical area because of the lifestyle it offers. It is a popular destination for retirees and young families as well. We are seeing a quite enormous expansion of the population on the coast. It is at the two ends of the age spectrum, I guess. The availability of affordable housing and access to the freeway and the railway make for an expansion of the metropolitan areas between Sydney and Newcastle.

Between 1996 and 2001, the population of the Central Coast grew by 24,000-odd people, representing a growth rate of 9.4 per cent. This is the fastest growing area of New South Wales on a percentage population basis. It is obvious as you drive around here when you see all the development going on.

This shows the proportion of Central Coast people in the specific groups. This mirrors most of the state except for the 65 and older category, where significant variation was recorded. Eighteen per cent of Central Coast residents are aged 65-plus, compared to the state average of 13 per cent. So we do have a large concentration of older people.

Amongst 'older' old people, we have a higher proportion of the population aged over 70 years. Based on the 2001 census, we had 37,400-odd people over the age of 70, representing 13 per cent of the Central Coast population, compared to the state average of 9.5 per cent. For 80-plus, again, the 'older' old age group has 13,000 people, representing 4.6 per cent of the population compared with 3.2 per cent for the state average. I work in the health arena. It is quite clear that advanced medical technology is keeping older people alive for longer. That does not mean to say that they are necessarily completely healthy. They can become isolated and have a whole range of social and health issues which need to be addressed.

Given that there are a range of players in the aged care scene, we thought it would be good to have an area-wide multi-organisational approach to address quality ageing issues on the coast. We felt that unless there was a coordinated approach to the needs of the elderly on the coast, their needs would not be properly met and people would not receive the services they needed. This shows the steering committee that we put together. You will notice that on this steering committee all levels of government are represented. Central Coast Health is my organisation. The Commonwealth Department of Health and Ageing has had a very strong involvement with this body since its inception. They attend every meeting and are very valuable contractors. There is also the New South Wales health department and both city councils. The councils, as you would be aware, of course, provide a range of aged care services. The local service providers include hostels and nursing homes. There is the New South Wales Department of Ageing, Disability and Home Care and the Central Coast Division of GPs. I think you are hearing evidence from them later. The division of GPs has the same boundaries as the rest of the Central Coast. We have consumer reps, carer reps, the housing department and DVA. There is a very large veteran population here on the coast. It has one of the largest veteran populations in New South Wales and, I think, in fact in Australia.

We wanted to have a strategy which achieved a number of goals, including raising the profile of the older population and portraying them in a positive light. Of course, older people are not always portrayed in a positive light. They can be looked at negatively in relation to people thinking that they drain resources and all those sorts of things. We wanted to have a more positive image of older people. We needed a person-centred approach to service delivery. When you have a whole range of different organisations providing services to older people, it is important to coordinate those services around the person themselves. We wanted to promote the coordination and integration of services.

We have never counted the number of service providers for older people on the coast, but it would run into hundreds. We wanted to develop innovative and integrated funding models. We wanted to develop and implement a strategy to improve the overall quality of life for older people. We wanted to advocate for older people in society by recognising their important role. Looking at population based funding equity, we felt that there was not funding equity in relation to some of the services which are provided, particularly in hostel and nursing home beds. We are looking at individual rights.

We wanted to look at broader lifestyle options for older people, promoting health, independence and self-fulfilment. We have talked already about integrative funding models and innovative models of care which are person-centred, coordinated, empowering and supportive of carers. Carers are an extremely important part of this whole process, of course. We have had a lot of discussions with carers, particularly with those who care for people with dementia.

The strategy was developed in consultation with older people, carers and service providers. We had a range of consultations across the area. This was two or three years ago now. We held public forums in Gosford and Woy Woy. We had a phone-in which went for a week or so. We had meetings with special needs groups across the area.

These are the issues that were identified. It really would not matter what you talked to people about because transport always comes up pretty much No. 1 wherever you go and whatever the services. These are the issues actually identified by older people themselves in the consultation process. The first is improving access to information. People were saying that they just did not

know where to go to get what help. Another is service coordination. Central Coast Health did not do too well because we got criticised in relation to our hospital admission and discharge protocols. People felt that people had been discharged into the community without proper support. At that stage it was the International Year of Older Persons, so we had quite a concentration on that.

We wanted to get some research done and look at retirement planning. It was a really interesting one. One of the things that came out of the consultations was that people were saying, 'We didn't know what it was going to be like when we retired. We never planned for it. We just thought we would ease from the workplace into retirement and it would work quite easily.' Some couples, for example, would find that they did not particularly want to be in the same house together all day, every day.

There were social pressures, relationship pressures and all sorts of other things which people never thought would happen. So we wanted to look at that. A more supportive living environment referred to trying to make sure that there was a proper physical infrastructure for older people. There were also issues around community security and safety and managing, planning and funding of aged care services on the coast. We wanted to try to get some coordinated view as to how aged care services should be provided.

I will go through what occurred. The strategy was launched in February by the state minister for health. A project manager was appointed. It was jointly funded by local, state and federal agencies. We passed the hat around and everybody contributed, which I thought was good. If you have their money, they are going to be more interested in it. Even though the funding for that position has now dropped away, my agency is still funding it. We put out a quarterly newsletter and we agreed at a later stage to formalise our role and become the Central Coast Quality Ageing Planning Consortium, which is what we are now. A partnership agreement was signed off between all those agencies in September 1999 by Faye Lo Po', who at that stage was state minister for community services.

I will go through some of the issues which were identified and what we have done about them. We set up a transport working party. We actually got the local transport operators involved in this, such as the bus companies. There are two bus companies up here and we got them involved in it. It is quite strange, actually, that bus companies own certain routes. Sometimes their buses go across the other company's routes. If they do, they are not supposed to pick passengers up while they go through there, which is crazy, of course. A lot of people say, 'Well, you know, the bus is going past my front door. Why can't it stop and pick us up?' We had a lot of negotiations with the transport operators. The bus operators have changed their routes and they have allowed people to be picked up on the other person's route.

We also had discussions with the department of transport, councils and consumers. We got a grant from the department of transport to put on a transport consultant. He has produced a report, which is a very interesting report. That is ongoing work. That report was presented to the planning consortium. The key recommendations to be explored will see a major reshaping. We are looking at a brokerage model for transport. So if somebody wants to get from A to B, they contact the central coordination point and it is arranged by either bus or taxi or whatever. Some of the other issues that we have looked at are the under-utilisation of some of the community transport which is available. The health services have a number of buses. The registered clubs have a number of buses. The old people's homes have a number of buses, many of which are

not doing an awful lot for most of the day. So some of those issues are being addressed, but that is still very much work in progress.

We have a transport development worker to process the strategies. We had another consultation later with young people in Wyong shire. Their No. 1 issue was transport as well. So it is not segmenting the market, I guess. Transport is a major issue for all of the community.

Improving access to information was an interesting one. We have had two or three Fact, Fiction and Reality seminars where all of the service providers on the coast have an opportunity to tell the other service providers about the services which they provide. We are pretty much doing that every year. We produced out of that a directory of services, which is available to anybody who wants it. But it contains all of the services available for older people on the coast.

We were also chosen by the Commonwealth Department of Health and Ageing to hold an information seminar for people whose relatives are going into a hostel or nursing home. We have run a number of these now. They are really good. People have no idea what is going to happen when their relatives go in or how to apply for a place, where they can go, what sort of support they can have and so on. So the Commonwealth has been very much involved in that. The Commonwealth is considering providing funding events to be held several times a year in each area. So that is a good one. The format that we have developed for that is something which will now be used in other areas, hopefully with some Commonwealth funding.

The Commonwealth also funded Wesley Mission to set up Carelink on the Central Coast. That is a phone advisory service, a 1800 number. Wesley Mission was chosen to coordinate or run that service. Because we had all of the people around the table as part of the quality ageing strategy, it was very easy for them to access all the information. We have provided them with a lot of support. All of the agencies have. They have found it quite easy, therefore, to get the necessary information. When information changes, they can contact the various agencies and so on. That is quite a heavily used number now by all the people looking for whatever form of assistance they need.

With regard to service coordination, we were one of the first areas to trial the client information and referral record. This yellow wallet was introduced in 1999 by the HACC service providers, community nurses, aged care assessment teams, community aged care package providers and so forth. This assists new clients to avoid multiple community service assessments. What really annoys older people and everyone else, I guess, is a number of people turning up from different agencies from time to time wanting to reassess older people and reassess them and reassess them because they have not been assessed for that service. Some of those assessments go right back to name, date of birth and all of those sorts of things. Clearly, some agencies do need specific information, but a lot of information provided on initial assessment should be useable by other agencies.

This yellow wallet provides a heap of information in terms of what services people are receiving. For example, if somebody is receiving a home help service, when they come into hospital with their yellow wallet, we know that we can ring up the home help provider and say, ‘There’s no need to go around today because they are in hospital.’ When a person is discharged to wherever they are going, we can coordinate their discharge with the agencies providing the service. It also provides information from GPs. It covers some of the basic health care needs and all of those sorts of things, which is a really good thing. The beauty of it, I guess, is that the

client carries it around themselves. That avoids any problems in relation to confidentiality issues.

We have appointed in Central Coast Health a clinical nurse consultant for continuum of care, who focuses on improving the transition of inpatients into the community. So we have a nurse whose sole job is to ensure that people come out of hospital and go back into the community in a proper manner and have adequate supports. The Quality ageing strategy is also part of a 4CN. This is an IT project which is going to be a database where all of the agencies who are providing a service to a client will inform the database of that so that if you then want to find out whether other agencies are providing a service, you get through to the database and it will tell you that HACC and home care and whatever are providing services to that person. That is still at the development stage and there are some issues that need to be ironed out in relation to the confidentiality of information.

We also supported a submission from the Dementia Advisory Service, whose core activities are identifying needs for people with dementia and advocating on their behalf. We have provided—I should send you a copy of it—a CD-ROM called *It's time to think about dementia*. That has been developed to help GPs with the early diagnosis of people with dementia. I will say myself—it is not my product—that it is a really good product and something which could be transportable across Australia. GPs are not always quick to pick up the fact that a patient may have dementia. This is a really good education tool in relation to that. That has been done in conjunction with the division of GPs. We have also set up a primary dementia care network to bring services together to share knowledge, experience and support. Dementia is becoming a major issue for us, of course. As the population ages, the mind does not always keep up with the body, I guess.

As I said, we had a problem with some of our hospital admission and discharge protocols. This was really an issue raised by some of the agencies, who were saying, 'Well, you are discharging patients who need community support and you are not contacting us before you do it'. So we had to clean our act up. We formed a working party with our discharge planners. We have discharge planners in the hospital, all of the agencies concerned, including local government, HACC providers and so on. We rewrote our discharge and admission protocols. I think we are doing a lot better at that than we were previously. Clearly, if you discharge a person too early, they will come straight back through the door. That is no good for the patient or the older person and not much good for the area health service either.

We have appointed a clinical nurse consultant in gerontology focusing on issues relating to the aged and their management. We are trying to make the health services have more age-friendly hospitals for patients and their carers. I suspect if you go to almost any hospital you will find that about 70 or 80 per cent of patients are over 70. Just look around the wards and you will see that that is how it is. So actually making sure that we run health facilities which are age friendly, if you like, and understanding the needs of older people on the wards and in our community facilities and so on is extremely important.

We got heavily involved in the International Year of Older Persons. We ran a number of events across the coast. It was a really great year, actually. It was a really top thing to do—to spruik a bit about the contribution that older people can make to the community. I think it went down very well here on the coast. There were a heap of things we organised. We had a calendar which one of my photographers did some work on and produced. We had a photographic

exhibition which went around the Central Coast. Again, it portrayed people in a positive light. We were involved in National Seniors Week. There was a whole range of activities on the calendar so that people could get to them. There was also a program called 'As Old as I am, as Young as I Feel'. It went around to all the Central Coast schools as part of IYOP, with older people talking about their experiences and so forth.

The ageing and disability department chose us to pilot Experienced Hands. It is a project that had older volunteers talk with younger people about how they could gain employment and those sorts of issues. I am not sure whether it is still around, but it was a pilot that we had. We started a 12-month research project looking at health outcomes in geriatric medicine. The use of the goal attainment scale is about setting people goals in relation to what they would be able to do, whether they can go to the shops or do the gardening or whatever. We have started to look at ways in which, with proper geriatric services, people can actually attain more goals than they currently are and arrest the decline, if you like, in their health status.

Retirement planning was an interesting one, which I spoke about earlier. We have developed a course which is called Starting Over Life After Work. Our learning and development service has developed it. We have implemented a couple of the courses with my own staff. We employ about 4,000 people on the Central Coast in any one year. A fair few of them are retiring, obviously. This is a course that we have been running with our staff and with invited people. Other attendees have come from local government and other areas. We can certainly provide you with information on that. It looks at a whole range of issues.

We are trying to get couples to come along—and single people as well, of course—to talk about planning properly for their retirement and the sorts of things they need to think about. We try to stay clear of the financial side of it. What we are really looking at is what you are going to do when you have retired and how your relationships with close people are going to be affected by your retirement. I will never forget a public meeting we had in a hall around the corner here. A number of women stood up and said, 'God, I never thought it was going to be like this when he stayed at home all day.'

This shows a two-day training workshop that we run. It is about preparing people for retirement. These are the areas covered: physical activity; leisure and lifestyle; handling stress; and nutrition. Nutrition is a very important one. Anybody who works in the aged care field will tell you that nutrition as a health issue is a major issue for older people, both within the community and elsewhere. That course was submitted for an award and got one.

There was also the issue of creating a more supportive living environment. A working party was established to progress the issues raised in the report and to look at opportunities for councils and groups to enhance supportive living environments for older people. We extended that to police, fire and ambulance because older people have a lot of issues in relation to security and so on. Some of it is imagined and some of it is not. That working group is ongoing. Similarly, we engaged with the police in relation to education for older people in terms of making their own homes safer.

Managing, planning and funding aged care services on the coast is where we are really at at the moment. We are looking at what sort of resources are needed to provide adequate care for people on the coast. Our whole area of approach has assisted DADHC to gain an insight into the needs of aged people on the coast. We have advocated strongly for additional nursing home and

hostel beds here. That has been heard. Significant resources are being put in by the Commonwealth in relation to additional nursing home and hostel beds.

