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, 19 MAY 2003

COFFS HARBOUR

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Monday, 19 May 2003

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

Members in attendance: Ms Hall, Mr Hartsuyker, 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 9.18 a.m.

GRAHAM, Professor Jennifer Margaret, Executive Dean, Division of Health and Applied Sciences, Southern Cross University

HILL, Dr Richard, Head of Social Sciences, Southern Cross University

SANKARAN, Associate Professor Shankar, Director, College of Action Research, Graduate College of Management, Southern Cross University

WILSON, Professor Peter Howden, Professor and Head, School of Psychology, Southern Cross University

ALLSOPP, Mr Timothy, Chief Executive Officer, Catholic Care for the Aged, Coffs Harbour

CURRAN, Associate Professor James, Associate Professor, School of Rural Health, Faculty of Medicine, University of New South Wales

FOSTER, Mr Christopher, Area Director, Nursing and Mental Health, Mid North Coast Area Health Service

GRIMSHAW, Mr Warren Albert, Executive Director, Coffs Harbour Education Campus

KUHN, Ms Deborah Mary, Project Manager, Future of Ageing: Coffs Coast, Coffs Harbour City Council

O'REILLY, Ms Karyn, Head Teacher, Nursing Section, North Coast Institute Technical and Further Education

ROCKS, Mr Kevin Leslie, Aged Care Manager, Ramsay Health Care

RYAN, Mrs Janice Shirley, Manager, Coffs Harbour, Bellingen and Nambucca Community Transport Inc.

SMITH, Mr Geoffrey Howard, General Manager, Astoria Developments Pty Ltd

CHAIR—Welcome to our inquiry into long-term strategies for ageing. Today we will hear from the Aged Services Learning and Research Collaboration, the Mid North Coast Area Health Service, and Dr Michael Peck, of the Mid North Coast Division of General Practice. The final item of today's proceedings will be an open community forum. The community has heard in other areas of the need for appropriate aged care facilities, healthy practices and community care. Today's witnesses will provide the committee with important local insights in each of these areas.

I welcome the representatives of the Aged Services Learning and Research Collaboration to today's hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead

the committee is a very serious matter and could amount to contempt of the parliament. Do you have any comments to make about the capacity in which you appear?

Prof. Graham—I am the chair of ASLaRC.

Prof. Curran—I guess I am the director of ASLaRC. Warren Grimshaw would like to welcome you on behalf of the campus, I believe—

Mr Grimshaw—We might do that at lunch.

Prof. Curran—Okay. The government started several schools of rural health in Australia in the last few years and Coffs Harbour was one of the campuses which gained such a rural school under the auspices of the University of New South Wales. When my colleagues in this town met to discuss forward planning for the medical school, it became very clear that one of our major areas of discomfort was care of the aged. We felt that there were many older people coming to Coffs Harbour and that we were in a fairly difficult position to look after them. So they asked me to bring together the various agencies and people involved in that kind of care, and you see before you today a fair collection. They have all been extremely helpful and extremely positive about things. We set out to see what we could build as a collaboration among the various agencies. Part of the planning of the University of New South Wales was that the local university, Southern Cross, had to be involved in what we were doing and had to play a very significant part in that. We have expanded that to include technical and further education, and indeed on this campus to include the high school. The private operators are well represented here today, the not-for-profit operators are represented, the health board, the university, the division of general practice and almost every agency in town, and very much the Coffs Harbour Council.

I would like to show you a couple of slides to demonstrate the problem we saw before us which generated the kind of activity we are doing.

Slides were then shown—

Prof. Curran—Coffs Harbour is not quite the same as many other parts of Australia. The school population remains pretty much the same. These are the real figures for the last four censuses, and these are the three projections. The school population stays the same. The aged population rises significantly. Most unusually, the work force does in fact increase. This is not the situation in South Australia and Tasmania. Internationally it is certainly not the situation in Japan or Germany, which are far worse off than we are. There are some anomalies in that. That takes no account of deliberate attraction of older people, and we have to allow for that. My best guess is that the work force will contract a fraction and the aged will increase very significantly.

The one which looks terribly complicated but in fact puts the whole thing in a nutshell is where the bottom four graphs are the last four censuses, the real figures. The top three are the ABS projections for this area. Until we had the 2001 figures, the blue line was up here as well. The bureau has been consistently predicting an increased number of 25-year-olds in Coffs Harbour. It just does not happen. There are half the number of 25-year-olds than there are 20-year-olds. They have left; they are gone. The numbers of elderly continue inexorably to rise. With the idea of sea change lifestyle, with retirees leaving the big cities and coming to live in places like Coffs Harbour, this is going to get worse, not better. One of the things we want to do

is to use that to leverage an improvement so that we find some way of keeping our young people here, because we do have to look after the older people who are coming.

In terms of the institutional facilities, the bed facilities, in Coffs Harbour, we have got high care, low care and community places. The 1996 figure of what we have now, what is actually here, is already behind where it should be in 2001. It is miles behind where it is going to have to be in 10 years time. Not that we are suggesting institutional places are the way to go, but what we are saying is that if it were the way to go we have not got them.

This is a snapshot from Coffs Harbour last year. The number of unemployed men include plenty of 20-year-olds in the work force, but 25-year-olds drop. The figures for women are a bit strange. There is a huge drop in figures here and a peak there when they finish child-rearing. Once again we would probably like to maximise that by saying, 'Here is a mature work force that we can use short term to help our immediate problems,' but this is a glaring gap of young women not available for work in this town and we must try to reverse that kind of scenario. These are all the slides I want to show.

So, when we start to look at it altogether, we find that the University of New South Wales is already committed to the medical school. The students are here but it is going to be some years yet before we can hope to attract them back to this town as practitioners. We find that the nursing home places for institutional care are difficult to sustain and that home care services, while they are there, are difficult to access and are quite severely rationed. But there is an enormous will on the part of all the organisations to do something positive about it.

At that time Coffs Harbour council, in the guise of a futures operation, was discussing with private investors and private operators new retirement villages for Coffs Harbour. There are two large projects on the drawing board and another couple around the edges. I met with them last year and brought to their attention the problem they are going to have with the work force. If we attract 2,000 or 3,000 new retirees to Coffs Harbour, the work force to look after them does not exist. At that stage—and I take my hat off to them—Astoria in particular realised that we would have to have a partnership to start developing the work force that is required in this town not for some kind of airy-fairy prediction but for actual numbers of people that we know are going to be coming. The whole thing snowballed from there and we started attracting funding from—

Mr HARTSUYKER—Excuse me, Jim, the members of the committee do not know what Astoria is.

Prof. Curran—Astoria is a developer. This is actually the first aged care facility that it is going to develop. Astoria is building a large retirement village immediately behind you in the valley which will have ageing in place right up to nursing home beds at the top end of the scale. It is a fully integrated retirement and old age facility. It will be quite close to the public hospital. This too is strange and has never happened before, but Astoria has a very close relationship with Ramsay Health Care, which is the operator of the local private hospital. While both of them are in the bricks and mortar business, both are very well aware of the need for community care outside the institutions. As I said, I have never come across a situation where developers have been prepared to start talking staffing levels, care levels and provision of staff so far in advance of actually building the building. To me it has been tremendous—

Ms HALL—So Ramsay is going to be building and running Astoria.

Prof. Curran—No. Perhaps Geoff can tell you himself!

Ms HALL—Yes, please.

CHAIR—Just a second. I think what we will do is take that as your opening statement.

Mr Smith—I am the General Manager of Astoria Developments. We are responsible for the development of a fully integrated residential estate at The Lakes, Coffs Harbour, part of which will be a fully integrated retirement village incorporating self-care apartments, villas and also an aged care facility. We have recently entered into an agreement with the Ramsay Health Care group, who will be responsible for the development and operation of the aged care facility.

CHAIR—Thank you. Associate Professor Curran, would you like to conclude your opening statement before I invite members to proceed with questions?

Prof. Curran—Yes. Things almost took on a life of their own; they started to snowball. The Southern Cross University has been thinking for many years of moving some nurse training courses to Coffs Harbour, but the Institute of TAFE already has certificate 3 and, hopefully, shortly, certificate 4 nurse training on campus here in this complex. We started looking at the somewhat more innovative idea of whether we could get a spectrum of carers proceeding to nurses, starting in the high school here. The high school is quite prepared to offer units of a nursing course as part of the HSC exams. TAFE is more than happy to train nurses to certificate level 3 and certificate level 4. If we can find some way of articulating that into the degree course of Southern Cross University, we can have a whole spectrum of carer nurse training delivered on this campus. That has become a major priority for all of us.

The major research project we now have in place is to get out there to the employers of carers, not necessarily of nurses, and find out the basics of the existing work force, retirement levels, who has got to be replaced, what we need to look forward to with the present workload and also what the projected workload is going to be and what we have to plan for in the near future and, more importantly, to define the skills that the carers are going to require. We do not see it as being a straightforward nursing line, occupational therapy line, physiotherapy line; we are looking at a much more generic carer training. That project is under way. Intuitively, I think it is going to tell us not whether or not we need a school of nursing but how big that school of nursing needs to be.

Many other things are happening around the town. The council, for instance, have really got the message that the problem they have is that retirees coming to Coffs Harbour have already paid their rates and taxes somewhere else and have paid for the infrastructure in another place. They are coming here and expecting the infrastructure to be here when there has been no-one here to pay for it. That has been a real problem for councils. They have bitten the bullet in many very good ways. Over your shoulder there you will see the hospital. Between here and the hospital there is a block of land owned by the council now given to the university for a new medical school. So the hospital, medical school and this campus are going to be very close together physically and we are going to be running very closely integrated teaching and using each other's facilities. The local community has been incredibly supportive. The division of

general practice has given us money for our research projects; council has given us money; TAFE has found us money; Southern Cross have found us a lot of money. Projects are now up and running.

The message I would like to give the committee is that we are not whinging about what we have not got; we are really waving the flag as to what we have got. What we have got I think is unique in Australia. We have two universities, TAFE, high school, community organisations, council, private developers and not-for-profit developers all singing the same tune, all working towards the same end—better care of the older people in our community, recognising that they are not going to be people who grow old here; many of them are going to be people who have come here.

This group does not expect the committee to find us any money. We are not asking you for money. What we are asking is that, should the opportunity arise in another place, you might lend us your support. Professor Graham is the president of the steering committee and I would ask her to direct traffic from here on in.

Mr HARTSUYKER—Could you define your concept of aged services?