We have also tried to encourage residential care providers to come up here. We have written promotional articles to attract nursing home proprietors up here. We have become a trial site for service provision targets in a whole range of areas for the Department of Ageing, Disability and Home Care. We have found that those wanting to set up nursing homes and hostels are finding it very difficult on the coast to actually find a suitable site to build on. Some people buy a site before they apply for beds without talking to anybody at all, which is not very sensible because they find it is in a flood-prone area or it is not close to public transport or it is really not suitable at all. We are trying to avoid that situation, I guess. We have been working with the two councils to put together a package of statistical information to assist those who are interested in placing expressions of interest for aged care places. We continue to work with the councils on that.

We got a grant from the Commonwealth Department of Health and Ageing to research care needs and to develop a strategic plan for quality ageing. This overhead is a little old. Twyford Consulting was employed to do that. That plan has been done. It has been ratified by the quality ageing consortium. I think this has been fairly successful as a strategy. It has tried to address a range of issues in terms of services for older people. I think it is about gaining the commitment of organisations to resource and support the project at the beginning. As I said, we passed the hat around. A number of agencies gave money. If people give money, then they are more interested in the outcomes. There was a shared understanding of and agreement on the issues. There is an understanding that partnerships are always stronger than individuals. It is not always about more funding; it is about changing ways of working.

Frankly, the way that the service system has evolved—I do not think it is anybody's fault necessarily—has been quite dis-integrative. Unless you can find ways of coordinating and integrating it, then it is not providing the service it should to the older population. We built ownership and mutual respect to reduce competitiveness. I thought when we started it would be very difficult for some people to sit around the table and talk to one another, as effectively they can be competitors in some way, but they did. We involved the community when we did those public sessions earlier. We have had a lot of political support. We have had the ability to look beyond the immediate term to find solutions which fit for the future.

In conclusion, I think that we have been pretty successful. There have been a number of gains in the area for our older population. The involvement of the three tiers of government and other key stakeholders in the process is the key. That has led to an intersectorial, area-wide approach trying to meeting the needs of people on the Central Coast. I think that is very much a first in Australia. There is still much work to do, but we are going to continue with the strategy. Thank you.

CHAIR—Thank you very much, Mr Blackwell, for that overview of Central Coast Health's activities in the area of ageing. I will start with where you concluded, which was looking forward a little to the future. Our terms of reference require us to look over the next 40 years.

In your introductory statement, you said that 18 per cent of the Central Coast population are aged over 65 and 13 per cent are aged over 70, which is well above state and national averages. Given that in the future we would expect, for example, people over 85 to be very high users of the health system and both the residential and community aged care systems, what sort of

forward planning have you done over the next 15 or 20 years in terms of the needs you think will have to be met?

Mr Blackwell—That is what we have identified as the main issue for us going into the future. We have set up a planning group. I have a couple of my planners working on it. Both councils are involved, as are a range of other unit providers. The Department of Health and Ageing are involved as well. That is the key issue. We have tried to address some of the existing issues in relation to those strategies that you have seen there, but the real issues running into the future are what sort of facilities we need to provide. We have to remember as well that most people never go into a nursing home or a hostel. By far the majority of people never go into a nursing home or hostel. So most of the people are going to be cared for in the community. A number of them will have chronic, multisystem disease, which will mean that they will have a number of health needs and a number of social needs. They will be quite isolated.

What happens is that people migrate up here to the coast when they are older. They might come up here to live in their holiday homes or they might sell their house in Sydney and get a cheaper house up here, if you like, or a smaller one, and live off the change, effectively. They become socially isolated. They have left their family, friends, support systems and so on. We really need to get our planning act into gear, I guess, in relation to how we meet the needs of those people in the future.

From a health perspective, the over-80s are the ones who are going in and out of hospital on a fairly regular basis. From a health perspective, we want to help people with chronic illnesses, either cardiac illness or respiratory illness or whatever, to try to care for them as much as possible in the community by educating people better in relation to their own disease and the disease process and working closely with general practitioners and others to ensure that people do have the supports and the necessary understanding of the disease to stay out there in the community.

CHAIR—In areas like that, are there any improvements you can make in the interaction between the health services and general practitioners in the management of conditions like diabetes?

Mr Blackwell—We run a number of programs with the division. We are very lucky, in a sense, that Central Coast Health covers the same geographic area as the division of GPs. That is not the case everywhere, as you would be aware. But that is really useful for us. We have an excellent working relationship with them. We have set up a joint unit with them which we fund equally. It has about three people working in it. All that unit does is work on joint programs between us. So some of the programs that we are doing with them involve diabetes. We are doing one on asthma. We have employed asthma nurses in the GP area. We have mental health working with them, as well as drug and alcohol. With mental health and drug and alcohol, Central Coast Health is providing a 24-hour advice line to GPs treating patients with mental health or drug and alcohol problems. That has been really successful because it helps with the level of expertise, which enables the GPs to provide better treatment and keep people in the community. We are running a heap of programs with them.

We got $400,000 from the state government to do a primary health care planning exercise, which involves ourselves, the GPs and the two councils. We will be looking at the primary health care needs of the population. As you would be aware, the health system is somewhat

fragmented in the sense that the GPs are not run by the Commonwealth but are clearly funded by the Commonwealth. The hospital system is a state responsibility. My view is that it does not really matter provided we can work together and work on a whole range of issues. My executive meets on a bimonthly basis with the executive of the division of GPs. We have the coordination unit, which is those three people we jointly fund. We are running a heap of programs with them. I think that is not too hard to do, basically.

Ms CORCORAN—I was going to ask about the variety of sources of funding and any problems that might throw up, but you have pretty well answered that, unless you want to add to what you just said. Is it a problem or is it not a problem?

Mr Blackwell—I think it can be a problem, clearly. If you have a vehicle which shows you the way to go, people are willing. I think the trick is not to make people think that they are being taken over or whatever, and you need to have an equitable relationship with the other service providers in the field. Then you can get some cooperation and coordination. I think that is the way to go. No matter what you do, there will always be, in any area—you can name any area—multiple sources of funding from the federal, state or local government. The key, I think, is to try to get people to work together to recognise what the problem is and to work together to try to solve it. You can then avoid duplication and so on. You can do that at the micro level—in other words, at the level of the individual. If they have a yellow wallet that says, 'These are the services I am getting,' people will know and they will not be duplicated and there will not be gaps. At the macro level, if you have the area structure that we have, which brings everybody together to talk about the big issues, then you need to coordinate at that level too.

Mr HARTSUYKER—There has been only one reference to family in your presentation. Does your strategy attempt to mobilise resources in the community such as family to basically supplement the paid health providers, as it were? You have mentioned migration. There is probably a large number of people who do not have families.

Mr Blackwell—They are quite isolated, yes. I guess society is changing a bit. Family does not always do what it used to do in relation to supporting older people. However, I think in some areas we have engaged people very heavily as carers—immediate family, in other words—particularly for people with dementia. I cannot think of a harder job than looking after somebody with dementia. It might be a partner of 50 years who does not recognise you and does not want to know you sometimes. We have got a whole heap of areas where we are providing support to carers for dementia. Other than that, I would say that we have tried to educate family, if you like, in relation to what is going to happen through some of the presentations I spoke of, which are about when somebody goes into a hostel or nursing home. They can then understand what their role is and so forth. Most older people, as I said, never go into a nursing home or hostel. Mostly that would be because the majority of people are probably supported by their families in many ways.

Ms ELLIS—Thank you very much for that terrific presentation.

Mr Blackwell—You're welcome.

Ms ELLIS—As migrants here for a day, it really gives us a pretty good idea of the picture here. You mentioned care packages and HACC and the dis-coordination that can occur. Could we go back a little. The formula for applying places to areas is 100 per 100,000 over the age of

70. I think it is 50:40:10 for low care-high care community packages. How does that apply, as far as you know, to this area? Is the formula currently meeting the demand?

Mr Blackwell—I do not have my expert with me on that.

Ms ELLIS—That is okay; just approximately, so I can get a feeling for it.

Mr Blackwell—The real issue is not the numbers of places we are getting; the issue is getting them built. You can obviously get the packages fairly quickly because you do not need buildings as such. It seems to me that it works well. The shift into providing more community aged care packages and those sort of things is really good. We should have it as a primary goal—maintaining people in their own accommodation for as long as possible, basically. But the major problem with the nursing home and hostel issues is actually getting them built. There are a whole range of reasons why that does not occur all that quickly. Some of them are because the applicants have not always got the right locations or the funding or whatever else. There are a whole range of issues there. Staffing is becoming a major issue for aged care facilities as well, particularly nurses. They are in competition with people like me to get nurses. There are some major issues there as well.

Ms ELLIS—Do you have a view as to whether the split of that formula, the 40:50:10 I referred to, is correct?

Mr Blackwell—No, I do not.

Ms ELLIS—You do not have a view on that, or you do not think it is appropriate?

Mr Blackwell—I could formulate one in a second. I have never thought about that, no.

Ms ELLIS—Are you aware of the degree to which there are waiting list pressures on the community packages?

Mr Blackwell—Yes. I know there are waiting lists. There are also waiting lists for hostel and nursing home beds as well. We have from time to time up to 60-odd people in hospitals across the coast awaiting placement in a nursing home or hostel. Sometimes it is not because there is not a bed. Sometimes it is just a matter of getting it organised. We have put on nursing staff to liaise between the hospitals and the community providers, be they residential or non-residential. That seems to work quite well. We can actually smooth a path.

Sometimes what really needs to happen is that the family needs somebody to work with them very closely and to advocate for them or the older person or whatever. You can have situations which get quite crazy where different members of the same family have not got the same view as to what should occur in relation to somebody. So you can have somebody sitting at home inappropriately without support or in hospital or whatever because nobody is there to sort out the issues between the various interested parties, and actually contact the nursing home and ease the path into the nursing home or hostel, get through all the paperwork et cetera. We put somebody on to help us do that and work with the industry. That has been reasonably successful, I think.

Ms ELLIS—You mentioned the difficulty in getting them built. I think we are hearing from the shire next. I will ask them that question and this question as well. What do you think can begin to be done, from your perspective, to smooth it over? I see it as an issue of planning, of planned acquisition and zoning and all the things that come into that, as well as the application for bed licences. At the moment it is not terribly well coordinated. Do you have a view as to how that could be improved?

Mr Blackwell—Yes, I do. That is what we have been trying to do, I guess. We have actually held meetings at Gosford and Wyong with their planners and potential nursing home or hostel providers. The Commonwealth has come along as well to talk about the needs they have. The licences are made available and there is then a process of bidding for them. I am sure the Commonwealth has criteria in relation to who gets the licences. I am not sure what they are. Some of the aged care packages and so on that come out go to people who are not necessarily providing a service here already or, in fact, anywhere else. Even though I guess there is a theory that this adds to the competition and competitive process, I think we have enough players in the industry already without inviting some more in. So what happens is that you can get inexperienced people who do not know the area or the industry applying and actually getting packages or getting hostel or nursing home places.

When there is a round of funding and the number of beds is set for a particular area—I think 700 or 800 beds need to be built here—it would be good to run some seminars, which would involve those players that I just talked about—potential providers, local government and the Commonwealth department—to look at some of the issues. Maybe you could get people to make a more informed application for licences. Local government, for example, could say, 'This is where we might have some land available and this is where, if you buy this land, you will never get a DA to build a nursing home or hostel on it.'

The other players are the GPs. One of the problems we have here is that we do not have enough GPs. With respect to people who live here now having access to a local GP, nobody can get in now, let alone additional people.

Ms ELLIS—I have two more very quick questions. You mentioned the CD-ROM on dementia. Who funds that?

Mr Blackwell—That was funded by the state Department of Ageing, Disability and Home Care.

Ms ELLIS—Was it a one-off? How is it distributed? How far is it distributed?

Mr Blackwell—We have just launched it here and we are distributing it to other area health services. We are sending them a copy. Would you like a copy?

Ms ELLIS—Okay. Depending upon the price, I will buy it.

Mr Blackwell—We will provide you with a copy.

Ms ELLIS—I would very much like to see it. I am fascinated. We will find out, if we can, through the committee whether this is a unique development or whether it is being done elsewhere. You mentioned a pilot program with volunteers and people with disability. I cannot

remember what it was called, but there was a pilot program you referred to involving people with disabilities. If you do not know this now, you could give us the information later; that would be fine. I would like to know about it because I think you made the comment that you were not quite sure whether it was still going. That is fair enough. What actually did come of it? What sort of assessment did it get?

Mr Blackwell—Yes. I will provide that information for you later. It was part of the IYOP. It was called Experienced Hands. It was about older people talking to kids leaving school about getting into the work force and so on. I can provide you with more information.

Ms ELLIS—That would be terrific. Thanks very much.

Mr MOSSFIELD—I have a question about age related illnesses. What have you come up with relating to the need to address these illnesses over a long time? Some comment has been made about dementia. What about other diseases such as Parkinson's disease and people with diabetes? From my own experience, I have had complaints in my electorate office that the people who supply Meals On Wheels do not particularly cater for people with diabetes. Have you done any research into those long-term issues?

Mr Blackwell—No, not as such. Within the area health service we are doing more research, particularly into neurological diseases such as strokes and things like that. Our geriatricians are doing a whole range of research but not into diabetes.

ACTING CHAIR (Ms Hall)—Could we have a copy of your presentation?

Mr Blackwell—I can leave you one copy here.

ACTING CHAIR—That would be great. Could we have a copy of the CD-ROM? I think it would be very beneficial for the committee if they could look at the yellow wallet.

Ms ELLIS—Absolutely.

ACTING CHAIR—That is a great aid for people and something that is really innovative that you have prepared in this area. You said that you have an outline of the retirement planning course, Starting Life After Work. It would be wonderful if we could get a copy of that as well. On a personal note, could I get a copy of the transport consultant's report, please?

Mr Blackwell—Yes.

ACTING CHAIR—I think it would be very useful. Central Coast Health have certainly been innovative in what they have done here in bringing in all government departments and all bodies and organisations that are involved in the provision of health services to older people. It is a model that could be used throughout Australia. It really gains its strength from this whole of government approach.

When you were giving your presentation, I noticed that you said initially this was funded by everybody but that Central Coast Health has picked up the cost of a number of programs to make sure that they are ongoing. Do you perceive it as a problem that you are funded for your

pilots but that when it comes to something a little more long term there is no ongoing funding? If you do, how would you like to see this changed?

Mr Blackwell—I might have misled you there a little. The only thing we are funding on an ongoing basis is the project officer, who works on the strategy itself. So all of the other bits and pieces have been funded by other agencies or in partnership with our agency, where we might be contributing or whatever. One of the problems, however, is that there is an issue around pilot programs, which there always is. I have to say that, without being prepared to be too critical, the Commonwealth loves a pilot program and does not always continue to fund it after that. That can be a real problem for us. To be fair, things like Carelink are ongoing programs. A whole range of those programs are ongoing. There is sometimes an expectation that because a pilot program has done well, other people will somehow pick up the funding. They do not.

ACTING CHAIR—Are the resources of both Central Coast Health and other organisations that are involved in the Quality ageing strategy in the Central Coast stretched?

Mr Blackwell—I think anybody in human services is always stretched.

ACTING CHAIR—What areas do you think need more financial assistance to enable the program not only to continue but to go forward and meet the terms of reference of this committee?

Mr Blackwell—In fairness, most of the issues we want to see ongoing are ongoing. Transport, for example, has been funded on an ongoing basis. We have ongoing funding for the yellow wallet, the coordination thing, and ongoing funding for a whole range of things. From my perspective, it is extremely important from a health point of view to work with other agencies. Therefore, I am prepared to continue to fund the person I have working on this. One of the overheads stated that it is not about additional funding; it is about working with other people. That is what I think

ACTING CHAIR—How often does the working party meet? What are its current strategies and projects?

Mr Blackwell—Most of them are shown there. We meet every two or three months. In between, there are a whole heap of subcommittees working on transport, coordination et cetera. So the steering committee itself is really a peak body. There are a whole range of issues going on at the moment. One that we are spending a fair bit of time on is the one I talked about, which is the 4CN. That is about agencies providing information to a central data repository in relation to services they are providing to individual people. For example, if somebody contacts you in relation to providing home help for a particular client, you would be able to contact that central data repository and see whether they were already getting a service from Health, from GPs or whatever. That is one which is consuming quite a lot of our energies at the moment.

ACTING CHAIR—I want to ask a question that does not relate to the Quality ageing strategy. What psychogeriatric beds are there on the coast? Are there sufficient numbers? Do you think that the issue of psychogeriatric beds and treatment or support for people suffering from psychogeriatric illness is dealt with sufficiently?

Mr Blackwell—It is a major issue. At the moment we have 25 general mental health beds on the coast at a place called Mandala in Gosford. We are building 50 new beds at Wyong hospital. Half of them will be psychogeriatric. It will meet the needs. I am saying that at the moment we do not have psychogeriatric beds, but we will. By the end of this year, the new mental health unit will be in operation in Wyong and will be meeting that need.

Ms ELLIS—While we are talking about the provision of beds, packages, psychogeriatric beds and all those sorts of things, we are talking about the current situation. If someone came along to see you tomorrow, as CEO of Central Coast Health, and said, 'Here's an enormous bucket of money'—this is the ideal world called utopia—'and you can apply it as you see fit,' how would you judge the current needs versus the requirement to plan into the future and actually pull back those needs into the future? In other words, how would you put out some healthy ageing stuff? You are doing all that, but how would you make that judgment on response, given the pressures now but given the need to address that into the future?

Mr Blackwell—We have to go through a proper planning process to do that. I am not sure whether you are asking me from the perspective of my being a health CEO or from the perspective of quality ageing.

Ms ELLIS—Actually, it is probably a bit of both. We are talking about the need to promote and enable healthy ageing—it is an easy phrase to say, but we know what it means—into the future as well as addressing the needs we are looking at now, in physical terms as well. So you have to make that judgment.

Mr Blackwell—Within the health service, we are going through another major planning process. A couple of years ago, we got funding for additional beds for Wyong and to redevelop Gosford hospital. The population has grown so quickly that just in the last year we built three new community health centres, for example. We will have another 150 beds at Wyong. The psychogeriatric beds will be part of that. We go through a proper planning process, which basically looks at the population projections, most of which we do not believe for a second, but we make our own best guess, too.

The rate of growth on the Central Coast is something which nobody can really put a handle on. As an example, using local government statistics, the population is around 300,000 people at the moment. If you actually used all of the land which is currently zoned residential to its full capacity and put everybody that you could into those residential units, you could have 400,000 people in Gosford and 400,000 people in Wyong. That is not going to happen because there is not the support and infrastructure and all those sorts of things. But people talk about additional land releases. We do not actually need additional land releases to get to a very large population. We probably need more water, and the council will tell you that later on. But the actual zoning to significantly expand the population is already there.

We at Central Coast Health, for what it is worth, think that the population will be around 400,000 or 450,000 within 10 or 15 years, and probably a lot more than that as time goes by. But our local government will have their own views on that. Certainly they would say that we need adequate infrastructure to enable us to do that. So from a health perspective we look at the population growth and at changing models of care. In other words, we look at how we are treating diseases differently than we used to.

A hip replacement is a good example. A few years ago, if you had a hip replacement, you would have been in hospital for a fair amount of time. You would have been in rehab for an even longer time. These days, you will be in for three days and then you will move on. You need to provide the community supports. We need to go through a planning process which looks at the population and changing models of care, not only in the health system but in the community system as well. As I say, the move is towards ageing in place and those sorts of issues. We would need to look at the epidemiology of the population. We look at what diseases are high on our list within the Central Coast. Then we would plan our services around that sort of information. That is how we do it. It is difficult to do that across a whole range of agencies when you are looking at the proportion of hostel beds, nursing home beds and so forth. That is what our planning group is trying to come to grips with, going into the future.

Ms ELLIS—Do you know how many young people you have in nursing home facilities at the moment in your region? That is anybody under the aged group. They are called the young people.

Mr Blackwell—I do not know. I do know that it is extraordinarily difficult to get them in. Whether they should be there or not is a different issue.

Ms ELLIS—That is a different issue. I was just wondering whether you had a feel for the proportion.

Mr Blackwell—I do not. I do not have the experts with me who know that. I am sorry; I cannot help.

Ms ELLIS—Would you be able to find that out at some point? Is that findable?

Mr Blackwell—I think it is. I am just wondering whether the ACAT could provide that sort of information.

Ms ELLIS—If it is possible, that would be very useful. Someone else is nodding.

Mr HARTSUYKER—Jill Hall raised the point that your quality ageing strategy could be attempted for other areas. Have you been having much discussion with other areas as to what you are doing here?

Mr Blackwell—Yes, we have. We have made a number of presentations on this at national conferences and a number of other areas have picked it up. We have worked with the Hunter and a couple of other areas in New South Wales. One size does not fit all, but we have made these presentations in a number of areas in New South Wales and, as I say, at national conferences. Hopefully, people are doing the same thing elsewhere.

Mr HARTSUYKER—What is the role of your current coordinator who is moving the ongoing strategy forward? What types of things are they addressing at the moment?

Mr Blackwell—As I say, they are mainly moving into the forward planning area at the moment in trying to get a handle on what the population is going to look like, what the disease patterns are, what sort of resources we are going to have to cope with the continuing influx and

the ageing in place of the population that we already have. So that is really the focus that we have at the moment.

CHAIR—There being no further questions, I would like to thank you for appearing before us today, and for the copy of the PowerPoint presentation, which we will make available to members of the committee.

[10.03 a.m.]

BEST, Councillor Greg, Mayor, Wyong Shire Council

CHAIR—Mayor Best, did you want to address the committee?

Councillor Best—I would like to thank you for giving the community of the Central Coast and Wyong shire the opportunity to meet with you today. In particular, I thank you, Jill Hall. I know that you have certainly made this area one of the stops during the committee's inquiry. We appreciate that. Jon Blackwell, thank you very much for your address. It certainly is very much in line with where we sit in local government.

We have a presentation coming up shortly from Mr John Burgess. I will not be able to stay for that. John has a number of copies that he can supply to you. I would like to thank John and his staff. I think it is very much to the point of where we are in Wyong shire. The growth here is astronomical. The growth is 4,500 to 5,000 people per year in our urban release areas. Those urban release areas have been identified by successive governments. We have to house the future. The future here seems to be an enormous population of seniors, and a lot of the younger families attract the elderly with them. Then there is the overlay of the well-known baby boomer set that is coming to town as well. So we have a trifecta of challenge before us in a unique way. On top of that, 30,000 people commute to Sydney and 11,000 commute to Newcastle. That puts enormous pressure on the social fabric.

The network that Jon talked about, which you would take for granted in many other communities, is not here. We have a very fractured community by virtue of the influx, so you do not have that high-wire safety net underneath the normal family structure that you would expect to exist. The challenge is extremely difficult. The figures that Jon has put down are very similar to mine. We are tracking it in exactly the same way.

I say to many forums that I address and speak to that in regional and Central Coast terminology we are building a city here in Wyong shire. The city will be the size of Dubbo—in fact, bigger than Dubbo in 15 years. It is called Warnervale. It is just to the north of us here. Quite frankly, I have never built a city before and there are not many others that have that I can ask a few questions of. So we have before us a unique but extremely challenging opportunity. As I say, we are only a local council. We have great relations with our state counterparts. Again, that tripartite approach to this industry's challenges is clearly an absolute imperative in order to deliver what you want to deliver in your heart—the very best outcome.

Feedback from some of the industry people that I am getting involves the issue of compliance versus care. We see in the media a whole lot of beat-ups in relation to certain issues. They have to be addressed. Some of them have to be dealt with. As a whole, looking at the industry, congratulations are due to them in general. They are delivering an extraordinarily good outcome, having regard to resources and the challenges that they face. They are the same challenges that we face. But compliance is clearly eating into their resources. I am not suggesting that there should not be compliance. I am saying that we have to look at that. I do not know how to do that. I am the mayor; you are the federal committee.

I want to touch on palliative care. Jon has done a wonderful job in keeping people at home for as long as we can keep them there. That is the best outcome for everybody. With respect to the palliative care issue, people are going into the system terrified of what the outcomes are going to be because they do not understand the palliative support unit that is there and which should also be strengthened. I do not think they understand. They are not worried about the passing process all that much; it is how it is going to be which seems to be one of the vexing and emotional issues that I discuss.

On a positive note, thank you for coming to Wyong shire. Thank you for taking the time to do so. I am really pleased that it has been raining here as well as in many other places around the state.

CHAIR—Thank you very much for that. We are proposing that after the break we will speak to Mr John Burgess, the general manager. You will be happy if we direct questions to John?

Councillor Best—Delighted. Thanks very much, Jill, for arranging this hearing here. It is appreciated.

Proceedings suspended from 10.07 a.m. to 10.33 a.m.

BURGESS, Mr Edward John, Director, Corporate and Community Services, Wyong Shire Council

NICHOLSON, Ms Nancy, Team Leader, Community Services, Wyong Shire Council

CHAIR—I welcome the representatives of Wyong Shire Council to today's public hearing. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Mr Burgess, would you like to make an opening statement before I invite members to ask questions?

Mr Burgess—Thank you, Mr Chairman. I will give a quick overview for members of the committee. I will turn the map around so that you can see it. It might be a little difficult to see it up there. It shows Wyong shire. This is to give you an appreciation of the size of Wyong shire. If you know Sydney at all, it includes Hornsby in the north to approximately Botany and Sutherland in the south and from Bondi Beach to Blacktown. Within that we have a significant area of what we call valleys and some national forest or state forest. It includes the southern lakes area, which has been extensively housed, including one of the famous holiday suburbs called The Entrance. To the north, you have Lake Macquarie, which is a large body of water. Of course, the deputy chairperson would be fully aware of our boundaries with the former council of Lake Macquarie.

Major growth centres are Summerland Point, Gwandalan and Mannering Park. Our most significant growth is occurring in there, which is what the mayor described as the new city of Warnervale, which will have a large population by the year 2020. Woongarah, Hamlyn Terrace and Wadalba are all major development areas. We have that little bit of water in the middle of the shire, which means that every service we have, for around 80 kilometres, has to track that lake system in some way, shape or form. So there are minor constraints. We have major flooding issues along the Wyong River. Of course, we have one of the worst arterial roads in Australia, the Sydney-Newcastle F3 freeway, which is occasionally blocked and almost impassable. Beyond that, it is an old shire based on fishing. We started to kick off back in the early 1970s in terms of population growth. So that is a quick overview.

A PowerPoint presentation was then given—

Mr Burgess—I will now turn to the presentation. We have named our presentation 'From Nappy Valley to God's Waiting Room'. I do so on the basis that approximately 18 per cent of our population is between the ages of 10 and 24 and 17 per cent of our population would be termed aged. Of course, the definition of 'aged' varies depending on who you talk to.

CHAIR—When you say 17 per cent, would they be aged older than 65?

Mr Burgess—Yes. We have one of the highest aged populations by comparison with any other local government authority. We will demonstrate that to you shortly. I have just spoken about our skewed population profile. We have a huge group of young people and a large aged population. When we get through one lot of God's waiting room, we will be back into the same process in 40 or 50 years time with that same age group of people. Wyong shire has one of the

highest growth rates of any local authority in New South Wales, and possibly Australia. It is annualised at 2.9 per cent. It has been as high as 3.3 and 3.5 per cent on various occasions.

To put our population growth into some perspective against the Australian population, I will show you this graph, which has been reproduced. There are a number of items shown here with the consent of MacroPlan in Melbourne. You will see that Australia's current population is 19 million. By the time we get to 2031, it will be 25 million. In 2041, it will be 26 million. We believe that the shire's population growth statistics will at least mirror that if not surpass it.

To put it into a little more context, Wyong is more concerned about the question of the baby boomers and their impact on every service you could possibly relate to. They are going to be a huge slice of the aged population and they are going to have some special characteristics. In terms of our population comparisons, as you can see, the figure for the Central Coast is 17.7 per cent. The New South Wales average is 13.9 per cent. Wyong is 17.7 per cent and Gosford is 17.8 per cent. Of course, the others, with Lake Macquarie at 15.3 per cent, are similar to the Central Coast profile.