Prof. Graham—I will turn that around a little to start with and say that we define aged services as accessible, affordable and appropriate services which will effectively enhance the health and wellbeing of our ageing community. How we define that in a chronological sense is difficult and you will find different definitions in different papers. We have different groups with different needs. In the 80-plus group, which is sometimes seen as the group which requires intensive input, there will be a series of needs which focus on perhaps illness—for many—rehabilitation and disability services. However, if we come down the scale and look at the accepted definition of retirement age which is 65-plus—more recently that has downscaled to 55-plus or 50-plus—we are looking at a range of other services which will enable members in our community as they age to live to their full potential and have an excellent quality of life.

So beyond those illness, rehabilitation and treatment services, which you find variously in acute care settings, rehabilitation, residential services and nursing homes et cetera, there is a range of other services with which we concern ourselves. They cover things like other forms of accommodation for the well aged and transport which connects people to their community; financial services because people need a degree of financial stability to live a reasonable quality of life; and information technology. A lot of people as they are ageing—even people within universities at the senior end of the scale—are not particularly information technology literate. It is not difficult to facilitate that literacy and we have some resources, which we believe can fulfil those needs as well. It is not just a question of personal needs being fulfilled by information technology; it is how you use technology again to provide the connectivity in the community—for instance, information technology can be used to facilitate transport routes or can be used in a management sense in a nursing home; there are a lot of uses. So that is another service the IT sector can provide. Other aged services include recreational and tourism facilities and tourism services. Coffs Harbour is an area of great mobility. People of all ages love to come here for holidays, including those who are ageing.

Last but not least, I am from the education sector. If we look at the concept of lifelong learning, many people as they age want to contribute very actively to their community—or

communities as the case may be. They want to learn new things. This is why we have the University of the Third Age springing up in some areas of Australia. So we would include lifelong learning in that constellation of services, which are required for aged care.

As I said, I have tried to turn that around to focusing on 'services for an ageing community' as opposed to just focusing on the care element. What I am talking about is a model—and I come from a community health background—which resonates with concepts of primary health care and health promotion. These are concepts which the Commonwealth government has been promoting from way back in time, but there was an impetus particularly around the mid-1980s and we saw that track through in the early 90s into developments like the Healthy Cities Program. I think what we are talking about is not terribly different from those concepts but we are now looking at implementing it rather than just talking about it.

Mr HARTSUYKER—Associate Professor Curran spoke about the proposed aged care research that your group has been looking at. Could you expand on that and detail, at a little more length, the types of research you are proposing and how you propose to make that happen.

Prof. Graham—In terms of the types of research?

Mr HARTSUYKER—Yes.

Prof. Graham—At this point, I think we need to have other witnesses who can very ably speak to some of the research which is on the table. I would then like to make some concluding comments. I will hand over to Professor Peter Wilson, who is a professor of psychology.

Prof. Wilson—I will limit my comments to the contribution that psychology can make to ageing research. Psychology, as you probably know, is a fairly broad discipline. It is concerned with understanding human experience, including human behaviour, thought processes and so forth. While it draws upon its own discipline base in areas such as human learning, development, social psychology and brain process, it also cuts across a number of behavioural, social and biological sciences. As such, it is an ideal discipline to bring together a number of different parties who have an interest in the ageing processes. In particular, psychology here at Southern Cross University could make the following contributions. I would be very keen to see a study conducted of factors associated with healthy retirement. The aim of this kind of project would be to develop and study a set of predictors of healthy adjustment to retiring—healthy in the sense of wellbeing and social engagement, and healthy in a more traditional physical sense.

Ms HALL—Have you done any research in that area so far?

Prof. Wilson—No, we have not been doing research in the area, but there are plans to apply for research grants on this subject in the next round of NHMRC funding next year. The aim of this would be to try to understand better what factors predict healthy retirement, taking into account the fact that we have two kinds of retirees in this particular community: those who move to the community and those who are already living in the community when they retire. As you would appreciate, there are also a number of factors that contribute to a decision to retire. We would be very interested to look at all of these kinds of issues with the aim of trying to develop pre-retirement programs that focus not only on the financial aspects of retirement planning but also on the social, psychological and leisure related aspects of retirement planning. At the

moment there does not seem to be a very good balance between these two kinds of areas. Information about those sorts of issues is badly needed for us to be able to develop the kinds of programs that I would envisage.

A second area is that of coping with chronic illness, pain and hearing problems such as hearing loss and tinnitus. This is my own area of research; I have been conducting research in the area of hearing problems for 20 years. I can bring a considerable level of expertise in that area to the study of hearing problems in older people. Of course, this subject is not disconnected from the previous one that I talked about—that is, the presence of these chronic disabilities presumably has a very big impact on people's adjustment to retirement. The good news is that there are things people can do to improve their quality of life while unfortunately also suffering from these chronic illnesses and disabilities. That is what a lot of our work has been about, but I would like to focus that very much more clearly on the aged population.

A third area, which is more in the heart of experimental psychology, concerns the design of better systems and training to involve older people in the use of computer technologies, particularly so that they can access banking and information services and engage in communication with other people around the world. This is an area many older people frequently feel they are cut off from because they sometimes do not have the knowledge and skills to engage in these kinds of activities. It is also quite daunting for older people to cope with systems that are not well designed for them—including, I have to say, even ordinary ATMs. It seems that we have a good opportunity here to combine the work of people in the areas of information technology and psychology to develop effective systems for older people.

I will not detail any of the other areas as much as that. I will just say that there are other areas, such as the early detection of memory problems and developing strategies to help people in their homes to cope with day-to-day memory problems. These have been well developed already in psychology, but there are a number of gaps in that knowledge base, and there is certainly a gap in the application to the elderly. We can also look at issues such as the cost-effective treatment for anxiety and depression in older people and also bereavement issues. Once again, depression is one of my own areas of research, from which I can bring some strength to this particular endeavour.

Prof. Graham—There are two other people who can talk to areas of research which are very pertinent to the interests of the committee. Associate Professor Shankar Sankaran is working on research which is linked with the ASLaRC Ramsay development.

Prof. Sankaran—One of the hats I wear is as director of the College of Action Research in the university. Basically we are involved in action research, which is combining action and research together, looking at change, developing change and understanding them together in projects, as well as making the research participatory. That means that people who are beneficiaries of the research actually participate in this research. We had some meetings with the ASLaRC committee, and we found that one of the areas where we have to take action is to find out the capacity of the supply of aged care facilities, as Professor Graham was talking about. We have just initiated a project where we will assess the scope of supply so that we can find out the gap between the demand for aged care services versus the supply. The next cycle of action research would be to find out what to do with this gap.

We have been involved in research with organisations in the community. That is the basis of why this institute was set up. It basically does multidisciplinary research. We have several doctors who are interested in aged care; they are doing their doctorates in this area. We have researchers within the institute from the management school, the College of Indigenous Australian Peoples as well as the social sciences school. We have done some research with Australian health care services, where we evaluated the accreditation program. Also we are now working with communities, especially Indigenous as well as the private and public sectors, in the area of knowledge management. Those are the areas of our research.

Ms HALL—What kind of research are you doing in the area of Indigenous ageing? Are you involved in the Indigenous community? I know there is quite a large Indigenous community locally.

Prof. Sankaran—I am not specifically involved in the research in ageing; that is being done at our College of Indigenous Australian Peoples. But I am involved in a project where we are looking at how knowledge is captured, stored and disseminated within communities, and we are looking at the Indigenous community as one of the communities.

Ms HALL—And they are participating in that project, and driving it as well?

Prof. Sankaran—Yes. The actual facilitation of the project will be done by a member of the Indigenous community.

Prof. Graham—I can come back to the engagement of our Indigenous Australian Peoples a little later on and answer that question, because they are part of my sphere of responsibility. Now can I introduce Dr Richard Hill.

Dr Hill—I am based on the wonderful Coffs Harbour campus. Before I talk about the particular areas of research that I and my colleagues are interested in, I will preface that with some comments about the research culture that is being developed within the university as a whole, because I think that is very important. The university, I think, for a regional university, is doing a magnificent job in promoting research as one of its principal activities. It has restructured its funding arrangements to ensure that that occurs, and it has provided various incentives for staff for that to happen. It is wonderful being part of a university that is so committed to research.

What is becoming very clear is that across various schools there is a strong commitment to research in the area of aged care and aged services. Certainly the school of social sciences is part of that drive and initiative. The areas that I have itemised are the areas in which members of the school of social sciences, of which I am a member, have discussed as ways forward in looking at aged services and aged related issues more generally. I will turn to them very briefly. One of the areas which we are concerned with—and some research has already been conducted in this area by my colleagues—is the transition from residential care to home care and the implications of all that, particularly for carers. One of the things that has emerged from that research is concern around carers who themselves are aged people caring for other people who are older than they are. That seems to be a very under-researched area.

Another ongoing area in which I am currently involved is a general study of poverty. I think that is particularly pertinent because up to about a quarter of the people in Coffs Harbour are on welfare benefits. We really do not know a lot at this point about the number of elderly people who experience poverty and related social isolation issues. It seems to me that, even though we have got this sort of sea change phenomenon occurring with people coming here, often with fairly substantial amounts of savings, there are probably pockets of elderly people who are experiencing fairly acute poverty, and we are hoping to look into that.

The other areas that we are hoping to look at are the needs of the ethnic elderly and, more broadly, the role of non-government organisations in the provision of various aged care services, particularly the churches and other such organisations. Our school has a particular interest in social policy issues. Some of the areas we want to look at relate to the broad demographic changes which are occurring and the specific implications of those for aged services in this sort of area. We are particularly interested in the implications for residential and nursing home provision and the consequences of growing numbers of people—in fact, people who are 55 plus—who are making demands on these services and the shortage of those services in these sorts of areas. Our other main area of concern in relation to social policy is the whole issue around carers and the provision of various forms of help and support for people who are caring for elderly people who may experience a whole range of physical and psychological issues. That concludes my submission.

Prof. Graham—In relation to those final comments, those examples in a sense have just scratched the surface of our capability. In Southern Cross University coming together with UNSW, we have got a very established university in UNSW and a relatively young university in Southern Cross. We have had some recent appointments, and we have got good research capability yet to be realised in a number of those appointments. If you take Southern Cross University and UNSW together, in the research domain we are amongst the five leading universities in Australia in terms of CRC engagement and ARC Linkage grants. So we do ourselves proud, particularly in those areas of research which require a strong link with other sectors. It is not just about researchers in universities but about connecting with developers, local governments and other providers, as far as aged care is concerned. We believe that we have considerable strength to realise. Again, we have just scratched the surface with a number of disciplines which were provided as examples. We have very good strength in research in nursing and health care practices, we have strength in exercise science and nutrition and some of the research ongoing is with general practitioners. It is in collaboration; it is in partnership. I would just like to say that as a summary statement.

Coming back to the Indigenous issues, we have the College of Indigenous Australian Peoples. It is headquartered on the Lismore campus, but the interests range across all of our campuses, including Coffs Harbour. We have a staff member based here at Coffs Harbour. The whole modus operandi of Gineevee, as it is called, is engagement of the Indigenous elders and the broader Indigenous Australian community—I should say communities, because they are very different. Those in and around Lismore are very different from those here at Coffs Harbour. We need to engage these communities in ways which are culturally appropriate to our Indigenous Australian people.

Our Professor in Indigenous Australian Studies, Professor Judy Atkinson, who is well known nationally, is developing an excellent profile internationally. She was appointed towards the end

of 2001. Almost every day of the week she receives invitations to be a keynote speaker somewhere, to facilitate a workshop somewhere else or to be a recipient of government grant moneys to innovate and get new projects off the ground. We consider ourselves fairly well placed to take on board the issues of ageing Indigenous Australian peoples. We have not yet moved into any specific research in the arena of the ageing process, but we have every capability.

Ms HALL—You have talked about the areas of research that you would like to be involved in. Are you actively involved in research in any area of ageing at the moment?

Prof. Graham—The area that Professor Sankaran spoke about is our key focus, for which we have actually managed to get $33,000—probably amounting to closer to $40,000 by the time we have finished—by virtue of multisectoral contribution to enable that research to proceed. As I said, ASLaRC is a very young development. It has plans to appoint a chair to head up this area for professorial appointment, and in fact the funding has been set aside for that. I think our youth should be seen as a strength rather than a detractor at this stage.

Ms HALL—Definitely.

Mr HARTSUYKER—What level of community support do you have?

Prof. Graham—Perhaps we have already covered some of that ground in the answers we have given. If you just take the membership of ASLaRC itself, it has engaged two universities, TAFE—with the potential for senior high school engagement—local government, the not-for-profit sector, the profit sector, development agencies and the health sector. That, in itself, says something. It is not easy these days to get people to put aside a time to come to committee meetings; people come regularly to ours and we do not have many apologies. We have established a fairly good modus operandi that will enable us to sustain the level of community support which is so essential. The current project that Professor Sankaran spoke about is an example of how we form a working group—it is a dedicated working group, so all the members have a very specific interest.

For each particular project we would customise a working group and we would project manage that to ensure its success. Beyond that, there will be points in time when we will also need to refer to broader reference groups. We will involve that as part of our modus operandi as time goes by and as is required, depending upon what our focus is at the time. I think it is true to say that we have an excellent level of community support. I can only speak to that from a limited perspective, in my role at Southern Cross and as the chair of ASLaRC. With the committee's agreement, I would like to defer to Warren Grimshaw, who could expand on those comments somewhat.

Mr Grimshaw—In some respects we have been considering options as to how we should progress in this regard for two or three years now. The direction that has now been adopted is really the result of the work of ASLaRC and the participation of the community. In saying that, what Coffs Harbour Education Campus offers is an incubator: it is a centre at which we can undertake research that will not only have application in Coffs Harbour but will extend more broadly into national and even international considerations. I think it is crucial that point be

made. While the focus is here because we have the institutions and the support here, that focus will obviously extend as time elapses.

From my experience and involvement in this project, we have had enormous support from the Coffs Harbour City Council in financial terms in establishing the initial feasibility study; we have had support from the Futures Development Board, which is a corporation concerned with regional development; and we have had support from the Division of General Practice. The Department of State and Regional Development, at the state level, also contributed in financial terms to the initial feasibility work. In the private sector, the Baringa Private Hospital has been financially supportive as well as supportive in the sense that the chief executive there has been driving the policy in aged services for this community. Deborah Kuhn, who will speak later, has been instrumental in developing that policy. We have had support from service clubs such as Rotary, and the ex-services club has contributed financially.

As executive director of the campus here, I am also a member of the area health board. We have support from the Mid-North Coast Area Health Service, and I think that is going to be crucial in the way we go forward. By virtue of the fact that on this campus, which is reasonably unique in having three sectors—the Southern Cross University, the North Coast Institute of TAFE and a senior college—the opportunity to reach out through those institutions and to develop strategies and approaches in dealing with this issue has been enormous. That brings substance and a wealth of knowledge and experience which otherwise would not have been available. When you look at the social institutions, the educational institutions, the community itself and, in the very broadest terms, the support from that, I am really encouraged about the prospect of developing something really worth while. I think we have already come a significant way in that development.

Prof. Graham—Last but not least, Professor Curran would like to make a few comments.

Prof. Curran—I have a very simple end statement. I have been in this business for a long time. I did this kind of work in Tasmania 20 years ago. I have never come across a project which had so much community support. Every single organisation in this town has been enormously supportive. We have not heard a single negative voice. I take my hat off to them.

Mr HARTSUYKER—What resources have already been committed?

Prof. Graham—I did make reference previously to the establishment of a chair to head the aged services domain. Chairs, as I am sure you appreciate, do not come cheaply. We are looking at approximately a $200,000-plus investment on the part of the university. That is really in response to the emerging opportunity and realisation that we, in this community, can in fact make a difference. We think we have the ingredients to do significant research, to run significant programs and to perhaps provide demonstration models, models of best practice, which can then be adapted and adopted by other areas in Australia or even perhaps internationally. The chair funding is one level of funding. In terms of the other resources, mention has been made of the labour force needs analysis project by Professor Sankaran. As I said, we anticipate that final quantum will be about $40,000.

When we go down the pathway of cooperative research or engagement or ARC Linkage grants then, depending upon the focus of the project and its size, you will see further contribution from

the university's own resources. We would also need to secure, by virtue of the conditions of those grants, resources from the wider community—as indicated by their name, cooperative research centre or linkage. At the moment, we have significant buy-in, if you like, in resources in kind on the part of a number of senior people across the various institutions involved and across the various other sectors. That is a significant resource. It is hard for me to attach a quantum to that at the moment.

I think that probably summarises it. That is about it for now, but we would hope that we would go down the pathway of matched funding of some kind. We see most of our opportunities lying in those domains which require ongoing institutional contribution matched by funding from providers external to universities and colleagues in TAFE.

Mr HARTSUYKER—How do you envisage meeting the needs that you actually identify?

Prof. Graham—I seem to be saying a lot. I would like to be the second one to respond to that question. Could I defer again to one of my colleagues, Karyn O'Reilly from TAFE. Karyn, would you like to answer that question in the first instance?

Ms O'Reilly—Firstly, the North Coast Institute is working in collaboration with ASLaRC in developing the research and looking at the needs analysis of the area and where the gaps lie. Currently, the North Coast Institute teaches about 700 assistant nurses across the area. Of those, approximately 130 are taught at the Coffs Harbour campus. We have a combination of TVET year 11 and 12 students. They come from as far as Dorrigo, from the senior college at Southern Cross University. We also teach students from Woolgoolga, so we cover quite a large area. We also have mature age students. The peak age of our students is roughly between 40 and 49. We have quite a lot of mature age women who want to become assistant nurses.

With articulation, currently we teach a certificate III assistant nursing course which leaves minimal articulation through to enrolled nursing or registered nurse training. With the introduction of a certificate IV course, in collaboration with the universities, we are hoping that the articulation through to registered nurse training would be increased. Our assistant nurses work in many areas: in aged care facilities, in home care, as private nurses and in community nursing. They currently are also employed at Baringa Private Hospital in theatres.

With the research project, we also need to promote that aged care nursing is a speciality. At the moment it is often perceived by people as a place of work—a place where you go when you cannot work somewhere else. Gerontology and aged care services are specialities that we need to promote. The research project that we are combining with the universities and the rural school of nursing will increase the perception that it is a decent speciality to be involved in.

Ms HALL—I agree wholeheartedly with what you have said. Do you think there are any barriers to that happening—it being treated as a speciality and people being encouraged to enrol in the courses and pursue work in the aged care industry as a career? If so, what are those barriers?

Ms O'Reilly—Obviously funding is a barrier. A lot of facilities are privately owned, with minimal subsidisation, and they cannot afford to send their nurses off to education. The majority of education in these areas is not in Coffs Harbour; it is in Sydney. The New South Wales

College of Nursing does postgraduate gerontology courses. However, you need to go to Sydney or your employer needs to fork out a couple of thousand dollars for you to do it as a distance education package. A lot of people cannot afford that. They also do not want to leave their local community to travel to Sydney to do courses. A lot of people would be very keen to do postgraduate study. However, financial restraints to stop that.

Ms HALL—Are there any work force issues associated with it as well?

Ms O'Reilly—Obviously staffing would be an issue. These facilities have minimal staff at the moment and sending one or two people off to Sydney to do a gerontology course would leave them short staffed. They cannot afford to put on casual or extra staff to replace them. The casual work force is quite large in Coffs Harbour and also quite expensive because they carry the extra leave loading et cetera. We are also looking at increasing our number of Indigenous students at Coffs Harbour TAFE. Next semester, we have nine scholarship places available for Indigenous students. We are only just starting to advertise for that at the moment. There is also a plan on the drawing board to put forward a submission for a non-English-speaking background certificate III in age care nursing at TAFE.

CHAIR—Professor Curran, in your PowerPoint presentation at the beginning you said that the trend had been that the proportion of aged people has been increasing, but you have also seen the work force increasing in the Coffs Shire while the numbers of people receiving education are remaining about the same. Do you have any projections of what you expect in the future?

Prof. Curran—Yes, the age group is definitely exploding on us. The work force is holding quite well and rising quite well, but older people are in the work force. The 25-year-olds are not here, and that is what we see as critical. If we can encourage the 25-year-olds to stay here and do nursing/caring education in this region, we can get that horrible dip out of the forward projection and there will be enough young people paying rates and taxes to pay for the infrastructure that the older people require. That is the terrible dilemma that council has. The people who come here are on rate rebates, telephone and motor vehicle subsidies. They paid all the money when they were working. Do I have to tell government how difficult it is to take resources away from somewhere else? My memory goes back to Crown Street.

CHAIR—In Coffs Harbour what are the barriers to efficient delivery of aged care services?

Prof. Curran—I am a very solid advocate of the one-stop shop. We do not have it. We have the usual problem of Commonwealth responsibility and state responsibility. Within these sectors we have even more artificial barriers—the HACC or Home and Community Care Program, the area health board and Veterans' Affairs—and it is not at all difficult to end up with one household with three different nurses coming in every morning. The Veterans' Affairs nurse comes to see the father, the hospital nurse comes to see the mother and disability services comes to see one of the kids. Within a single street, you could easily get four or five agencies appearing at the one time. There is a huge possibility there to rationalise the individual deliverer of care and to do the reconciliation, as it were, of the various program requirements as a block rather than as an individual. You could say that 14 Veterans Affairs' visits were done but that they may not all have been done by nurses specifically employed to do that.