In terms of the population aged between 55 and 64—the people progressing into that higher age bracket—again, the New South Wales average is 9.2 per cent. The Central Coast is 9.4 per cent and Wyong is 9.6 per cent. That is principally because a number of those existing development areas have converted from holiday housing to permanent housing with a number of people migrating to Wyong shire on a continual basis. I used to work as the general manager of a small council in country New South Wales called Glen Innes. We plan and build a town the size of Glen Innes every year. It has a population of 6,000 people. Again, there is the impact of those baby boomers as time progresses and the corresponding impact on all of the services that we will have to provide. When I say all of the services we have to provide, I mean by the federal, state and local governments.

With Australia's ageing population, the labour force will also age. Currently, the Central Coast has a major commuting population, with something like 45,000 people travelling back and forth to Sydney either by road or by rail daily. As they age and if those employment trends continue, the significance for health and other issues is major. By 2016, more than 80 per cent of the projected growth in the labour force will be those people aged 45 years and over. There will be no youth to replace those who currently work.

In 1998, 10 per cent of the labour force was aged 55 and over. As I said, this group will account for more than 50 per cent of all growth in the labour force. Women's participation in the labour force is projected to rise in every age group except those aged 15 to 19 and those aged 65. Conversely, the male working population is expected to fall. There is a graph depicting those particular impacts on labour and the reduction in the 15 to 19 age group and the 20- to 24-year-old work force. I raise that as a serious issue because work does relate to health, wealth and happiness and we need to be very clear that in anything we do the labour planning issues are part of any ageing strategies.

Baby boomers were born post 1940. They have what I would say are some particular characteristics. They are certainly going to be better educated and less likely to be financially dependent on the community and governments. They are going to be far more mobile. They are going to be looking for a whole range of diverse activities, particularly more part-time work and more travel, be it intrastate or overseas. There will be greater expectations in terms of their

leisure, recreation and their lifelong learning. I will emphasise lifelong learning a little later. They will be far more adaptable to exposure to new technologies. They will be far more articulate in the use of those technologies to access their choices. There is likely to be a significant special needs group. Whilst having come through the baby boomers generation, there will be those who will be left out. Whilst not trying to marginalise any groups, it is more likely to be those who have gone through the work force on low or concessional incomes. They will be the group looking for the support of government into the future.

How do we address that? We believe there is a new mix of services. Again, I re-emphasise that baby boomers are issuing their demand on our societies. There will be fast growth and fast ageing. By that I mean that, being part of that baby boomers clique—I guess most of us in this room are—there will be a huge impact on all of the services of government. There will be a huge range of people growing old at a much quicker rate. In addition, there will be a change to the household structure as we know it. The old atomic family of husband and wife and the average of 2.3 or 1.9 children, depending on which group of statistics you read, will no longer be dominant and will change. There will be singular households. There will be a much greater need for diverse housing types and ranges of housing. There will be a new fringe dwellers characteristic, which will seek a balance between economic activities and lifestyle requirements. There will be a move back to the bush. The characteristics of this group show that the environment is going to be a significant attraction. That is part of the attraction of the Central Coast—the environment. Our current housing meets today's needs, but will it meet tomorrow's? Will we be able to build housing stock in the style we build it to accommodate the people as they want to live in it today when we already know they want to be far more flexible and far more capable of moving?

We believe that there will also be people who will want to work and shop locally. The impact of commuting on people on the Central Coast is a significant issue. There are those who are happy to travel up and down to Sydney all day every day because there is a significant salary difference between well-paid positions on the Central Coast and those in Sydney. But as they age, they are less likely to want to work in the city for a salary's sake. Those issues are gone. Their needs have been met. They have built their homes and their families have grown up. I can give you an example of that. I employed a contracts manager who dropped $40,000 per annum in salary to save travelling 3½ hours per day.

These people, because of their cash flow, are going to be able to create their own markets. As I said, there will be 2.4 to 3.4 million people living alone by the year 2021. That is a significant issue for all health planners and all governments, be they state, local or federal. There will be an increase of between 52 per cent and 113 per cent from the 1996 level of 1.6 million. To address some of those issues, the approach of the Wyong shire is to take a strategic approach where possible and start planning for a number of these issues before they happen.

You had a presentation from Jon Blackwell. I would be remiss if I did not say that, through the action of this council and its strategic approach, a number of key Central Coast issues are being addressed in concert with a whole of government approach. One of them, of course, was area health. We are regular partners with area health and Gosford city and a number of others in the development of that strategy. I want to highlight and reinforce what Jon said. It is a strategy based on whole of region. It is a strategy that involves the elderly through forums and consultation. How many times do we all make the mistake of believing that we know what

people really want and forget to ask? We believe the strategy reflects the community's priorities regarding significant issues.

The strategy addresses—and I reinforce Jon's comments but in bullet points—transport. If there is one issue on the Central Coast that absolutely begs some form of panacea or fix, it is transport. It does not matter what part of the Central Coast you are on, it is a significant issue. The strategy also addresses access to information. Jon, of course, commented on that. It also addresses service coordination. We are like area health: we believe that you do not necessarily need new dollars. What you do need is people coordinating the services to get service delivery. We do not believe in employing administrative people, the shiny suits. We believe in on-the-street service delivery. The strategy addressed and developed a hospital admission and discharge protocol, which Jon also spoke about. He spoke about ongoing research. He also spoke about supported living.

Most importantly, an area in which we believe we have the most significant role to play is the planning of services. We do not advocate that we are a typical local government unit. We are not here to not be critical of other levels of government or ourselves in the role of service delivery and service planning. We believe that our role is to facilitate. If that means bumping against some corners and bumping some edges, that is what we believe we need to do. But we also believe that, where we possibly can, we will do it in cooperation with our federal and state local members.

In terms of strategy outcomes, you heard Jon talk about the transport working group and the establishment of a coordinator. Part of our Wyong shire plan is to have a biannual transport conference where we can workshop issues, developments and concerns. Out of a recent launch of the community development profile and package, we have one group in The Entrance working with local schools to work on an integrated form of transport which will include both the youth and the aged.

A seniors information and awareness kit has been developed. From Wyong's point of view, HACC services have been co-located. We intend, with any new developments in the north that receive any funding, to do exactly the same thing. They should all be in the same place. We are introducing client information and referral records. Again, Jon spoke about that. We have developed coordinated protocols for admission and discharge. Again, as Jon commented, it does help to reduce the interplay between all the different health providers and it does aid in getting the aged to either another facility or back into their own home. We have research programs that we have initiated through the University of Newcastle's Ourimbah campus. That particular university has taken a great interest in this community and will continue to play its role in researching the issues of both migration and health patterns.

I will comment quickly on community attitudes. As I said before, age is in the mind of the beholder. I am not 42; I am a bit older than that. I have always thought someone at 42 is not old and that 65 is old. To a middle aged person, middle age is 46 to 49. To an old person, middle age is 51 and old is 72. To my mother-in-law, 89 is young. People's expectations as they age are linked to freedom of choice. I think that is a key, critical aspect in any planning—that question of freedom of choice.

It is about doing what one wants to do when one wants to do it. To highlight that, we have just been to a family wedding in Muswellbrook. My father-in-law is 91, a World War II veteran.

He has just had his licence taken away. He can drive around Emmaville but he cannot drive anywhere else. But he was hell-bent on driving down to that wedding until we talked him out of it. It is this question of freedom of choice. But he still saw it as his right, although society had said he was no longer able to exercise that right to drive to that wedding, irrespective of the other poor buggers who might be on the other side of the road.

The three positive associations with ageing are having more time for activities of choice; having great-grandchildren or grandchildren; and not having to work. Let me put another one in there that we had contemplated but did not believe belonged there. It was the question of the associations that are built with the ageing, particularly with the club. The club seems to be identified and associated with a lot of ageing activities. It is not necessarily the poker machines or the like, but it seems that that is where you go to meet somebody. That is where the friendships and associations occur.

Addressing some of the specific issues that Wyong council sees as important, commencing with health, we believe there needs to be a continued emphasis on health services. We say that with all due deference to the presentation by Central Coast Health. Wyong shire has undertaken work jointly with Gosford City Council for the development of one of the first New South Wales state government regional plans. The New South Wales state government plans do not extend much beyond four years. If we are going to address the issue of health and the provision of health services, it has to be a whole of government approach. It cannot ignore any of those particular areas.

We need an emphasis on healthy lifestyles. If we are going to reduce the costs on health services, we need to do something different. Finally, to highlight the reality, those 65 years and over consume 35 per cent of the available health budget.

What are Wyong shire's concerns? I guess they are like those of almost every other region in Australia. We believe there is a chronic under-resourcing of hospitals. At the end of Central Coast Health's planning phase, it will provide for the existing population. It will not provide for the 40,000 moving into Warnervale city. There is an acute lack of medical practitioners. There is a widespread, wholesale removal of bulk-billing options. It is unfortunate, but true, that general practitioners, because of their workload, generally do not support home or facility visits for service delivery.

What does Wyong shire need? Quite simply, we need money to deliver education services in concert and consultation with our other regional players. We need doctors. We need the improved coordination of health and community services. By that I mean it is easy for each level of government to blame the other. That is not helping the overall coordination of the delivery of those services.

I must say that I am a great admirer of the Japanese system of lifelong learning. They provide dedicated facilities where people can partake in all forms of lifelong learning activities, stimulation, education, renewal and revival. If we are going to be faced with a number of people entering the labour force or continuing on in the labour force, we need skill retention and enhancement of those skills. We cannot ignore those people back in the early 1970s and assume they are still computer literate when they are not, if society wants them to continue to add value in the work force.

From a council perspective, we need expanded access to libraries. Almost 50 per cent of all local government populations belong to a library and access it in one way, shape or form. It is severely under-resourced. Of course, people will need access to the technology that will deliver those new educational platforms.

We believe one of the objectives is to expand the publicly owned stock of housing. I know that is a particularly big ask. There are certainly protocols between the state and federal government involving that issue. But it is an issue that has to be addressed, particularly if we move to one-person occupation of a housing unit. There will need to be some significant changes made to how we address that process of building housing stocks. Whether we like it or not, there will need to be some form of rent control on private housing stocks used for public housing, particularly where people are on concessional incomes. Of course, to make it attractive for people to move where there are accommodation options, health options and transport options, as a society we need to look at how we can rehouse some of those people.

The concerns for the council are these: we certainly support and strongly advocate that the longer people can stay at home, that is the best and the most affordable option for any level of government. We also believe that respite care options are very much limited and are resulting in a drain on hospital resources and need to be addressed.

What Wyong shire would need is this: we believe that, certainly from the community point of view, we are already under housing stress. As the population ages, that stress will increase dramatically. We need increased resources for the HACC program. I know there is some criticism of the HACC program and its deliverables, but at the moment I see no options other than to rejuvenate and resource the HACC program. We need increased funding for respite care. I do not believe there is a lot of support for it, but there is a lot of talk about support for families acting as carers where one partner may have to give up work to look after two sets of aged parents. Maybe the system, through some tax relief measures, could provide for those people.

In the residential care sector, we know that 800 beds have been approved that have not been built for the Central Coast. There needs to be adequate provision of hostel and nursing home care at an affordable cost and, significantly, the timely planning and delivery of those care facilities. The issue for council is the cost of placement for the individual or their family. There are no obligations on the provider to place local residents in care. So those on the waiting list that meet the requirements and can possibly self-fund are probably given preference, although that is anecdotal on our part and we have no evidence to support that. There is inadequate funding of construction costs of the facilities by government. Again, anecdotally, we believe it costs about $110,000 for each carer whereas the current subsidy is around $60,000. Of course, there is the issue of family dislocation when family move away and mum or dad go into residential care somewhere else or when mum or dad in fact go into residential care here.

I guess what we need relates to some of the questions coming from the committee earlier. The coordination of private and government service delivery, I think, is an absolute priority. It is no good for the government at a federal level to issue the places if the planning approvals are not being provided at local government level. I echo Jon Blackwell's comments that often somebody will pick a block of land on a map, buy it on spec and expect the council to provide an approval. We need pre-planning of the facilities. It will not receive any criticism from this council if there is a push nationally through the state back to local government to say, 'We need you to identify those sites.' But we also need to identify the bigger ticket issue, particularly in

Wyong, where we can get any number of hostels but we cannot get nursing home beds. We will not approve hostels without a progressive plan from hostel to nursing home.

We believe there should be a mix of both public and private ownership. I guess that is a question that could be debated for some considerable time. But if there is public ownership, we believe that the standard of care, anecdotally, could be higher in those operated by the public—by that I mean the charitable institutions—as opposed to those that are privately owned. There is the integration of services with other health providers. Jon Blackwell from Central Coast Health certainly spoke at length about that. We need to see some reduction in the waiting lists. I guess it is a chicken-and-egg situation. If you have the facilities built, the waiting lists reduce. But that reflects the current population. I do not believe that the federal perspective has any regard for the growth in the population of Wyong shire.

Of course, there needs to be an adequate assessment of need and condition before entry to a facility, with some people entering on a self-care basis when in fact they are really high care, which causes all sorts of frustration among the health providers themselves. There is the transport issue. I have already spoken to you about access to transport on the Central Coast. We need access to reliable, affordable transport. We need access to specialised transport options. We need locality based services to reduce travel.

Of concern to council is that public transport systems are inadequate now. As foreshadowed by the Central Coast Health submission, state regulation does not foster competition between the bus companies. We have some buses that take three hours—the deputy chair would understand this comment—to go from Tacoma, one of our suburbs, out to our Westfield shopping complex. It could take a 3½ hour round trip on a bus. Aged people will just not make the trip. It is impossible.

There is always the issue of the private sector being slow to react to changing needs. For example, there are a very limited number of taxis on the Central Coast which will cater for wheelchairs. Of course, there is always conflict in terms of transport planning between cars and pedestrians. We are good at building roads. Our engineers build wonderful roundabouts, but they have no regard for the aged person who will eventually walk across a flow of traffic which is possibly travelling at high speed. We are suggesting that we need integrated transport planning strategies taking a whole of government approach. Of course, we need funds to promote road safety to elderly folk.