There are barriers—and I get into trouble all the time for this—such as: how much longer do we have to have a demarcation dispute about dishing out drugs in nursing homes? There are times when a state registered nurse is appropriate. There are many times when handing out a Webster pack is not really a terribly difficult job, but it is a big industrial barrier and it is one we have to address seriously. The whole system is full of these kinds of anomalies of 'I can't do this' and 'You can't do that; somebody else will have to do it'. In my ideal world, the Aged Care Assessment Team, ACAT, would sit at the centre of the web and decide the packages for each individual and ensure that they were delivered. That means they would have to be given some fairly solid administrative support to satisfy the requirements of the various programs which they would then be overseeing. It is not impossible, but the barriers are more administrative and industrial than they are real. The caring staff are perfectly capable of doing it.

Prof. Graham—Chair, before we leave that particular topic, may I make just a few more comments?

CHAIR—Certainly.

Prof. Graham—I would echo the comments made by Karyn, particularly in terms of our capability to deliver nursing programs and to satisfy needs in that regard. In fact, the university is working hard to deliver greater proportions of its programs which are based in Lismore here at Coffs Harbour. We are doing that in association with the base hospital, so there is a nice collaboration there. But equally we are setting our sights higher, and it is this thought that underpins the research which we have just initiated. We really need to reassess the need, and in reassessing the need we need to decide on whether health professional education and training should continue in the form that it has taken for a number of decades or whether there is time for a change.

We have seen some changes in medical education in terms of graduate entry. We have seen some changes in nursing, in preparing people to be nurse practitioners. But the question is: is there now a different mix required? That is not to say you get rid of the nurses, the OTs, the physios and the various others who contribute to health care, but is there room for a different role description and how can we as education providers rework our curricula to ensure that the people we are graduating have the response capability and the flexibility to continue to meet those changing needs being identified by evolving societies? We are really keen to work with whoever will work with us, and that includes government. It includes government because ultimately there will be some industrial relations issues in terms of any workplace or job restructuring. We would like to think that the agenda is sufficiently open to take those issues on board. Of course, we would also be working with the professional associations. These issues would be very dear to their hearts insofar as they would not want to see the professions diminished in any way.

Southern Cross University—and I can speak for Southern Cross—has a history in innovation. If we take nursing and health care practices, for example, the school in association with South Sydney Area Health Service—and this is well before my time—designed specific professional carers programs. For some people, that may have been threatening. For our School of Nursing and Health Care Practices, it was not. Again, with the kind of multidisciplinary and intersectoral engagement we have here, we have the opportunity to break new ground in that regard with the end outcome of producing professionals—that is, health care workers from certificate level right

through to those who have postgraduate awards—who better meet the needs of our ageing Australia.

Ms HALL—Before I ask any questions, I would like to congratulate you on what you are doing here. It sounds very exciting and innovative. In a smaller community, I think you have a lot more flexibility and can involve the community a lot more than you can in larger areas. It sounds to me like you are grabbing that opportunity with both hands. As a result of it, down the track I think you will be able to undertake some very exciting research. Congratulations. Some of the questions I am going to ask are pretty grassroots, so forgive me. Maybe I should have gone to your web site and done a little checking. I gather that you run the AIN courses here. Do you run enrolled nurse courses and registered nurses courses?

Prof. Graham—Perhaps Karyn should answer that in the first instance and then I will pick up on the RN program.

O'Reilly—Enrolled nursing currently is not run within the North Coast Institute. Our closest campus is Newcastle, which means that anyone who wants to do their enrolled nurse training needs to travel down to Newcastle. That is prohibitive. The area health service has got some traineeships happening with enrolled nurse training. However, again, that is part of the Newcastle TAFE campus. There are negotiations at the moment to try and obtain enrolled nurse training here at the North Coast Institute. Registered nurse training is not currently held here at Coffs Harbour at all. Students need to travel to either Lismore, Armidale or Sydney. Again, they have to leave their homes, their families and their children, and they are very reluctant. At the moment, approximately 40 to 50 of our students at TAFE doing assistant nurse training want to go on and do either their enrolled nurse or their registered nurse training. They are finding the need to travel prohibitive.

Ms HALL—That was a very good point. Thanks.

Prof. Graham—I will make a further comment on registered nurse education. However, we are progressively implementing modules or units here within the Coffs Harbour context to limit the travel for those people who do not have the ability to pay for and sustain that travel for family reasons et cetera and to enable them to at least take portions of the course here. Were we to achieve additional funding through whatever means, we would consider establishing at Coffs a satellite program for Bachelor of Nursing across all three years.

At the moment we are not one of the largest schools, as you would probably gather from the size of our whole university. With an intake of just over 100, we have to look to economies of scale in the Lismore situation. But, as far as we are able, we are progressively shifting the implementation. If there were a boost in funding numbers to Coffs Harbour we could well take advantage of that. We have the facilities here to run a full RN program in this locale.

Ms HALL—What allied health courses are run on this campus?

Ms O'Reilly—As part of TAFE?

Ms HALL—As part of TAFE and the university itself.

Ms O'Reilly—Very few. We do not currently run any occupational therapy, physiotherapy, community nursing—again, you would have to travel to Sydney to the College of Nursing—or health and fitness courses. The closest health and fitness course with TAFE would be at the Port Macquarie or Kingscliff campus. So our allied health courses are very minimal. At the Coffs Harbour TAFE we are looking at increasing our commercial courses to include enrolled nurse and registered nurse postgraduate courses but, again, those would be commercial courses and cost may be very prohibitive. We would need to look at developing distance education packages to keep the cost down.

Prof. Graham—Most of our programs in the allied health area, as far as they exist, are headquartered at the Lismore campus. We have very strong programs in exercise science and nutrition, and we have natural and complementary medicine—in fact, Southern Cross University is a leader in that domain. That may be a sensitive subject to raise, given the recent press, but nonetheless there is a huge need for those sorts of practices in relation to ageing population. However, I should also add that Southern Cross University has another collaboration—a partnership which is not with UNSW—which does take in this geographic area, and that is with the Northern Rivers University Department of Rural Health, in which Southern Cross is a collaborating partner with the University of Sydney. The University of Sydney has huge capability in all of the allied health disciplines. We have begun conversations about extending beyond the northern rivers into the mid-North Coast area health services, perhaps to start with in the areas of supporting the clinical components of allied health more appropriately and ongoing continuing professional education. There is a link there that we could use to our advantage in the future—in precisely what ways has yet to be determined. But you have identified a major weakness in what we can directly deliver in the allied health arena. Finally, we also have some professional linkages with the University of Newcastle, which also has reasonable strength within the allied health professions but nothing like the strength that the University of Sydney can offer if it chooses to deploy those resources into regional Australia, including Coffs.

CHAIR—I think Professor Wilson would like to make some additional comments.

Ms HALL—I was going to say something about psychology, so that is great.

Prof. Wilson—I would add that, while psychology is concerned with a number of subject areas, part of its concern is indeed with health. We operate a Bachelor of Psychology honours degree program here that is a four-year degree in psychology in which students are introduced to issues related to physical and mental health. At this stage, a graduate from that program would be able to apply for conditional registration in New South Wales in order to complete supervised experience in a hospital or other setting. They would also be able to apply to undertake more dedicated master's programs such as a master's in health psychology or clinical psychology, although we do not offer those programs at this campus at the moment.

Ms HALL—And there is a social science course that runs through here, too?

Mr Grimshaw—I was just going to add—and Peter has picked it up mainly—that one of the reasons for the emergence of ASLaRC and the concept of developing some profile and some research capacity not only here but elsewhere is the prospect of this leading to the establishment of additional programs in Coffs Harbour based on research that is being undertaken.

Prof. Graham—I understand that Chris Foster feels that he would like to make a comment on this particular issue. May we invite him to do so?

CHAIR—Yes.

Mr Foster—One of the issues that we have to deal with in the public sector—and I am only responsible for the public sector; my major portfolio is the recruitment and retention of nurses—is that the current age of the nursing work force in the mid-North Coast region is 47 years of age. That will have a major impact on us certainly in the next 10 years. In support of everything that is being said here today, any program that will assist AINs to progress to ENs to progress to registered nurses or any other health profession has to be beneficial to the Coffs Harbour area. Some of the university graduates have a drop-out rate from registered nurse programs at the moment of up to 40 per cent in their first year of graduating, but the early data is telling us that people who have been AINs and ENs have a drop-out rate of around five per cent. So that in itself supports the argument for any sort of program that would allow the people from Coffs Harbour to graduate through to the registered nurse program.

But one of the very real difficulties for the students—and I know Karyn will support this statement—is the cost factor. A lot of students are going through the TAFE AIN-EN course and then through the university conversion course due to the fact that they cannot afford to do it via any other fashion. It means that they take up to seven years to become a registered nurse. Some of the students here in Coffs Harbour—and I have only been here 12 months myself as the area director of nursing—have not had annual leave for the four years that they have attended the conversion course because there is very little sponsorship. They work a 38-hour week as an enrolled nurse and do their conversion course via external studies. A component of that course is that they must do four weeks practical experience in a hospital other than the one they are currently employed in. Therefore, during their four weeks annual leave they go off to, maybe, Port Macquarie, Lismore, Newcastle or wherever. So there is a very real impact, a very real benefit, in sponsoring the program and making it easier for people from Coffs Harbour to stay in Coffs Harbour and become registered nurses.

Ms HALL—When I mentioned social science, Professor Graham, you nodded your head; could you answer so that we have it on the record?

Prof. Graham—I think that Richard is the best person to address that; he knows more about that territory than I do. We have had some changes in structure of recent times within the university.

CHAIR—While we have Chris here, can I ask whether there has been any targeting of aides in nursing or enrolled nurses through scholarships, for example?

Mr Foster—Yes, there are a certain number of scholarships available, and the New South Wales Department of Health has a very good scholarship program to assist enrolled nurses through to registered nurses. It costs in the vicinity of $370,000 per year state-wide, but that does not cover all of the costs needed for nurses. The best a nurse can get from that, I suppose, is about $7,000 over the three-year period. There is certainly some support from the state department of health, but I am not aware of other support.

CHAIR—With respect to Coffs Harbour, I noticed your submission has identified that there is a shortage of nursing in all areas. What are the reasons for that? Is it lack of supply of nurses or is it because there are opportunities elsewhere? What do you attribute that shortage to?