In summary, we have believed for some time that the resolution of future issues must be contemplated now. I guess that is why the committee is here today. We thank you for that. We need planning for an aged population to begin sooner rather than later. Planning should be undertaken at all levels of government, including local government. I believe local government needs a genuine seat at that table. Local government requires direct funding initiatives. Local government should not be required to fund the cost of ageing initiatives. We are already picking up the tab from the New South Wales state government through the pensioner concessions. If that is to continue, then we will all end up in a local area subsidising what we believe is a federal function, and that is not a reasonable fiscal share of the funds. I guess in nappy valley we like to say that we all age. Thank you again for coming here today. Do you have any questions?

CHAIR—Thank you very much, Mr Burgess. I will start with questions. I should point out that we only have a limited time for questions. I will ask people to keep their questions and the answers as brief as possible. First of all, I would like to ask you a question which relates to the stuff you said initially about the labour force. You also said that the private sector and transport were slow to respond. I was interested in your impression of how businesses are adapting to the changed aged profile in Wyong Shire Council. Wyong Shire Council is already ahead of most of the rest of Australia in terms of the age profile. I was particularly interested in whether you are seeing any evidence that businesses are adapting both in terms of their attitude to mature age workers and in terms of how they actually target their customers.

Mr Burgess—I will ask Nancy to respond. My view would be that at this stage some businesses have and others have not.

Ms Nicholson—I think what businesses have done for the most part is to introduce the seniors card. I think that is what they think they have done for the seniors. Unemployment is a factor here. I know that some people who are older have experienced not being able to get a job. I think it does have an impact here. I do not think the business sector—this is my personal opinion—has really thought about what is going to happen in terms of the aged population.

Ms HALL—I have one quick question. You were talking about housing. One thing that I think is peculiar to the Central Coast or more predominant in the Central Coast is the number of people living in residential parks. Could you share with the committee some of the initiatives that have taken place there and some of the special strains and stresses this places on the local government area. At the same time, could you touch on the mushrooming of independent living units or 55-plus developments. I think it is State Environment Planning Policy 5.

Mr Burgess—SEPP 5. Wyong shire has a large number of what I would call long-term resident parks. Most of those people are coming from a lower socioeconomic background. The parks have been developed sometimes in isolation because they need broad, open spaces, which causes all sorts of social problems irrespective of the council consents that cause them to put in place transport and the like. I guess one thing is issuing the consent and one issue is seeing it built. Another issue is it being delivered.

In terms of the State Environment Planning Policy 5, we have a proliferation of the development of those aged units. There is no forward planning that requires the developer or the council to plan for the eventual movement of those people from that development into hostel or home care. Those developments are being approved and they are placing great strain on the existing available beds for hospital and nursing care. Council has little or no control over the approval of those by either the government or the Land and Environment Court.

Ms HALL—And you feel that that is a power you need?

Mr Burgess—It certainly is, yes. It is a certain significant power we would like.

Ms HALL—Thank you, Mr Burgess.

Ms ELLIS—I have so many questions, I am going to have to be disciplined.

CHAIR—I have some too.

Ms ELLIS—Could you please take us through the planning process from the local council's point of view in relation to the development of aged facilities. Could you elaborate? You made some points in your presentation.

Mr Burgess—From our perspective, the process of people building nursing homes and hostels begins with a developer identifying a block of land. Without any reference to or research with the council, he or she or the company decides that they can build a facility on that piece of land. When the council refuses, it is often a matter of going off to the Land and Environment Court, with a gross waste of public money on both sides.

Ms ELLIS—Why would the council refuse?

Mr Burgess—Because it is not zoned appropriately. It might be flood prone. The zoning might be totally inappropriate for that sort of development. It might be within some major residential areas and there is conflict between the users. The council has put in place a process which we advocate that every developer uses. If you want to do something in Wyong shire, come and see us. We will sit down with them. We will develop an overall profile of what sort of land would be appropriate, where the zoning would be appropriate, what would accommodate their service and where infrastructure will support the service. Often they want to build a nursing home and hostel where there is no capacity for sewers. We might have to build major sewage pumping stations or whatever the case may be. So we actively encourage them to come and talk to us in the first instance, to sit down with their particular development and then plan it through so that we can give them advice about traffic access, transport access, other support services in terms of community services, planning services and what will make the DA get a far better treatment within the council than if it were just a poor quality application that was thrown in. There are a number of other issues that are impacting, such as the state government's fauna and flora legislation, which is restricting the type of land that can be cleared to build those facilities.

Ms ELLIS—Am I being overly critical if I suggest that in some cases maybe the purchaser is being purely belligerent in the sense that the person who owns the land must know about the zoning?

Mr Burgess—That would be reasonable.

Ms ELLIS—You mentioned 800 beds approved and not yet built on the Central Coast. How many beds did the Central Coast get in the last round? Do you know that? How many places, I should say, because they are not all beds.

Mr Burgess—No, they are places. I think it is something like 200 or 240. We are not sure.

Ms ELLIS—Is that part of that 800?

Mr Burgess—Yes, I believe so.

Ms ELLIS—Do you know what the oldest of those 800 are in terms of how long you have had them?

Mr Burgess—No.

Ms ELLIS—Would it be possible to find that out?

Mr Burgess—We can find that out, yes.

Ms ELLIS—I have another very quick question. In the new development areas of the shire, you have said that there is one particular area where you are building a mini-city. What process is the council going through, given that you have brand new greenfields development occurring, I gather, to ensure that the needs of an ageing population will be catered for in the infrastructure development of the new areas?

Mr Burgess—In terms of the development, the council has prepared an overall strategy plan for the development of the whole of Warnervale city, which addresses transport, health, lifestyle and all of those sorts of issues. In collaboration with all those, part of the actual redevelopment of Wyong hospital is five kilometres down the road from Warnervale. The concern will be that the hospital will not have the capacity in the year 2020 to provide the care that they might be able to provide in the year 2004 when the development is complete.

Ms ELLIS—That will include transport considerations as well in those new areas?

Mr Burgess—Yes, it does. The planning addresses that currently.

Ms ELLIS—You had quite a bit to say in your presentation about the baby boomer group. What you said was factual. To what degree do you believe that we as a community are currently looking at the baby boomer movement in a very negative sense? To what degree do you believe we should be seeing opportunity rather than merely pressures on systems?

Mr Burgess—Principally, there is the fact that a lot of these people are very articulate and will be able to contribute to society for a long time to come. They do not tend to get to the age of 60 or 65 and say, 'It is time to hang up my hat.' That is where the educational aspects need to kick into gear to say, 'You are of worth. You can still contribute.' We have a number of programs where we are harnessing those people with mentoring programs—as business mentors and school mentors—where we are harnessing those people and their worth within the community.

Ms ELLIS—Can you see Wyong council being actively involved in the continuing employment of those ageing baby boomers or the intake of older workers into the future? Do you see that you can play a leading role? I do not know what your role is now. Do you see that as important?

Mr Burgess—We have already removed the age restrictions from our recruitment processes. We have done that some time ago. We appoint on merit, not on age or any other discriminatory factor. If you are the best for the job and you are 65 years old, you will get the job.

Ms ELLIS—Thank you. I will hand over to my colleagues.

Mr MOSSFIELD—I have three questions. They relate to employment, which Annette has covered to some extent. Firstly, you indicated that local government should not be expected to fund the ageing community. What concessions do you give to the ageing community, such as pensioners, with respect to rate concessions and any others? You said that that is basically the Commonwealth's responsibility. How can the Commonwealth fund these activities that the council currently does?

Mr Burgess—I wish Wilson Tuckey were here at the moment because we have often had a lengthy debate about the federal government's responsibility and its legal right, in my view, to fund local government with an equitable share of funding. But putting that argument aside, in New South Wales, the New South Wales government legislation provides that the council pay for the pension concession, which is $250. We pay half of that. They also then get a rebate for both water and sewerage, because we are the water and sewerage authority as well. That will depend on how much water they consume and the like. My view is that, as we progress further and if there are further people added to receive benefits and concessions, that will be a greater cost for the local community to bear. Admittedly, we receive federal government assistance through the FAGs, and that is fantastic. But from a local government revenue point of view, I put it to the committee: why can't we have a direct share of GST and why can't we have a direct share of taxation? If you want us to be equal partners, give us the money and the trust and we can deliver the services.

Mr MOSSFIELD—What percentage of the current population move into your area to retire? We know that that happens quite a lot. What challenges does that create for your council, bearing in mind that these are not the people that have lived in your area for a while but have come in since they have retired? Do you have any record of that?

Mr Burgess—I do not know that I can answer directly. Nancy might be able to help me. Of our total 60,000 rate assessments, we have about a 10 per cent per annum turnover, which is about 6,000 properties. They are made up of people moving in and people moving out. With the expansion of freeways going up as far as Port Stephens and Nelson Bay and the like, we are finding people moving from here as it is getting too big. They are moving back to the country. There is an emphasis on quality of life. I can get that figure and certainly send it to the committee.

Ms Nicholson—One of the things I find is that a lot of people will move out of Sydney and retire on the Gold Coast. They then find they are too far away from their family, so they sell up there. We are finding quite a lot of retirees moving into our new estates area because it is affordable for them. In the process of moving they have lost a lot of their money. It is close to Sydney and their families. So there is quite a percentage of retired people moving in.

Mr Burgess—To finish answering the question, there is a huge support network. The Central Coast has lacked in the provision of human services. We have been addressing that progressively through the state government and the premier's department, particularly with things like welcoming initiatives, support initiatives and trying to build community spirit and social capital within those communities. But I guess it is fair to say that the backlog is significant.

Mr MOSSFIELD—I have a question on the employment situation. You have indicated there is this difficulty of older people getting employment. When I say older, that could be anything

from 45 up. On the other hand, you have the suggestions that people should be encouraged to work longer to ease the economic burden of our ageing population. Are these two views compatible? Even in the policies of your council, do you think they are working towards overcoming those two more or less opposite decisions we are faced with as far as the employment of older people is concerned?

Mr Burgess—I think it is quite obvious that if we do not provide for the employment of those older people, we will have to import labour from elsewhere in the world. The young people will not be there to take the jobs. As we move forward in the next number of years, unless we retain some of the older folk in their current jobs, the young folk will not be there to replace them in the workplace. That is a very strong statistic that is coming out nationally. We either go back to net migration, bringing specialist skills into Australia, or retain those skills within the work force. I guess it is a conflict in that regard. Our biggest conflict is that we would like to provide for people to work here on the coast. The problem is we need to create 3,000 jobs every year just in Wyong shire itself.

Ms CORCORAN—I want to make this a very precise question, I suppose. It relates a little to what was asked before about facilities and infrastructure. I am thinking of little things like doorways, big signs, ramps and stuff like that. Is there a role for council as residential and commercial areas and public spaces are developed and built to build these in the first place rather than adapt buildings later on?

Mr Burgess—I guess we would all love to have that 20/20 vision. But we do have an active program within the council of upgrading all of our facilities. We do have state legislation that says that all facilities must now be built to comply with the building code, which allows for disabled access. We also have an active disabled access committee. If they identify a problem, they will knock on a business's door and say, 'You have people who would like to shop here but they can't get in.' Some shop owners are more than willing to help. Others will be less than willing to even consider the idea. But on the whole, most of the major shopping areas will readily respond.

Ms CORCORAN—As the development grows, is there a role for council? In the new township, for instance, shops need to be built with certain doorways and so do houses.

Mr Burgess—That is a state requirement now. So whatever is built now will actually comply with and allow disabled access and any other form of access.

Mr HARTSUYKER—You mentioned the need for rental control on private rental stock. Experiments with rent control in the past have resulted in a fairly substantial decline in the availability of the private rental market. How do you encourage landlords to continue the supply of rental stock whilst imposing rental controls?

Mr Burgess—I think that is a good question. Having been a member of a local housing board for a short time, the only way I can see that being addressed is as part of the state planning process, maybe with some assistance from tax incentives at the federal level. It would require major developers when they are building major land stocks to provide for a small amount, be it five or 10 per cent, of assisted type housing, which is maintained locally. That is the only reasonable way I can see that we will end up with something that will be ongoing. As I say, if they get a benefit out of local government in terms of the planning process, they might get an

extra sale of a unit by providing three housing units and some federal tax incentives for providing them. I think you would then see a change in the marketplace. But the marketplace will only provide what they can currently sell. If they cannot sell it, they will not build it. In terms of the tax incentive and the support of ongoing housing needs, I do not believe that there is any way other than for the government to be the housing provider.

Ms ELLIS—You were talking about the adaptability of the new developments, new facilities and shops. Does the council have very much of a promotional role in adaptable housing?

Mr Burgess—Yes.

Ms ELLIS—Given that we are saying that people like to stay in their homes for as long as they possibly can, it seems to me eminently sensible that we promote as much as we possibly can, throughout the whole country in fact, that housing in the future be developed and built as adaptable housing. Would you agree? Where do you see your council fitting into that?

Mr Burgess—The council certainly has looked at a number of housing styles and initiatives. One of them is adaptable housing. Again, it is driven by what the market will bear and what the market will provide. But it certainly is an issue that we have taken on. It is an issue that we are looking at pushing particularly through the HACC forum to try to get some money so that they can adapt the housing. But for those initially built, no, we have not had any great support for it. We have recently released a new development control plan, No. 100, which does address in small part the adaptable housing issue.

Ms ELLIS—Maybe it is also market driven. It is also educationally driven.

Mr Burgess—Yes, it is.

Ms ELLIS—People may not be able to imagine what an adaptably built house looks like if it is a house for a wheelchair. They do not look adapted if they are done well.

Mr Burgess—No. That is right.

Ms ELLIS—You were going to send a bit more information later on the 800 places, I think, if you could. Would you be in a position to give us a breakdown of that? Out of the 800 places that are outstanding, how many are high care, low care and community packages? It would be very useful.

Mr Burgess—I will clarify for the committee the number you are looking at. In 2001, the Central Coast was allocated 171 community aged care packages and 316 low-level care beds.

Ms ELLIS—So the 800 you said were not built include those figures?

Mr Burgess—That is my understanding.

Ms ELLIS—What you are going to attempt to send is the breakdown of all of them and the time line for them—how long you have had them, when they all came onto the books, so to speak?

Mr Burgess—Yes.

Ms ELLIS—Thanks.

Ms HALL—Is it true to say that there is a chronic shortage of rental properties in this area at the moment?

Mr Burgess—Yes, that is very true. With the Community Tenancy Scheme, the stock of housing available is extremely limited. It is of very poor quality.

Ms HALL—My second quick question is to do with the population question that Frank asked. As well as people moving to the area, a number of people have moved to the area and then move away. So there is a fairly transient population. Is that also true? That creates issues in this area as well.

Mr Burgess—Yes, that is true.

CHAIR—Thank you very much for the presentation and for responding to questions. I ask that we receive a copy of the PowerPoint presentation for the benefit of members.

[11.34 a.m.]

HANRAHAN, Mr Matthew John, Chief Executive Officer, Central Coast Division of General Practice

CHAIR—I welcome the CEO of the Central Coast Division of General Practice to today's public hearing. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Hanrahan—Certainly. I do not have a formal presentation. People are pretty much aware of generic issues in relation to general practice. Certainly the issues are those that are nationwide in relation to the proposed shortage of general practitioners. The issue of access and the issue of decline in bulk-billing are evident on the Central Coast. As an example, over the last 10 years, we have had a 19 per cent decrease in the number of GPs. I stress 'number', because one GP does not equal one full-time equivalent. I will talk in numbers at this stage. Certainly there are differing views on that. So we have had a 19 per cent decrease and generally about a 17 per cent increase in population. That is just pure numbers.

There is literature around in terms of the increase in morbidity and chronic disease rates and the general decrease in mortality rates. Our GPs are telling me that they are busier. In fact, they are probably seeing the same number of patients, but their workload has increased exponentially in relation to that primarily because of the complexity of care that is required with ageing people. I think it is well documented that people over the age of 65 are high consumers of health care. I think the number is about four to one. Obviously there is a huge demand. You have probably heard the population figures of the Central Coast, where we have a higher than average 65-plus population. So the demand means that our GPs are busier and dealing with more complex cases. Obviously, with new medications and treatments, they are saying that their day is busier and more mentally exhausting. Our GPs are saying by seven o'clock at night they are mentally exhausted. The issues of after hours care and nursing home care are obviously complicated because of that.

That is a general statement. I am happy to field questions. Some of the information will come from anecdotal evidence from our GPs. If I have factual evidence, I will certainly let you know it.

CHAIR—Thank you. What sort of challenges are general practitioners from your division facing in caring for older Australians?

Mr Hanrahan—We recently did a needs assessment of our GPs. One of the main issues that came up in relation to care was accessing state funded services. In relation to the aged, there is certainly chronic care, allied health services and orthopaedic waiting lists. Other waiting lists—ear, nose and throat waiting lists—have also been raised by our GPs as being a major issue for them in care.

Another issue is the provision of after hours care. That is certainly a concern, as I stated previously. They are very busy throughout the day. Their ability to provide after hours care in a formulated way is becoming more and more demanding. Certainly, in relation to aged care facilities and the provision of services to aged care facilities—I was not here for the previous presentations—my understanding is that there is an increase in the number of aged care facilities being built on the coast. There is a decrease in the number of GPs. The maths says we have a problem now and we will have a greater problem in five, 10, 15 or 20 years.

CHAIR—What is the division finding with some of the blended payments—for example, better practice and so on? Is that leading to an improvement in the health of the patient population?

Mr Hanrahan—We talk to our GPs a lot about a whole range of issues. Last year, the Australian Divisions of General Practice held a GP financing summit in Adelaide. It was conclusive that our GPs do not think that the blended payments system works. They do not think it improves patient care. They see fee for service as the cornerstone of general practice. They often say that we need to increase the rebate and get rid of blended payments. It is too complicated. There is too much paperwork and it does not really make a difference to patients. That is just anecdotal evidence and feedback from our GPs.

The second comment is that the division has been running a successful diabetes care program in conjunction with Central Coast Health. Nurses and diabetes educators go into GP practices and run diabetic clinics with patients. It is based on New South Wales best practice guidelines. We recently did some research to evaluate the evidence of that from a process care point of view. There are now about 107 or 108 GPs, which is about nearly 40 per cent. Evidence from process shows there is a high compliance with best practice care. There was some evidence to show that from a clinical outcomes point of view there was improvement. Obviously, there needs to be some maintenance in the health of the diabetic patient and some improvement in their health. So that is an example from one perspective.

You were asking about SIP payments. Back in 2001, we introduced the care planning process to that program. That has worked quite well. What we are finding, though, is that the process part of it for the GP, the paperwork—what they call jumping through the hoops—is becoming more complicated. From their perspective, they do not have the time to do a lot of this. Therefore, they are starting to again move away from it.

Ms HALL—I would like to concentrate a little more on this doctor shortage. What would be the ratio of doctors to patients within the Central Coast? Break it into the northern part of the Central Coast and the southern part of the Central Coast.

Mr Hanrahan—I do not have the actual figures here, but I can provide them for you. The information comes from what the division knows in terms of GPs. Again, based on the number of full-time equivalents, there are a couple of definitions. Generally speaking—I will provide the facts so do not quote me here—it is about 1:1,600 on the Central Coast. Certainly Wyong shire is about 1:2,500. Gosford shire is about 1:1,100. So there is a balancing. Purely on numbers, I guess there is a higher ratio in the Wyong area than there is in the Gosford area.

Ms HALL—What is a desirable average of GPs per head of population?

Mr Hanrahan—That is a good question. Certainly in the past there has been a ratio of 1:1,000. The source of that, I do not know. Generally, it used to be said that best case scenario was 1:1,000. In recent times that has changed from 1:1,100 to 1:1,200. Just looking at numbers, it does not take in the true picture. We need also to look at, for example, on the coast, the collection and make-up of the patient population. There is a higher number of over 65s and higher numbers of the lower socioeconomic group. They all indicate a higher demand for health care and more complexity. That also needs to be taken into consideration, particularly in this area of Wyong. We have fewer GPs but also higher numbers of the lower socioeconomic group and the ageing, which again indicates more demand and complexity back on the GPs.

Ms HALL—So you are saying that we have a population here that has high health care needs and we are well below the national average as far as GPs per head of population?

Mr Hanrahan—That is what our figures are showing, yes. As to solutions to that, we have been working on this for three years. We have been working with council. We have been working with Central Coast Health and, more recently, with the Central Coast Economic Development Organisation. We have developed short-term strategies to try to meet the needs of GPs. Practices have identified that they have been recruiting for over 12 months and have had no luck in getting an Australian trained and registered GP. Therefore, in looking at those areas of need, it means getting an overseas trained doctor in a limited capacity, such as for 12 months, and they can come in and practise.

Unfortunately, from a federal perspective, the Central Coast is classified as an RRAMA1, a rural and remote metropolitan area. This means that this area, including here, is classified as a capital city area. We have been asking for flexibility in looking at specific areas, particularly in the north Wyong area, where there is a particular growth in population. Few GPs are there at all. We have been trying to get some flexibility in that. We have been marketing the Central Coast.

I have talked to trainee GPs and have supplied them with marketing material from the local economic development board saying that the Central Coast is a great place to live et cetera. To date, that has not been successful. When I talk to my colleagues in other divisions, it is ironic that we are often advertising and trying to get doctors from areas. Often if a doctor does come, they come from an area that has fewer doctors than here. So it is almost catch-22 that everyone is competing for a shortage of doctors. Unfortunately, we are all competing against each other bar parts of Sydney metropolitan areas. So we have been very proactive, but we feel we have been pretty much unsuccessful in trying to attract doctors to the coast. It does not mean that we are giving up. We are still working on it, but I think we need to look at other strategies.

Ms HALL—What about waiting times for elderly people to see doctors?

Mr Hanrahan—That is certainly an issue. If we are talking about access, there is the issue of waiting times. The second is the issue of bulk-billing.

Ms HALL—That was my next question, so you can deal with it at the same time.

Mr Hanrahan—It is interesting because it all relates to accessing your GP. Certainly anecdotally most GPs would have emergency appointments blocked out on their books. It is pretty much par for the course that if you need to see a GP urgently they tend to have bookings. However, one of our board members was saying even with his emergency bookings, if you

wanted to see him, you would have to wait two weeks to see him because all his emergency bookings had gone. At some stage he was referring people to the hospital because he could not see them. So certainly that is an issue. Again, I don't have facts on this but anecdotal evidence says that, depending on where you are, it can take up to a week, two weeks or three weeks. For others you can get in pretty much the same day.

As for the issue of bulk-billing, which is obviously an access issue, again, we do not have the facts. It is interesting that people ask whether or not you bulk-bill. It is not as easy as that. I know GPs who have been private billing for 10 years and yet still earn about 50 per cent or 60 per cent of their income from Medicare bulk-billing because they will bulk-bill certain procedures or health assessments or things like that. What they are not bulk-billing is their standard consultation, which is your 15-minute consultation, for a whole range of reasons. One of the major issues is financial viability. They need to be able to provide quality care, yet they provide 15- or 20-minute consultations, and some have overhead costs of 50 per cent. They are moving away from bulk-billing to be able to run a financially viable practice. What is often misconceived is that they are small business owners and operators that have to worry about increasing costs such as rent, staff salaries and wages and, obviously, the medical indemnity issue, which is also going to increase their costs.

Ms HALL—And that relates to pensioners, who are not being bulk-billed?

Mr Hanrahan—Certainly in practice, again, a lot of GPs, if they are not bulk-billing, will provide some sort of discount for either pensioners or health care cardholders. They look at the individual. It varies. Some practices will, after five visits, bulk-bill the rest. There is a whole potpourri of billing processes out there. It is entirely up to the individual GP as to whether he bulk-bills a patient or not. The trend we are seeing is that most GPs, if they have moved away from bulk-billing, will provide some sort of discount for pensioners and/or health care cardholders.

Ms HALL—My last question is about after hours services, home visits and visits to nursing homes. Can you tell us about that.

Mr Hanrahan—The division was successful in getting a grant under the After Hours Primary Medical Care Scheme. We have established that after hours care site in the Gosford area. One of our big issues—it is related to work force—is that currently for accreditation purposes patients need to have access to 24-hour home visit services. We are finding that extremely difficult to maintain. We run a site that operates from seven until 10.30 at night seven days a week and Saturday afternoon and all day Sunday. We have advertised in Sydney, Newcastle and Central Coast-wide. We pay an on-call rate of $20 per hour. We did not get one response for someone to go on the second on-call roster, which means that they are on call from nine o'clock at night until nine o'clock in the morning for people who need a home visit. So it is obviously a work force issue.

Our GPs are happy to do site visits. They say, 'It's very difficult for me to even see my own patients. I am concerned about my safety. I don't want to go and see another doctor's patients at a house I do not know at three o'clock in the morning.' However, we have been successful in getting three GPs to cover the roster on a temporary basis. In that time, we have had about six home visits. If you look at the average cost of that home visit and paying the doctor, we have an average cost of $6,500 per home visit. So it is certainly not economically viable. It is certainly

not a good use of the health dollar. The problem there is that we are working again with Central Coast Health. There are issues of accident and emergency. One of the questions we need to look at is how we can better work together to maintain and continue to provide 24-hour care but work out the best way of providing and delivering that care. It could mean a blend of general practice, after hours and area health service

Ms HALL—Like the Maitland model.

Mr Hanrahan—Similar to the Maitland model. Certainly the Maitland model has worked well for that. We looked at the Maitland model. Talking to our GPs, we found that the Maitland model has a GP after hours co-located on the hospital site. Maitland is a lot smaller hospital than, say, Gosford and/or Wyong. Therefore, we looked at that and found it did not work. We are currently located fairly close to the Gosford ED. We do work with them. We cross-refer patients to each other. In July, we will be hopefully moving into an area health service facility in Erina on a rental basis. But certainly we need to look more at how we can share the responsibility of getting better value in terms of providing that 24-hour care.

There are different models around the coast in terms of how GPs do provide after hours care. Some of them are in their own cooperatives and just do home visits for their own patients. There is an after hours service down at the Kanwal Medical Centre that runs during the night on weekends. There is one down at Woy Woy. Again, anecdotal feedback is that it is becoming harder and harder due to the fact that they are finding their days are not only longer but more intense. They are finding their capacity to provide after hours service is becoming a bit of a difficulty.

Ms ELLIS—I want to move from after hours care to ordinary care and the problems I believe exist in getting access to GP services when you move to an aged facility, no matter what time of the day we are talking about. The scenario is that if a person moves into an aged facility within their own neighbourhood, therefore being able to maintain their own GP, that is like winning Tatts. In general terms, that does not happen and they have to move to another area. Am I right in assuming that when you move in, the operators of the facility say, 'Welcome to your new geographical location. Here is the list of the doctors'—this is a good case—'who currently visit here.' Then you have to hope that one of them will take you. It often happens that they do not. Do you agree with that?

Mr Hanrahan—Yes. In fact, not in the Wyong area but in the Gosford area we have certainly had calls from certain aged care facilities along the lines of, 'We are opening next Saturday. Can you give us a list of four or five doctors who will come and see our patients?' The response is, 'Certainly we can give you a list of doctors, but we know that their books are closed and that they aren't taking any more patients.' This should be core business planning for aged care facilities. To ring two weeks before opening is certainly not a good strategic way to address the issue. I do not know if there is an easy answer to that. Certainly in one example, a group of four GPs agreed to share a load so that those people could at least access a GP. So they took on patients, knowing that their books were closed, to ease that load.

What we are saying is that when you are starting to do your strategic business plans, in looking at the blueprints and the architectural designs, you should also be taking into consideration all these services, such as general practice. Having said that, in moving into the

area, when the GPs are already flat out, will you get a good response? Probably not. But at least there needs to be consultation in terms of looking at alternative strategies.

Ms ELLIS—I want to be contentious for a second. This is not about you but about the situation. The reality would be, would it not, that in the case of new facilities, no matter how well they are planned, if they planned with that in mind, they would not build them because the doctors are not there, anyway. I make that as a comment. My other observation is that it applies to already standing facilities, not just to new ones.

Mr Hanrahan—Yes, I agree with that too.