Mr Foster—There is an international shortage of nurses at this point in time. I think, realistically, Coffs Harbour and the Northern Rivers in New South Wales have been particularly lucky. They are the very last to see the effects of the nursing shortage. I believe there is no one factor that we can attribute it to but there is a multitude of information and data out there telling us why people have not been joining the nursing ranks.

The most recent data is telling us that we have more inflexible work practices than people are prepared to tolerate. I think the X and Y generations are starting to impact on us. The managers are historically the baby boomers, and we are not quite ready for the impact of the X and Y generations and their expectations. We have to change ourselves rapidly to cope with that fact and make nursing more appealing to that generation of people. They are not prepared to give to the community what the baby boomer generation was prepared to give. They are certainly prepared to give their 38-hour week—do not get me wrong; they have a fantastic work ethic—but they are not prepared to give what the current system expects of them. They are telling us that with their feet. That is my belief.

Dr Hill—With regard to Ms Hall's question, the school of social science has arisen from the disestablishment of two previous schools: the School of Social and Workplace Development, which was based on the Lismore campus, and the School of Human Services, which was based on this campus. The school of social science is one of the biggest schools at Southern Cross University. Essentially, we run two main undergraduate degree programs. The first is a bachelor of social science and the second that is run through here is the bachelor of human services. Graduates in the area of human services go into a number of different areas, some of which include work in the aged services, aged care area.

Ms HALL—I have one more question, although maybe it is more a comment than anything. It links into the shortages that you have in various areas like nursing. As somebody who grew up in this area, I can tell you that I knew that when I left school I would have to leave here. Once someone leaves this area and establishes themselves elsewhere—goes to university elsewhere—there is no incentive for them to come back. Maybe to develop your work force and fix up your shortages in other areas, you could develop your university so that your young people do not need to think the way I thought: as soon as I left school, I thought I had to leave. Instead of this, they might think, 'As soon as I leave school, I will go to university at Coffs Harbour.' I suppose that is more a comment than a question. If you would like to comment on it, please do.

Prof. Graham—I think it is a very interesting comment. It is not the sole underpinning reason for the establishment of a research presence here but it is an underpinning. As we identify what is really happening in the community, what is making it tick and what is responsible for things not working, that research becomes a vibrant part of university activity. You can actually pull that information back into your curricula and you can excite people about the prospects of work in a regional location, in a place like Coffs Harbour or Port Macquarie. We see this as a long-term goal. The whole establishment of ASLaRC will be facilitative not just in terms of service provision in the broader community but in the less direct sense of promoting interest in engaging

the energy and enthusiasm of people to stay in this area. That is certainly one of the underpinning rationales.

Mr Rocks—Ramsay made a corporate decision to become a major provider of aged care services in Australia. Currently, we are the second largest private hospital network in Australia. We have 26 hospitals. The private hospital has had a presence in Coffs Harbour for 18 years. The issue that we are talking about at the moment is very pertinent in that we have had good local discussions and we have got an agreement with Astoria to build a major aged care facility. In doing this, we are meeting two needs: we are meeting the needs of the elderly and we are also becoming a major employer, which is good for the community. But of course we face a problem: where is the educated work force to provide the quality aged care? If you have got a new facility, the easy option is to advertise and poach workers, but we would much prefer to support and work with the local community in its endeavours to retain its young people and educate its middle aged people so that it has got a work force to meet the needs of the people who are coming here and who currently are here. If we are going to be in aged care, we want to do it properly, and the only way we can do it properly is to have good employees.

Mr HARTSUYKER—How does the work of ASLaRC fit with federal government strategies?

Prof. Graham—I guess we might start by asking which strategy. All that we have said thus far resonates with the National Strategy for an Ageing Australia. It also resonates with the Myer Foundation project *2020: A vision for aged care in Australia*; there are many similarities. We have not really touched on some of the financial sustainability elements. They are some of our concerns; we do not have the only expertise to apply to that area but that would then link us to the Intergenerational Report as well. So there is actually good synergy or, if you like, it fits like a glove with those various strategies. This is not surprising and these strategies, whilst they are the newer strategies, have been in evidence in many other forms really since the late 1970s and early 1980s. We have seen this in various Commonwealth funded programs; there has been a very strong attempt to engage the whole of community to cross the sectors and to get strong community ownership of development, and as I said before it is an excellent fit.

I now turn to the Myer Foundation's 2020 vision project, which is a very large tome and covers a lot of territory and covers it very well. In a sense, we are the local version of something which is more nationally focused. If you take ASLaRC, it is the task force. They recommend setting up a task force; we actually have our local task force. They have a very strong focus on work force planning; that is where our research is targeted in the first instance. We are looking at the needs, and we will initiate things once we have identified those needs. So in a sense you have got a local parallel to that work force planning orientation as well. That vision talks about a national research agenda. You can see by virtue of the responses thus far that we have many things to contribute to that. Use of new technologies: that has been spoken about this morning as well. There is also the engagement of the various sectors, including the not-for-profit sector.

Those points were just in the Myer Foundation's 2020 project, but if we look at the documentation which was provided on the government's web site which has led to this committee of inquiry we see similar foci. We see a focus on the intangible as well as the tangible. We see a focus on how you might use a volunteer labour force and not just a paid labour force. We see a focus on the softer side of the enterprise, on changing community

attitudes. I hope that everything that we have said today would indicate that we also have that breadth as part of our set of activities. In summary, I think we actually fit very well with those various elements.

There is one other study that we have some synergies with as well, a study conducted by La Trobe University recently which looked at the recruitment and retention of nurses in residential aged care. That study had funding from the government—it was sponsored by government—as well as from other sources. It comes up with a number of recommendations pertaining specifically to nursing education in all of its aspects. Again, we think we have the capability to respond to a number of those recommendations. The study was done by what was originally the first centre of gerontology, which was established at the Lincoln Institute of Health Sciences in Victoria before it amalgamated with La Trobe. If you take that study, the Myer Foundation and the government, then the fit is excellent across all of those dimensions.

Mr HARTSUYKER—How is the work of ASLaRC going to improve the quality of life for older people on the ground in practice?

Prof. Graham—I think we need to see ASLaRC as a pivot point. Jim talked before about a one-stop shop in terms of service provision. In a sense, in terms of enhancing the community's capacity in providing those services, ASLaRC can provide the pivotal point for that. I think it is because it is in the breadth and integrated nature of our research agenda. We have the capability to serve as a resource not just in research but in evidence based or data driven policy initiatives, and that is important to both government as well as non-government agencies. It is important not to just operate on assumption but for it to be underpinned by reasonable evidence, and some of that is on the softer side of the equation and some of that is the harder data.

I think that we can serve as a clearinghouse. This is certainly part of our original terms of reference as we saw them—a clearinghouse for knowledge and models of good practice. We talked before about the possibility of becoming a demonstration centre in key areas. We can definitely innovate in education and training. We may not have all of the disciplines but we are very good at forging linkages, partnerships and cooperative relationships. UNSW and Southern Cross have demonstrated that but we can extend beyond that, as I mentioned earlier, and we have some other collaborations which can assist that, like the Northern Rivers University Department of Rural Health. We have a very special opportunity here because of the rural clinical school. If you are going to change the face of health professional practice, you really need an in situ laboratory in which students can experience how things might be different. We have that opportunity with medical students from the University of New South Wales, and we see that as a major plus.

It is a major plus because medical practitioners become very influential, if you like, in terms of policy directions for the future, in government and in a number of other organisations, so we think that we have something very special to offer there. Hopefully, we have demonstrated today that we have a pretty strong can-do attitude. As Jim said, we are not here to complain about what we have not got. We will observe on what we have not got, and certainly we do not have some things yet, but we are finding ways to continue our work with what we have. It is through these various means that we are going to be able to improve the quality of life for older people, because this is what will underpin the strengthening of community capacity across all its various facets.

Mr Allsopp—As an operator of aged care within Coffs Harbour for the last 30 years, I would like to reinforce that we do not need a can-do attitude within this research initiative; it is a must-do. Unless we address some of the critical staffing shortages within aged care within this community, we are going to suffer a crisis within the not too distant future, and that will directly affect the quality of care for our aged residents. We only operate residential aged care but—to reinforce what Kevin Rocks and others have said—with any recruitment process within the Coffs Harbour community at the moment, it is a poaching exercise. It is a cyclical move of staff around the various facilities. We have vacancies that we have recently advertised, and the applicants come from other facilities; once they advertise, we will lose staff to them. It goes round in a cycle. It is a closed community. We need to break that cycle by these sorts of initiatives to train the local community and in much the same way to discourage people from leaving the community. But the only way that we can do it is to put in place valid research that supports the education of our community, otherwise the residents will suffer in the very near future.

Ms HALL—What area has the greatest shortage? Is it RNs, AINs, enrolled nurses?

Mr Allsopp—It is right across the board. The need for articulation between AINs, ENs and RNs is absolutely critical because people cannot afford to go away to do the RN training. They want to work in aged care and they can do it through AINs. The problems there are that it is woefully underpaid and they cannot get the skills to move up through the grades to ENs and RNs. Right across the board there is a critical shortage within the community. I know it is a national and international concern, but at the local level we are suffering from it to a very great extent.

Mr HARTSUYKER—Firstly, I would like you to detail any differences between Coffs Harbour and other centres that you might wish to bring to the attention of the committee. Secondly, we have mentioned Astoria a number of times. Before we conclude, I think it would be great to have a very quick run-through of what Astoria is doing in terms of being a different approach to property development which ultimately flows through to aged care.

Prof. Graham—We are almost coming full circle from where Jim began, aren't we? Perhaps I will invite Jim to address the question in the general, and then it would be nice to finish on the Astoria example and local government.

Prof. Curran—It brings us back to where we began—why Coffs Harbour and why are we different? We are not arguing in any way that our problem is different from anyone else's problem—Yamba, Port Macquarie, Batemans Bay and Victor Harbor all have the same problem. What we are arguing is that we have a unique opportunity. There are few other places of this size where you can have the community support that we have, which is incredible. The place is small enough that I know everyone, they all know me and we are all getting on very well together. Very few places with that positive also have two major universities, a TAFE, a high school, educational facilities available and the willingness of a whole campus—information technology, hospitality, tourism, the school of management; it is everyone—to direct themselves towards the problem we have. Suddenly, plonked in the middle of it all, there is this magnificent opportunity of two major developers starting from scratch, so that we can use them as a crucible to put in the things that we see need to be done now.

For instance, I have been talking to Geoff about putting a fibre-optic cable around all his units and houses so that people instantly have cable television, Internet access, banking, fire alarms, personal alarms, movement centres and whatever else we need to do. So we are really arguing that we have the potential to develop regional solutions which I do not think could be developed in the cities—I do not think anyone can get their community together as well as we can—and which can be exported to other parts of Australia and, indeed, to other parts of the world that are heading for the same problem. I would not like to be running these systems in Japan just now—they have got a dreadful problem. The coincidence of development, the sea change movement, universities, the School of Rural Health and my own retirement—as I thought it was and is not anymore—has given us an opportunity. We welcome it and want to grasp it with both hands, and we seek your support. Geoff, would you like to tell them what you are doing?

Mr Smith—It is hard to summarise two years of work but, essentially, we came to Coffs Harbour to develop a residential estate. We followed the sea change and recognised that Coffs Harbour would form part of that. I came to Coffs and discovered the site that we now call the Lakes. It was never our intention to develop anything other than conventional residential property.

Along the way, we met Coffs Harbour Council, who were probably the most encouraging local government body I have ever met in my 30 years experience. As a result of those discussions, Deborah Kuhn, the project manager of Future of Ageing: Coffs Coast, happened to ring me and say, 'Have you thought about putting a retirement village in?' I said, 'Well, not really.' I came back, we talked about it and recognised that there was a real need. We subsequently entered the retirement village business on the Central Coast as a result, indirectly, of those discussions. We looked at the facility that we bought and said, 'Why did it not work? Why did it fail?' It was a mortgagee in possession, and we now have a resolution to that to make it work.

Ms HALL—What retirement village on the Central Coast is it?

Mr Smith—It was the Lisarow Gardens, a Lutheran church facility. Unfortunately they went into liquidation and they lost everything they put into it. Their misfortune perhaps is our good luck. It was our good luck because we recognised that there was an opportunity there. What we found from that was that the successful retirement village model would be one that had not just a whole bunch of self-care apartments, a community centre, swimming pool, tennis courts and bowling green; it had to have something else. It had to have an aged care facility. That is our business model and we recognise that that allows our first residents to come in. Whilst they are never guaranteed of a place, it gives them a sense of security that, if something does go wrong, there is an opportunity for them there.

The other thing we noticed in this business was that a lot of the retirement villages tended to be tucked away in the back blocks; it was usually on the cheapest block of land that any developer could find and they would maximise it. It just did not seem to me personally in looking at that that it was a particularly good model. I heard, in talking to people in Coffs Harbour, that a number of younger people want to come to Coffs and want to bring their family infrastructure with them—Mum and Dad—which is part of their support base. There was nowhere really in Coffs Harbour that that could occur.

I started thinking about it and I thought that at The Lakes we had an opportunity. We had a greenfields site which will ultimately yield, with the lands that we have acquired, in excess of 400 residential allotments. We had the opportunity to develop the retirement village and say, 'How do we make that part of the community? How do we make it so that it is not tucked away at the back of the valley on the worst block of land, basically in a swamp that has been filled?' We came up with a model where the retirement village sits on its own but is part of the entrance to the whole community. So, if people came into our community and wanted somewhere for their mum and dad—or their mother or father independently—to live in a secure environment but close by, we could do that. That is how we developed it.

We then started to talk amongst some of the not-for-profit groups in town. I attended a meeting with my friend Jim Curran. We were talking about all the motherhood statements and how good it was going to be et cetera. We were in the boardroom of the Coffs Harbour ex-services club and he turned to me and said, 'How are you going to staff this? Where are you going to find the staff?' That is not something that we had ever thought about; it just was not thought about. Jim set my mind thinking. You thought that there was plenty of unemployment; you would just go and pluck them off the street. Then you hear the things that Tim talked about—the poaching that goes on. We thought, 'That is not really where we want to be.'

All of a sudden we started talking about forming a working group, and from the working group came ASLaRC. Some of the parties know my feelings about acronyms; I cannot understand half of them, coming from the private sector. It made sense that we form part of that together with Ramsay. Unless we get people in our facility—it is the same in the aged care facility—who are properly trained, who come from the local area and are not poached from some other institution, the thing is just going to go round and round and round. That is where we have got to. We have now signed an agreement with Ramsay Health Care which will provide, going forward, our aged care facility. Between Ramsay and ourselves we will work up a model whereby the facility will run fairly seamlessly. It has been a real education for us and one that I think and the company—my directors and shareholders—think is ultimately going to be beneficial for Coffs Harbour.

CHAIR—Thanks for that. Is there anyone who wants to add anything more?

Ms Kuhn—Good morning and welcome officially to Coffs Harbour on behalf of the Coffs Harbour City Council. I am project manager of Future of Ageing: Coffs Coast. I will be as brief as I can, but it is very important that we mention that the Coffs Harbour City Council's role here has been one of leadership. I suppose one of our initiatives and innovations is in connecting with Jim Curran, who keeps coming back into the conversation and who plays a pretty vital role. We are able to have Jim here and we have not let him go into retirement as yet, and we do not intend to do that for a while either.

Coffs Harbour City Council acknowledges that retirement and aged care is a major industry. It was often looked at from local government as not being its problem, as not being its core business: 'What are we doing involved in it? Let's leave it to the Department of Health and Ageing.' But over the last two years we have set up what we call the Future of Ageing: Coffs Coast. This is a collaborative partnership between a range of players that are here today and also the New South Wales Department of Health and particularly the Department of Veterans' Affairs, Aboriginal Hostels, Aboriginal Housing—and the list goes on. We now have around 115 people

and organisations involved, but we have a particularly strong focus from the consumer. The chair of the Future of Ageing is Cath Brewster, who sits as the President of COTA New South Wales, Council on the Ageing. She brings with her the view of the consumer. Each day that we collaborate in partnership with our other bodies, we are all the time remembering what we are here for.

When I brought in Geoff from Astoria, he was dragged along kicking and screaming originally because it was not his core business either. It was not the interest of Astoria to work in areas of retirement and aged care. But the city council felt that, unless we stopped the roundabout and started looking at how health and ageing impact on the local community, we would just keep getting it wrong. Here sits a fantastic campus which we have been strongly marketing for some time for students.

Answering the problems of how we keep our young people here, how we have affordable housing and how we have the jobs to support that housing is the real issue. What better place to do it than in retirement and aged care? The beauty of that industry is that you have it first of all in the construction. You build facilities which run into millions of dollars and hundreds of jobs, and then you go on to residential aged care and retirement villages, which are long term and sustainable. We felt that it was very important, from the perspective of the university and TAFE particularly, that we could do these local courses and local training and use those facilities to train people on the job.

We could go on and on about what we are doing through the Future of Ageing project, but we are here to support strongly the need for something that has the full potential of being set up here as a centre of excellence.

CHAIR—Thank you very much for that. ASLaRC has given us submission No. 151. I propose that the committee accept the submission and authorise its publication. There being no objection, it is so resolved.

I thank you very much for your evidence today before the committee. It has been very broad ranging and the committee does appreciate it.

Ms HALL—I have one question. Could we have a copy of the slides that you showed us?

CHAIR—They are in the submission.

Prof. Graham—Thank you for the opportunity to appear before the committee. We realise that we had a large block of time to get our message across, to give you our evidence, and that is greatly appreciated by all of us.

CHAIR—We will now have a break for morning tea.

Proceedings suspended from 10.59 a.m. to 11.21 a.m.

BARTLETT, Mrs Kerry Anne, Discharge Planner Clinical Nurse Consultant, Coffs Harbour Health Campus

BURFOOT, Mrs Carol Anne, Clinical Nurse Specialist/Dementia Counsellor, Coffs Harbour Health Campus

CABAN, Mr Peter Lloyd, Clinical Nurse Consultant, Aged Care Assessment Team; Acting Program Manager, Aged Care, Mid North Coast Area Health Service—Aged Care

SNEESBY, Mrs Dolores (Anne), Clinical Nurse Consultant, Aged Care Assessment Team

CHAIR—Good morning. I welcome the representatives of the Mid-North Coast Area Health Service to today's hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to contempt of the parliament. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Caban—Good morning. I extend apologies for Dr John O'Callaghan, our geriatrician, who was to appear here today. He has been called away on an urgent family matter. Thank you for the opportunity of appearing before you today. Our panel consists of two members of the Coffs Harbour Aged Care Assessment Team and the discharge planner from Coffs Harbour Health Campus. Together they bring many years of experience and expertise in caring and working with the aged population in this area. We service the municipalities of Coffs Harbour, Bellingen and Nambucca in the electorate of Cowper. The main focus of our presentation today is on the current gaps in services and needs for our older people.

You would be aware that our aged population is well above the national average. ABS statistics estimate that in 2006, 12,660—that is, 12.66 per cent—of our population of 100,000 will be over 70 and 2,025, or 2.02 per cent, will be over 85. Our over-70 population will increase by 50 per cent and our over-85 population will have more than doubled in the period 2001 to 2016. Lack of support due to the great distance of many older people from their families frequently compounds the problems of care in this area. In our presentation today the panel members will discuss our views on the current situation and field ideas for improvement for your consideration. Dr O'Callaghan has provided the standing committee with a report highlighting several areas of concern for the ageing population, particularly from a rural perspective. I would like to hand over to Anne Sneesby, clinical nurse consultant with the Aged Care Assessment Team, for her discussion on community based services and residential care.

Mrs Sneesby—The experience of the Aged Care Assessment Team here is that the vast majority of ACAT clients wish to remain living in their own homes, despite the fact that they may be living alone and with very little or no family support available. Coffs Harbour is a lovely place to retire to but not such a wonderful place to become frail. We have most of the home and community care services such as Homecare, Meals on Wheels, Neighbour Aid, community transport, and home maintenance and modifications. The problem is the extent of those services and the amount of funding available for them.

Some of the concerns we have in relation to services at home are that older people are generally unaware of them, quite often support is not initiated early enough, the guidelines for entry leave some people ineligible, some services have extended waiting times, some older people find it too difficult to negotiate their way through the system and some older people have the capacity to pay for private services but there is no way of ensuring their safety.

Some of the things we really need here include an increase in funding for HACC services which also should reducing response time; regular advertising of services available to people living at home, because people do not take much notice of what is being advertised until they actually need it; and a single point of entry for services, because it is so difficult to negotiate through services. We also need to ensure that guidelines for services are flexible. An example of that would be that a 63-year-old with cancer is ineligible for a HACC service because they are neither frail, aged nor disabled. Having something there that says that they have a disabling condition rather than a chronic disorder would be appreciated. We also need government accreditation or registration for private services to ensure the safety of vulnerable older people.