Ms ELLIS—I have seen a couple of examples around the country where we have good outcomes. There are still, I am told, disincentives to encouraging an available doctor into a facility. For instance, I have not yet seen a facility built with the provision for a visiting doctor's room, for argument's sake, where he or she could come in and plug in their computer facility and operate like they would in their surgery. To what degree do you think we need to pay more attention to that?

Mr Hanrahan—Certainly very much. It is a high priority. Certainly we have been looking at the issue of linking in GPs with the aged care facility and carers. We have been running a few pilots only with a couple of GPs where we coordinate whether the GP goes in, the nursing staff or allied health staff, the pharmacists or the carer. They have been very successful. The feedback from the GPs is that the facilities are not totally appropriate. It is often about the communication between staff and GPs. This is not directed at the staff; they are always busy as well. Some people say, 'They ring me Saturday night at 10 o'clock so that I can tell whether someone needs to take another tablet or not.' They are saying that when they are being called, it is for inappropriate reasons and that there needs to be better planning and better communication electronically.

As you said, if there were systems whereby the GP could monitor a person's medications list, for example, there would be better opportunities for coordinated care. The feedback from the program we were running that I mentioned before was that, yes, it is great, but it is too time consuming. If I have 20 patients and I need to spend half an hour—you can do the maths—it is very hard to maintain that. My understanding—again, do not quote me—is that in Victoria there have been different models trialed, where you have better coordinated care, with facilities for the doctors who go in there.

Ms ELLIS—Do you have anecdotal evidence or any figures on the number of times patients are sent to A and E out of hours because there is no available out-of-hours GP service? In some cases, I am sure they are probably inappropriately sent to A and E, but there is no other option for staff because they cannot get a doctor to attend.

Mr Hanrahan—I do not have the facts on that.

Ms ELLIS—Anecdotally?

Mr Hanrahan—Anecdotally, yes. Certainly it is particularly more so in Wyong. There is the example I gave about the GP who was dealing with emergency cases by booking them ahead two weeks. He was sending people to accident and emergency because he could not see them.

So, back to your question, yes, up here there has been anecdotal evidence to say that new people who move to the area and do not have a GP have no choice but to go to—

Ms ELLIS—I am talking more about facilities.

Mr Hanrahan—In what way?

Ms ELLIS—An aged care facility or an older client residential centre. No doctor can come so the staff have no option but to take them to err on the side of caution.

Mr Hanrahan—As I say, I do not have facts on that, but certainly anecdotally that does happen. Probably Central Coast Health would be able to help you there.

Ms ELLIS—The last question is: to what degree does the division have any relationship at all with gerontologists, the association or the college thereof? Do you see a need for that to happen?

Mr Hanrahan—We do not have formal relationships with their associations. Locally on the ground with our local gerontologist in Central Coast Health, we have a very good relationship. One of the geriatricians is on several of our committees in terms of the use of quality medicines, and the division is also involved in the quality ageing strategy. We are also involved in the dementia care network.

Ms ELLIS—So do you think that is done well enough?

Mr Hanrahan—Certainly at a local level our relationship with the gerontologists is good.

Ms ELLIS—And the bigger picture?

Mr Hanrahan—Would the local division get benefit out of the association? I do not know. I would put that back to our geriatricians and ask: what benefit can we, by working together, get out of that? A good example is that we have just developed in conjunction with Central Coast Health a CD-ROM for educating GPs on the management of dementia.

Ms ELLIS—Yes. We heard about that.

Mr Hanrahan—Again, local relationships are good in that area.

Ms CORCORAN—I want to make sure I have my facts straight. Did you say in your introduction that you have had a drop in GP numbers—I understand it is heads, not effective full-timers—of 19 per cent?

Mr Hanrahan—Yes. Over 10 years.

Ms CORCORAN—So there is a dramatic drop in the number of doctors on the ground and an increasing population. The point of my question is how patients are coping with that and how doctors are coping with that. I have heard about how they are sent to A and E and how there are long waiting lists. Are other strategies being employed by both sides to deal with that?

Mr Hanrahan—There are. The diabetes example is one. You can increase the volume of patients you see—that is, work longer hours. That is what a lot of GPs are doing. They are also trying to look at better ways of linking in more practices and employing practice nurses to look at providing patient care that may have traditionally been provided by a GP but can be done by a practice nurse.

Ms CORCORAN—Can you give me an example.

Mr Hanrahan—Health assessments. Part of the enhanced primary care package that came out in 1999 meant that people over the age of 75 and Aboriginal and Torres Strait Islanders over 55 can have a health assessment once a year. It is an overall review of the person's health. GPs were finding it very difficult—ideally, it should be done in the person's home—to get out there. By using nurses to go out and visit the patient, look at medications, look at the home safety, cooking et cetera and whether there is food in the cupboard, they can do an overall assessment. The patient is then booked in to see the GP. The nurse has done a lot of the background work. The GP can still see the patient for a 15- or 20-minute consultation and get a good overview of the care and then refer them on.

We are certainly looking at ways of working smarter, linking with, as I said, our diabetes program and asthma programs to try to focus on the chronic conditions out there. That is linked in to what the chairman was saying before about these new item numbers and PIP and SIP payments. So we are trying to do that but, again, time and access are the big issues.

Ms CORCORAN—Are you aware of what patients are doing to overcome the long queues and not being able to see GPs for two weeks?

Mr Hanrahan—I do not know what they are actually doing. I know some—

Ms HALL—Are going to hospital.

Mr Hanrahan—Some may be going to hospital. I do not know the answer to that. I guess you could assume a couple of things. One is that they do not go at all unless they get to an acute stage where they have to be admitted or go to hospital. This is particularly in preventative care and surgical screening. The person will come and see them about an acute illness and they just do not have the time to say, 'Have you had your pap smear, breast check, or done X, Y and Z?' because there is a waiting room full of patients. It takes longer and there is pressure to see patients. Often they are reacting to what is presented and finding it more difficult to do the preventative side of it. We are certainly looking at recall and register systems on GP computer practices that remind them every three months to send out a letter to diabetic patients or to others for cervical screens to try to do better preventative care. Again, it is that time issue that is pressing on them.

Mr MOSSFIELD—The committee, of course, is looking at strategies to address the ageing population over 40 years, so we have time on our side in some areas. What do we need to do to increase the number of doctors and GPs? Clearly, that is a major short-term and long-term issue Australia-wide.

Mr Hanrahan—Certainly the AMA have conducted a work force survey, which has come out. I think the Australian Institute of Health and Welfare also had a work force report. There was conflicting evidence.

I think there is general agreement now that there needs to be more doctors, more university places at an undergraduate level and more GP registrar places. Obviously that is a long-term proposition. If you add more university places, you will get a GP in about 13 or 14 years. So that is certainly a long-term strategy. Obviously there are costs involved in that. In the short term I know there are strategies such as the outer metropolitan strategy that the government is introducing to try to get overseas trained doctors or other registrars doing specialty training to do some GP work. Whether that works or not remains to be seen. Certainly there is some scepticism in our area about whether we can get doctors and what incentives there are for doctors to move out of Sydney or other areas to come here. So we need more doctors, but it takes 10 to 14 years for a GP to hit the ground running.

Mr MOSSFIELD—With the shortage of doctors in the area, what impact is this having on local hospitals? Do you see some problems developing there relating to the hospitals handling that extra workload?

Mr Hanrahan—Certainly in New South Wales you may be aware that a fairly big issue is GP shortages, particularly relating to after hours. It has increased the demand on hospital services, particularly in accident and emergency. I do not know the specific figures on the Central Coast. I guess Central Coast Health would have a better idea. We have discussed the issues with them when talking about the after hours issue. It has not been the GP type patients that have kept them busy. Therefore, they are happy to look at sharing some of that care with us. But certainly that is what New South Wales Health is saying. I do not have the figures on that, so I do not know the answer to that. But that is certainly the hypothesis that is out there at the moment.

Mr MOSSFIELD—Following that, are specialists for age related illnesses readily available on the Central Coast?

Mr Hanrahan—The feedback from our GPs is that they have trouble accessing orthopaedics. Certainly with the population—again, it is another Central Coast Health issue—and with gerontology and geriatricians I know the number has doubled over the last five or 10 years. But I am sure there is more demand for that. The main specialty our GPs say they are having trouble accessing is orthopaedics for hip replacements and things like that. They are referring out of area—that is, to Sydney and to the Hunter. Having said that—

CHAIR—Do you have a person on the Central Coast?

Mr Hanrahan—Certainly, yes, we have. I think there are about four or five orthopaedic surgeons. They are finding it difficult to access them. I should clarify that is for public patients. Privately, patients can be seen. That is not an issue. It is more public patients accessing public orthopaedics. Secondly, they also have issues with ear, nose and throat specialties. But certainly orthopaedics is the one continuing to be raised. They are referring out of area.

CHAIR—Any other questions?

Mr Hanrahan—It is interesting that one of the GPs I consulted with prior to coming here wanted me to raise the issue of the potential ethical debate in 40 years regarding elderly people and their right to end their own lives. There is the issue of, I guess, euthanasia. I do not have a comment on that. Certainly, if you are looking at issues in relation to ageing over the next 40 years, he sees that as a potential issue.

CHAIR—We thank your member for raising that. The federal parliament did consider this issue, of course, in 1996 and 1997 as well. Thank you very much for your statement and for your responses to questions.

Mr Hanrahan—If you need any more information, please contact me and I would be happy to oblige.

Ms HALL—Thank you.

[12.10 p.m.]

EDDY, Mrs Jennifer Olwyn, Secretary, Central Coast Regional Committee, Aged Services Association, and General Manager, Woy Woy Community Aged Care

GILLINGHAM, Mr Glen, Vice Chair, Central Coast Branch, Aged Services Association

WEST, Mr Kevin Joseph, Vice Chair, Central Coast Branch, Aged Services Association

CHAIR—Good afternoon. I would like to welcome representatives of the Central Coast branch of the Aged Services Association to today's public hearing. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Mr West, would you like to make an opening statement before members ask questions?

Mr West—Thanks very much, Mr Chairman. The first thing I would like to do is extend apologies from Mr Harry Linsell, who is the chair of the committee. Harry had a work related matter that needed immediate attention.

Firstly, the regional council of the Aged and Community Services Association represents charitable and not-for-profit residential and community care providers across the Central Coast. The membership is extended to all people providing care, both community and residential, and we have been formed to discuss those relevant issues. We have regular telephone conferences with other members of the association throughout New South Wales and meet outside the quarterly conferences if there are matters of importance that need to be discussed between those meetings.

We are here today really to address any questions that the committee may wish to ask. We have put a submission to the committee. These were my ideas, my opinions and my comments. They have been looked at by the regional committee and have been endorsed. Other members who are here today can answer any questions that the committee wishes to ask of them regarding that paper.

CHAIR—Thank you very much for that. We did meet with your peak group on our first day of hearings in Canberra. We are also going to be meeting with the Hunter branch tomorrow. Firstly, I will ask whether you have any areas of focus for ageing policy that would be important for you, looking in the long term.

Mr West—From a long-term perspective, I think the industry needs to look at the way it is regulated at the moment. Across all sections, we have federal, state and local government bodies which have input into the way in which residential aged care is provided. It provides us with a myriad of problems in so far as there are a lot of conflicting legislative requirements to meet the various areas. I would like to see the Commonwealth assume responsibility for aged care. The fact is that we receive our subsidies for the provision of care from the Commonwealth. The fact that New South Wales Health administers the Nursing Home Act is a minor contributing factor to aged care in the state. It has a very small role to play. However, it is a compliance role. It is a

legislative document that we are very, very mindful of. We then have the problems expressed by Jon Blackwell from area health and by the Wyong council. We have problems dealing with the local government in the administration of local government acts, including the building codes and compliance with the building certification requirements for aged care facilities. I would like to see a review of the various areas of government control in aged care with a view to having it administered just by the Department of Health and Ageing.

Ms HALL—Firstly, we have had a lot of talk this morning about council approval and the allocation of beds. How does the industry find the current process of the allocation of beds and the approval for the building of a facility or an extension of a facility? What needs to happen, if anything, to improve that situation?

Mr West—The situation is fairly well handled at the moment, given now that there is a time frame set by the government when places have been allocated. Having received allocations under the 2001 approval period, we have until January 2004 to get those cases online. Now we have to report on a quarterly basis to the department as to where we are in so far as that goes. The fact that we are building on an existing site has made things a little easier. However, legislation does change and legislation is introduced from time to time.

A problem faced in one area is the introduction under the rural fire services of an asset protection zone which was not in place when the approval was granted. It means now that the approval has been deferred pending compliance with legislation that was not in place when the application was granted. It is going to be a difficult piece of legislation to comply with. That is one area. The comment made by the council representative regarding the provision of low-care accommodation or the branding of the development application for low care was interesting. He would see that as not being granted unless there was an alternative high-care provision there. The ageing in place philosophy that most providers have adopted would allow for the provision of high care in a low-care facility over time. I think it is only a natural progression in the industry that we are able to care for people in the community for as long as possible. However, over the past few years, people coming into low-care facilities are the old high-care residents, and the high-care type facility now has almost a palliative type care resident. So providers are very much aware of the change in health of that person once they enter that facility. The aged care assessment team are mindful of that when they do those assessments.

Ms HALL—How many beds for the whole of the Central Coast were allocated in the last round?

Mr West—Including aged care packages?

Ms HALL—No. We will look at beds and then packages.

Mr West—It was around 200.

Ms HALL—And packages?

Mr West—I think around 100 or 110 packages. It was interesting to hear from the committee member regarding the allocation of the 50:40:10. I think that is something that needs to be looked at now given the push to keep people in the community for a lot longer. That provision for 10 in every 1,000 people aged over 70 is hardly appropriate. I think that does need a very,

very strong revision in so far as high-care and low-care places go. I would not like to come up with a ratio, but I think 10 in 1,000 is too few.

Ms HALL—That is a good point. The next thing I want to ask you about is the RCS and the fact that your patients are constantly being reviewed and reclassified. What kind of impact does that have on facilities?