We have community aged care packages here, and they have had a very positive impact on the ability of frail or older people to continue to live at home. Although we have had an increase lately, there is still a long waiting list for community aged care packages. I think if community service providers were resourced to enable faster, more comprehensive home support services, the demand on CACPs would lessen and they could be utilised more effectively. Sometimes, because there is no other service available, CACPs are used where maybe the person involved could have managed quite well with a HACC service and the CACP could have been kept for coordination for frail or older people.

At this time we have a shortfall of 57 high-level residential care places and 68 low-level residential care places. On the estimated over-70s population by 2011, we will have a shortfall of 156 high-level places and 192 low-level places. Older hospital patients requiring residential care who are unable to return home are living in hospital and sometimes require being transferred to outlying hospitals to await placement. Our outlying hospitals are a long way from the city, which creates great difficulties for the person involve and also for their carers.

The Commonwealth respite for carers respite coordinating program has had a positive impact on making the most of available respite. It has some expansion funding for respite for ageing parents, for people with a terminal illness and for people with dementia. However, residential respite is inadequate at this time—particularly high-level crisis respite and flexible respite times such as being able to find respite at the weekend. A new facility opening soon will have extra residential care and residential respite places, but that will not really solve the problem of crisis respite and flexible weekend times. So we have problems there as well.

There are approximately 150 admissions to palliative care services each year, with 50 per cent of people electing to die at home. There are no dedicated palliative care hospital beds and no dedicated residential respite or hospice that can provide symptom management and terminal care for people. Many of those who need the service are under the age of 65, and we have no other option at this time but to consider residential aged care places. We actually need dedicated hospital beds and a hospice, possibly a dedicated wing of a residential care facility. We may not have the numbers to support a stand-alone hospice, but perhaps a dedicated residential wing could provide symptom management and terminal care with the staff available.

There is no appropriate residential respite or permanent places for younger people with severe disabilities. Where there is no other option, they are required to access aged residential care. That would also be in relation to palliative care people under the age of 65. We need further negotiation between state and federal governments in relation to the funding younger people requiring these services and younger people requiring palliative care services. We need to develop a cluster system in which a facility provides a suitable environment and skilled staff for the care of younger people. Younger people today are living in an aged care facility with 90-year-olds in an environment suitable for the older person.

CHAIR—Looking over the next 40 years, what do you expect will change about the cohort which will be aged in 40 years time? Do you expect differences in the ageing population? Will their health needs be the same as the cohort which is currently aged? Will there be differences in their expectations as well?

Mrs Sneesby—I think there will definitely be differences in their expectations because the people today are expecting a lot more than is available. We really need to be looking at the use of private services more now. Perhaps the population that is ageing now will be able to afford more private services. I think that is important. Regardless, I do not think that we will ever get to a time when people will prefer to live in residential care. People will always want to live in their own homes. That is the feeling I get. We need to be concentrating on community service provision, on private service provision and on making sure that people remain as healthy as they can.

In regard to health education for people who are retiring now, I do not think we get through to people if we consider things that are disciplinary. People have been disciplined all their work life and now they want to break away from that. When we are talking about education for older people in regard to maintaining their health we need to be looking at making suitable activities available, making sure that they are enjoyable and making sure that the people know that they are available. We need to be looking at one liners rather than an enormous education in relation to health needs of older people.

Mr HARTSUYKER—What issues does the region face in relation to caring for dementia sufferers and how do we address those?

Mrs Burfoot—I was going to read our little paper about dementia services. If I could do that that would probably be a good thing.

Mr HARTSUYKER—Yes.

Mrs Burfoot—In the local government areas of Coffs Harbour, Bellingen and Nambucca there are approximately 1,000 people with dementia. This figure is expected to increase by approximately five per cent per annum. At present, there are very few services in the area for people with dementia and their careers. Many more people with possible early dementia are now being referred for assessment and management. We very much need resources to assist in this such as has occurred in other states.

In relation to community aged care packages and the dementia respite service, people with dementia have equitable access to community aged care packages. However, their care needs

often exceed what can be delivered by a package. There is a very effective dementia respite service, auspiced through community care options, which offers support, assistance and respite for people with dementia and their carers for up to five hours per week. The down side of this is that there are only 10 of these available and the criterion for accessing the DRS package is that the person with dementia must have a carer. There are a very large number of people living in our community who do not have carers; people who in fact live at home alone at risk. These people are unable to access a DRS package.

A range of carer support and education programs run through Alzheimer's New South Wales are available to people in Sydney and areas such as Wollongong and the Central Coast. But for people living in the regional centres these programs are not accessible.

There is very little in home respite available. Respite—and particularly in home respite for obvious reasons such as familiar environment, routine and behaviour—is much needed. Carers of people with dementia become tired. It is truly a 36-hour day. Carers are often frail and aged themselves; therefore, they become isolated, lose their friends and are often unable to leave the home. When asked what they need, respite is always a priority.

Residential respite is also often difficult for people with dementia to access. It is difficult to obtain as there is only one suitable facility in Coffs that does high-band respite at present and will take people with dementia, and they have an enormously long waiting list for respite. Aged care facilities often do not have a safe environment to care for these people and are often unwilling to take them.

There is only one day centre in Coffs Harbour and, although they are willing to take people with dementia and manage them very well, they are not a specific dementia day centre. A dementia-specific day centre is badly needed in Coffs Harbour to allow for specific programs, activities and behaviour management in a suitable environment.

In relation to specialist psychogeriatric units, Henry Brodarty, in his recent paper published in the *Medical Journal of Australia*—and I believe there is a copy of that in Dr O'Callaghan's report that he has left for everybody—discusses the seven-tiered model of service delivery. Tiers 6 and 7 discuss severe and extreme behavioural problems and state that these people need psychogeriatric or intense specialist care units, neither of which are available in this area. We do not have access to a CADE or similar unit and there are no psychogeriatric beds at the local hospitals. Therefore, there is absolutely nowhere for these people to be managed effectively.

Numerous aged care facilities in this area contain secure units, but it takes very much more than a secure or purpose-built unit to manage people with dementia effectively. Skilled, appropriately trained and experienced staff are a core element, as are suitable behaviour modification programs and activities. Education for nurses in aged care facilities is essential and must be provided locally. It is also essential to have sufficient registered nurses in aged care facilities.

Mr HARTSUYKER—What are the typical programs that would be provided at one of those day centres for sufferers of dementia?

Mrs Burfoot—Certainly behaviour modification programs. In a controlled environment, staff would be looking at what might provoke the behaviours that people are experiencing at home and hoping that that would help carers when the person goes home. Staff would be looking at useful things that dementia sufferers can still do, enhancing the skills that they still have and working on changing or modifying any difficult behaviours so that they can be managed more effectively at home.

Mr HARTSUYKER—Given most people's desire to stay in their own home, there are some very great limits on the ability of a CACP to help in a dementia situation. Do you have any comments on that?

Mrs Burfoot—Certainly what community aged care packages do is excellent, but it is probably just not enough. We need more of these DRS packages and probably need people who are accessing existing aged care packages to be able to have more hours on those packages.

Ms HALL—I am really pleased that Luke stopped there, because I want to link into the packages and the availability of HACC in this area. How many people would you have waiting for the aged care packages at the moment?

Mrs Burfoot—I think there are about 40 at the moment.

Ms HALL—I noticed that you gave us the figures in the other area but not for this area. I have taken note of the fact that you said that there is a chronic shortage of respite places. You have one in Coffs Harbour. I also noted that you cover Bellingen and the Nambucca Valley. What about in those areas?

Mr Caban—Are you talking about the day centre respites?

Ms HALL—You can give me day centres plus the availability for people to access two weeks respite.

Mr Caban—Both the Nambucca and the Bellinger have day care centres, but they are not specific dementia type day care centres. I think they are pretty right as far as access is concerned. As I said, it is not specific. It is in with the general population.

Ms HALL—What about accessing set periods of a couple of weeks respite in a facility?

Mr Caban—There are still long waits for that. It can be months.

Ms HALL—And once again no access on a crisis basis either?

Mr Caban—There is no crisis accommodation, no.

Mrs Sneesby—I do not think there is any high-level residential respite in either Bellingen or Macksville.

Ms HALL—Thank you, that is what I was looking for.

Mr Caban—The only high-level respite is in this particular town.

Ms HALL—What is the waiting time to access HACC? What is the availability of home care? If someone who is a little older needs someone to come along and do a couple of hours housework a week, is that available? Or are there long waiting times for that? Is the care that is available through home care being directed mainly toward people who have high-level needs?

Mrs Bartlett—I would like to comment on the hospital-community interface, which concerns me because of discharge planning. HACC services are not designed for post-acute care or for short-term care. Therefore, when people go from hospital to home we cannot access HACC services at all. Currently how the system works is that when the assessor in the area receives the referral she has a target time of doing her assessment in five days. Then, depending on the workload of the local HACC service, it could be two weeks before the service is actually implemented.

Ms HALL—You might like to continue talking a little bit about the discharge process and how it interfaces with the community, how it impacts on older people and also whether or not—from the area health service's point of view—the lack of services available in the community can actually lead to older people spending longer periods in hospital.

Mrs Bartlett—That is definitely true. I find it very difficult with the elderly, with a shortened length of stay in hospitals becoming much more acute. There is a thought that an elderly person who has a fall or a fracture can come into hospital and be discharged after a very short stay. I see people with chronic and complex needs and I do lots of risk assessment, and sometimes the easy part is identifying the risk but the very difficult part is finding what you are going to do to address that risk.

My colleagues have spoken about the lack of respite. Respite is very rarely an option. Sometimes we have to book respite a couple of months down the track; that is the earliest respite we can get. So these people, because they are too much at risk to go home, have to stay in the hospital system until we can get a safer environment for them.

Ms HALL—I think the Cowper electorate is the oldest and the poorest in the country. Would you like to comment on how those two factors impact on what happens with the provision of health services, whether there are unmet and unidentified needs in the community and whether or not any strategies are being put in place to deal with those?

Mrs Bartlett—Sourcing community services for elderly people who access the acute hospital system is very problematic. There is no crisis respite, there is no service that can be put in in a crisis situation, yet that is often what happens when an elderly person is admitted to hospital. With our discharge planning now we look at the whole picture, the big picture, for somebody—the environment that they are going home to. So there is much more of an assessment process when people come to hospital. It is often an opportunity for people to be assessed and for relatives to look at more suitable accommodation for their family members.