Mr West—All three of us will probably speak on it because it is probably one of the main contentious issues in aged care at the moment, and that is the degree of documentation that workers within the industry are required to comply with. What I say is meant to be in no way demeaning of AINs, or assistants in nursing, or care service employees in low-care facilities. They do not come to us with great literacy skills. They are not meant to be literary giants when it comes to the industry. However, it is very, very important that they document in accordance with what the validation units from the department see as being a correct manner.

The level of care they provide is exemplary. However, the accountability and validation are something that is very much restricting the ability to provide hands-on care. Some RNs are saying that they are spending upwards of 60 per cent of their day in the presentation of documentation. Naturally, that takes away from the level of care that they can provide. Retaining RNs is getting increasingly difficult. They do not want to do documentation. Their counterparts in the public sector are not as federally accountable as far as the documentation goes. The wages parity has just meant a greater work force transition from aged care back to public care for the RNs. There is something well in excess of $100 a week difference with the new award that has been granted for state nurses.

Mrs Eddy—I feel that the residential aged care industry needs a whole restructuring of its staffing. It is very difficult to get registered nurses into aged care. It is very difficult to get registered nurses into health. We seem to be at the bottom of the barrel. Firstly, if somebody trains to become a registered nurse, those people want to go into an exciting clinical area rather than aged care. Documentation is prohibitive. People do not want to train to be a registered nurse and spend their days documenting. So we need to look at some sort of education stream for workers in aged care where we get the type of person that perhaps wants to focus more on the documentation side rather than on the clinical side. I do not know how we will go there.

We need to also look at the regulation, as Kevin said. For example, registered nurses must administer medication in a hostel. The Nursing Home Act doesn't apply, so your personal carers can administer medication. There is some wonderful education out there for enrolled nurses, but there are no opportunities for them to fulfil that role within the aged care sector. So there needs to be a whole revamping and examination of that whole staffing issue.

Mr Gillingham—I will add to that. It is a little broader than just the registered nurses, but it is also to do with the documentation. Trying to attract staff to aged care is becoming harder. We have an older work force even now. In 40 years time that is going to be worse for us. Things like improving productivity in aged care is not possible. You are dealing with people. You need to improve productivity when there are higher wages and funding is not matching it. So you are struggling and you are under pressure there with the funding not matching the wage increases. If there is parity in wages between nurses in the acute care sector and the aged care sector, that is going to place even more pressure on that. But certainly our awards need to be more flexible with regard to our ageing work force. We are getting workers that are coming along towards the

end of their career who therefore want some more flexibility in the way they can work and the way they can structure their work within the aged care sector.

Ms ELLIS—I will just go back to what you were saying a moment ago about the validation process you have with the reclassifications and so on. Can you explain, any one of you—I do not mind who takes this—what happens with the validation? I am keeping in mind in particular, Kevin, your comments about the literacy requirements, so to speak. I would actually say they are idiosyncrasies in the system that throw up some outcomes that one would not quite expect in the validation process. If you agree with that, can you explain to the committee what happens if that validation process comes out in the negative in terms of your funding? Are you not sure what I mean?

Mr West—Yes, we are fine. The validation process in itself is—

Ms ELLIS—It is a complication. I want the committee to understand this part.

Mr West—The validation process itself is purely looking at documentation. There is no reference made to the resident. There is no consultation made with the resident. It is a public servant's role. They look to see if they have included the papers and whether or not they match with what is in the residential care handbook itself at chapter 5. They look at that. If it does not comply, there is no ability for the approved provider or the nursing unit manager or the director of nursing or hostel manager to be able to discuss that care. There is no ability to have that resident's relatives available. There is no process whereby the resident is involved in the process. So it is purely looking at what is written on that piece of paper against what are the requirements of the care manual itself.

That is where it is difficult to explain to staff that the future viability of an organisation very much depends on the subsidy levels we receive from government and the subsidy levels we receive from government are based upon the paperwork they are required to fill out. If it were an exception type reporting system, there would be probably an easier way to comply rather than going through 20 questions and ensuring that there is regimented documentation for each of those 20 questions.

I am critical of the RCS as it currently stands because there is no transparency. It is a very, very unwieldy document that is only known to the validators and not to the providers. There has never been an opportunity to put it out on the table and ask for a great deal of comment. There are currently committees looking at the RCS and a better way. They have looked at various models. I am hoping that something comes out of this that will benefit the industry as a whole.

Ms ELLIS—Is your organisation locally putting a submission to the RCS inquiry, the review?

Mr West—Through the peak body.

Ms ELLIS—How well do you think ageing in place works? Is it reflecting its original intent?

Mr West—Ageing in place, in conjunction with maybe a national benchmark of care—

Ms ELLIS—My next question was whether there should be a benchmark of care.

Mr West—I do. I think there should be because I think the two go hand in hand. The providers can know exactly what is expected of them. With a national benchmark of care, all players know exactly what the requirement is. They would look towards ensuring compliance with that as far as the documentation itself goes. Ageing in place is a marvellous thing. It gives the resident an opportunity to know that they have security of tenure in a place they enjoy and a level of care that can be provided to them. There is nothing worse in an older person having to relocate, at a stage of their life when they are very, very frail and very, very vulnerable, to another facility. Given the opportunity to keep them under that one roof, I would go for that as being—

Ms ELLIS—Can I be contentious for a second. Given that there is no accepted benchmark of care through the process, it does not exist, and given that there are no minimum staff levels—I am not being critical of the sector here; they are two statements of fact—how well do you think ageing in place works as against the potential for ageing in place? Is there a problem?

Mr West—Personally, I do not think there is a problem, but there may be in various areas. I am speaking purely from an individual point of view here. Across the industry there probably are. It comes down to a duty of care at each facility as to how well they engage in the ageing in place philosophy. The organisation I work for very much embraces ageing in place. I think it is the philosophy of most stand-alone facilities that they do have that ability to embrace the wishes for the governance of their organisation.

Ms ELLIS—I agree with what you have just said, but should it rely more upon something legislative than upon the goodwill of an organisation?

Mr West—Definitely, yes. As I say, the national benchmark of care has not been introduced. If it is, then there is the benchmark itself. That is what you comply with in order to embrace an ageing in place philosophy.

Mrs Eddy—Ageing in place is restricted by the intervention of the department of health.

Ms ELLIS—How do you mean?

Mrs Eddy—There are restrictions on ageing in place in a hostel because hostels are not actually licensed as a nursing home is by the department of health. So you have those regulations.

Ms ELLIS—So how does it work in a case like that?

Mrs Eddy—That is where the difficulty is. If you have built a hostel that is a class 9(a) or class 9(c) building, it is not as difficult. But if you have not, it is almost impossible to have ageing in place and still meet those regulatory requirements under state health. Another comment I was going to make was allocating staffing levels. I really believe it is a backward step.

Ms ELLIS—I am not advocating it.

Mrs Eddy—Good.

Ms ELLIS—I am just asking the question.

Mrs Eddy—Good. Because we did have that before under the old CAM and SAM. I really think it needs to be left up to the individual organisation to put the staffing levels in place that each individual organisation needs. Again, that duty of care and that compliance under accreditation will sort out that staffing level.

Ms ELLIS—Some organisations you represent—I think I am right in saying this—probably operate CAPS packages as well. Some organisations do. They have a facility and they have an arm that does the CAPS packages as well. Given that, would you agree that there needs to be probably two benchmarks of care? One would be for community packages, for which there is no benchmark at the moment. In fact, I do not think there is measuring of any kind. There would be another for facility care.

Mr Gillingham—Yes. We would highly agree with that.

Mr MOSSFIELD—My question follows from what we have been talking about. The experiences we have as members of the general public and politicians are when our own family or constituents are confronted with the ageing process. I see it continually where people get too old and cannot be left at home. They go straight into a nursing home. That is one concept. Another concept is that maybe one partner passes away and the other one can still look after themselves. They go into a self-contained unit. As their health deteriorates, they go into a hostel. From there, as their health deteriorates a bit further, they go into a nursing home. It is all part of the one complex. Is that the type of organisation that you people represent? Is that what is called ageing in place? Is that the terminology we are talking about?

Mr West—Not quite. The organisation I work for embraces all three. We embrace self-care, low care and high care but not all on the one site, unfortunately, because there are nearly 200 places involved in that. But others do and they see a transition through from self-care to low care to high care. I think it may have been an expectation of people entering residential care that they are able to move through those three tiers if and when it became available. But it is not a prerequisite that you would build a facility. The organisation I work for will give preference to someone moving from low to high care. If we can place them in our nursing home, by all means we will do so. But we are not able to give these guarantees.

Mr MOSSFIELD—Fair enough.

Ms CORCORAN—I have a question about the ageing of your staff or volunteers. I am not too sure how much reliance your organisation has on volunteer labour or perhaps labour from religious people, who do not cost as much, to be quite frank, as other staff. Is there a problem of less access to volunteers because the volunteers just are not there any more or are in fact themselves ageing? Is there a work force issue looming?

Mr West—It depends if you are looking forward 40 years. It depends on the attitude of people now as to whether or not they would volunteer their services to work in the industry. We have people who are of similar age to the residents that provide a volunteer type service such as calling bingo or playing the piano or other recreational activities. I would find it difficult, I

think, to recruit a younger person to come into an aged care facility as a volunteer to provide that type of service. As Glen mentioned earlier, the average age of staff we were meeting the other day in one facility was 58 years of age. They were the RNs. It sits around 50, of the 120 staff I have. I think Jennifer would be in the same situation. So the people who work in aged care are predominantly older members of the work force in that bracket.

Because of the nature of the work they do, they can become quite selective in what they will do. They might work while the kids are at school. If the grandkid comes over on Tuesday, they will not work on Tuesday. They will work on Wednesday. So it is difficult to arrange rosters with people like that. But there is no importance placed on training younger nurses for the aged care role or the aged care industry itself. It is not portrayed as a glamour industry. It is not an industry in which there is a lot of self-satisfaction, I suppose, unless you work in it, and then I think it is a different thing altogether.

Ms CORCORAN—I have a question related to that about the 50:40:10 ratio. You do not want to put a number on it. You did indicate that the figure of 10 needs to be increased. I am hearing that the decrease should come in the low-care places. That is what I am hearing anecdotally. Where do you tweak it? Where is the demand moving to or from, or is it simply a need for more?

Mr West—What you are hearing is probably the right way to go too, given that people are kept in their home a lot longer. Therefore, when it was time to provide residential care, it would be at that higher level, even at a palliative level, rather than the old nursing home style. So maybe that is the thing we do. You take from—

Ms CORCORAN—Do we need a fourth level?

Mr West—Yes. I suppose four into 100 makes it even more difficult. But that fourth may have to come down to 20 and that 20 go on to the other 10 to make 30 into packages. And only 20 would go into low care. This area seems to be fairly well bedded—low care. The studies we have are to look into a totally unrelated thing, SEPP5. We will have to be very, very mindful of the fact that we are looking at something like 30-odd places per year between now and 2016 to meet the demand for high care just in the Gosford area alone. I do not know what Wyong's figures are, but they would be fairly similar, given that the growth is pretty much the same in both shires.

Ms HALL—Kevin, do you think that the delineation between high care and low care should be removed and that it is really rather artificial? Should there be one level of care plus ageing for packages?

Mr West—I suppose there is merit in taking away that area. There are eight different categories based on an assessment. As far as the funding tool goes, we have eight categories. Maybe we do not look at low or high care.

Mr Gillingham—You would have to look at the present stock of facilities you have and the way they are designed. I know certainly our facility would not make an easy progression to that sort of proposal. But if you are talking about 40 years time, the housing stock we have now is going to be out of date anyway. And the funding of the replenishment of that housing stock is another issue that needs to be looked at.

Mr HARTSUYKER—This area obviously is going to need the construction of a great number of new facilities as time progresses. You mentioned the interface with federal, state and local government rules. Do you see that the local government planning requirements and the building requirements for aged care facilities are appropriate for the industry? Do you see that those planning requirements are making it more difficult for providers to provide aged care facilities for people?

Mr West—I do not think it makes it difficult. The only thing that makes it difficult is any change or amendment to them following the initial planning. But what they have in place at the moment here works quite well. It was interesting to hear the council say that they have a planning process whereby they can identify areas where they would be quite happy to give developers the opportunity to build residential care facilities. I think that has to happen because the number of beds that have not come online in that Gosford area alone because of the providers not understanding the zoning requirements there is a real eye opener. I am pleased to see that Wyong council has adopted that policy whereby they can identify areas in this shire that are appropriate for aged care facilities.

Mr HARTSUYKER—What about in the actual building design itself?

Mr West—The building design is governed by the building code of Australia, which has undergone some recent amendments. And the certification requirements by providers require a capital outlay that probably was not originally intended because of the need to meet these stringent requirements. But it is in the best interests of the industry itself to meet these requirements. They have been looked at from that perspective. It is best practice to adopt this code at the highest possible level rather than just at an acceptable level within the community. So I do not have a problem with compliance with that type of legislation because the industry itself has had input into it and has agreed in principle with the amendments

Mr Gillingham—It is clear to us as an association that both Wyong and Gosford shire councils are moving towards a policy of less and less low care and moving towards community aged care packages in the high-care area in their planning policy. Gosford council is proposing a set of amendments or changes now.

Ms ELLIS—You just commented on the planning and the allocation of beds and licences versus planning. Whilst it is definitely an improvement if we can see councils working more progressively on the land management issue, I find it a bit surprising that the vetting is at the other end of the system. In other words, the process of the granting of the licence does not actually pick up in that application for this very important resource that maybe the land is not clearly available. Would you agree with that? It seems to me that it is good for us to encourage the councils. I am pleased to hear that. However, there is the other end as well.

Mr West—In the application, I think it says something like, ;Do you own the land? If not, are you prepared to acquire?' There is nothing about where the land is or what zoning requirements there are.

Ms ELLIS—So there is definite room for improvement at the other end?

Mr West—Without a doubt. That is the reason why—the expression has probably passed its use-by date—phantom beds continue to exist.

Ms ELLIS—Exactly.

CHAIR—Thank you very much, Mr West, for the submission, which we would like to receive as a submission. I should say that although you were concerned about the deadline of 29 November 2002, we have still been accepting submissions, even as late as last week.

Mr West—We thank the committee for the opportunity to appear before you today and provide that information.

Resolved (on motion by **Ms Ellis**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.40 p.m.