I also see a lot of people who are very socially isolated here on the North Coast. They have come here to retire. Often their families are from the city, so they do not have any family here to support them. A lot of the time we have people from afar come in for family meetings. It is very

much a crisis management focus for elderly people with chronic and complex needs. Often their illness is the precipitating factor to a whole lifestyle change. Unfortunately, we do not know what to do with these people when we have not got adequate community services to support them when they leave the hospital.

Ms HALL—From a government point of view, what do you think should be being done to address this issue?

Mrs Bartlett—I certainly think, as my colleagues have said, we need to increase the availability of respite, especially crisis respite. Sometimes people's health will improve, but with the shortened length of stays in hospital we cannot allow them the luxury of having that time. There is a lot to be said for day centres for elderly people and improvements in health promotion. The statistics on falls in particular, and the cost to the health services in the future to care for people who have had falls, are of great concern. The other thing is community services. Community services can be responsive in a much shorter period of time. That includes community aged care packages.

Ms HALL—How do the services, the availability and the issues that you have mentioned here go across into the Nambucca and Bellingen area?

Mrs Bartlett—Unfortunately for us, sometimes we have to send some of our people that are awaiting placement in a nursing home or a hostel to one of our ancillary hospitals, such as Bellingen, because in the Coffs Harbour Health Campus they have to jockey for acute beds, so to speak. That is very sad because Bellingen is very isolated and there is a very poor transport system; there is no transport for people to go over there. But sometimes we have to do that because of the bed situation in the acute facilities.

Ms HALL—That means that hospitals like Bellingen and Macksville could end up having a higher proportion of older people who are just waiting for a placement in a hostel or a nursing home, and they cannot go because of the shortage of 57 high-level and 68 low-level places. In effect, one of their roles is that of a de facto aged care facility.

Mrs Bartlett—I cannot speak so much for Macksville but certainly for Bellingen Hospital, because we do liaise more closely with Bellingen because it is geographically closer for our clients to go to Bellingen than to go to Macksville.

Ms HALL—Because Macksville is more isolated from Coffs Harbour, does that impact on the services that are delivered in the Nambucca Valley?

Mrs Bartlett—I cannot speak to that.

Ms HALL—Maybe someone else might like to. I do not want to direct everything at you, Kerry.

Mrs Bartlett—Peter has worked in that area so he may be able to speak to that.

Mr Caban—Macksville has perhaps a slightly different role to Bellingen, in that it has more acute theatre and those types of services happening there, so there is pressure for beds there as

well. They have had quite a number of aged people awaiting placement in that area. From time to time there have been placements out of area because we have needed to locate people into the correct types of facilities.

Ms HALL—How far out of area would people have to go to be placed?

Mr Caban—It depends on factors such as where they might have family, but sometimes Sydney.

Ms HALL—Maybe you are not the people to ask about this.

Mr Caban—Try us.

Ms HALL—When I look at my own area, I notice that there are a number of beds that have been approved but not built. I think that there are a high number of those within the Mid North Coast area—is that still the case?

Mr Caban—Yes. There is a fair time period—and I am not sure what it is; generally it is two to three years—from approval to construction.

Mrs Sneesby—I know that Woolgoolga has been approved for places, but they are certainly on the way to getting construction done. There does not seem to be a long delay, although there is a long delay in getting things through council, getting the place up and running et cetera. But I do not think people are holding back on actually building—not that I know of.

Mr Caban—It seems to depend also on whether there is an existing facility. If it is a brand-new facility, it will obviously take a lot longer to get up and running.

Ms HALL—Has thought been given to putting in place a process between the council and health and aged care providers et cetera? Once the application for a bed goes in and the approval is given, can it be streamlined? That is, a similar sort of approach to the university, a whole-of-community approach.

Mr Caban—I could not comment on that; I am not sure.

Ms HALL—Can you identify problems in the interface between Commonwealth and state, and solutions?

Mrs Sneesby—In relation to younger people with major disabilities who require residential care, I know that there has been some negotiation between state and federal, but I do not believe any decision has been made as yet as to whose responsibility the funding is. In situations where we have no other option but residential care, the person is admitted to residential care, even if they are under the age of 65 or 70. So it is continuing. There are not large numbers, but it does happen. Those people are being placed in aged care facilities, which are not really suitable for younger people with disabilities.

Ms HALL—What about the fact that health is funded by the state and aged care is funded by the Commonwealth and the linkages there? Is that smooth? There are no problems there?

Mrs Sneesby—Not that I would know of, but this is a different situation, where we are talking about residential care. In aged care and health I do not know of any difficulties. I do not think they would be involved in that negotiation.

CHAIR—Mrs Burfoot, what is the most effective means of preventing cognitive decline in aged and ageing people?

Mrs Burfoot—I do not think there is any sure method of preventing cognitive decline. Because of the new medications that are available, a lot of people are being referred to our clinic for assessment as to whether they have a dementing illness or just early cognitive impairment. Again, there is no follow-up except referral back to us for these people. There are no support services they can tap into. More and more we are seeing earlier diagnosis and a lot of people with early onset dementia.

CHAIR—Can anything be done to prevent dementia before it happens?

Mrs Burfoot—No, unfortunately. There are lots of theories about education, not having aluminium and all sorts of things, but nothing has been proven at all.

Ms HALL—In some areas we have heard about issues of elder abuse. Does that exist in this area and, if so, what needs to be done to address it?

Mrs Sneesby—Yes, we do have referrals in relation to elder abuse. We have a welfare officer who works with us and the referrals would be taken up by the welfare officer. There are strategies in place to deal with that. She would need to be here to explain that fully. We do get referrals in relation to elder abuse, and they are dealt with. Quite often we have the use of the Guardianship Board as well.

Mrs Bartlett—If I could speak from the hospital perspective, it is certainly something that forms part of the risk assessment when we have people admitted to hospital. I have also been involved with elder abuse cases. As Anne said, we usually go through the Guardianship Board.

CHAIR—Thank you very much for appearing before the committee. Thank you for your evidence.

[11.58 a.m.]

PECK, Dr Michael James, Chief Executive Officer, Mid North Coast Division of General Practice Ltd

SPENCE, Mr Peter Mark, Executive Officer, Mid North Coast Division of General Practice Ltd

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

Mr Spence—You may find in the earlier submission by the Aged Services Learning and Research Collaboration a written submission by the Mid North Coast Division of General Practice. At this stage I do not feel that there is much more we could add to that written submission. It may be more appropriate to respond to questions from the committee.

CHAIR—I will start by asking you what challenges are general practitioners in this area facing in caring for older Australians within the community?

Dr Peck—I think it would be fair to say it is probably having sufficient GP resources on the ground to actually give consultation times in an appropriate manner. I think a lot of general practitioners in this area would have waiting times in the order of three to four weeks for routine appointments. That creates a lot of stress. Obviously the ageing population have a higher demand on health services and increased demand for medication and investigation and they present with acute problems, so having long waiting times for appointments tends to make life difficult. As far as the general practitioner is concerned, once the waiting time extends it does become quite difficult to provide what you might consider to be your best or optimal standard of care to the patient group. Therefore, once those waiting times start to blow out, you often need to restrict access to the GP, so you get that situation where people are so-called closing their books to patients because they really cannot manage the increased workload. I think in this area particularly that is a problem. As stated in the submission, we worked on GP to patient ratios according to hours worked and full-time equivalents and we calculated that in the Coffs Harbour area it is about one doctor per 2,300 patients, and that certainly makes life difficult for the GPs and particularly for the patients getting access.

CHAIR—Does the division have any views on how the expertise of general practitioners could be better used in the provision of services to older Australians?

Dr Peck—Probably the basic need is to have people in the consulting rooms consulting on general medical and family related issues. A lot of GPs, particularly in this area, are finding that because of workload issues, pressures and also a lack of appropriate specialist referral services, they are doing other things. They may be doing obstetrics, anaesthetics or skin—for their own personal interest but also because there is a perceived need in the community. Other areas are

counselling and psychiatric services. I think that, if there were more general practitioners available, you would find that they would be able to home in on those more essential services.

CHAIR—How well are nurse practitioners utilised within the practices that fall within the division?

Dr Peck—It depends what you mean, I suppose, by nurse practitioner. I do not think we have any nurse practitioners within our division within my understanding of the definition. The general practices are trying to incorporate specifically trained practice nurses to provide certain standards of care for their patients.

CHAIR—That is really what I meant: someone who can help with management of things like asthma, diabetes, immunisation and so on within the practice.

Mr Spence—I think there may be some confusion about the term 'nurse practitioner'. Is a certified nurse practitioner actually a practice nurse? There has been a reasonable uptake of practice nurses in practices throughout the division for that purpose, to support the areas of enhanced primary care and chronic disease management. There has been a reasonable uptake but there is still more that could be done in that area.

CHAIR—Looking at the issue of dementia and other cognitive disorders, does this region have any particular issues in that area?

Dr Peck—From the GP point of view, one aspect is the provision of medication where appropriate for those issues. According to the pharmaceutical benefit services, to the best of my understanding there are medications available to provide medical help for people with cognitive dysfunction for certain forms of dementia. As far as that is concerned, you do need access to a psychogeriatrician or a specialist in the area. We certainly have quite a marked lack of resources from that point of view and it certainly does place a lot of demand on the one geriatrician—I think that is the expression we use these days, I forget now—to provide that service.

From a practical point of view, that does provide some difficulty. There would appear to be a lot of difficulty in carer support. Domestic nursing becomes an issue and then, as people move from domestic care to needing some sort of institutional care, obviously there are difficulties in accessing nursing home beds and specific dementia related nursing home beds as far as I am aware.

Mr HARTSUYKER—We are part of an area, obviously, that has a much higher proportion of older people. Do you think that the actual management of medications by a large number of older people is presenting a problem in this region as far as making sure that necessary medications are being delivered in an effective way and taken as prescribed?

Dr Peck—On a personal level I would have no doubt that a lot of aged people have trouble managing their medications and the research generally backs that up. Anyone who is taking more than three or four tablets is probably having problems with interactions and problems with remembering these things. Something like the domestic medication review as conducted by pharmacists, those sorts of programs, certainly would have a lot of merit. Generally, most of the general practitioners would be quite supportive of that level of monitoring and supervision. I do

think that the aged population has a lot of trouble with medications and I am sure that does contribute to a reasonable amount of morbidity as well.

Mr HARTSUYKER—Do you think that we need to get more proactive in that area? It is still basically very much up to patients to approach pharmacies. Do you think there is an opportunity there for the community, if you like, to more actively manage that medication?

Dr Peck—Yes, I think so. At the moment, it is often the carer or the family who will come and say that they do not think mum or dad can manage their tablets and ask what can be done. They may approach the pharmacy and they will provide the Webster paks. As you say, it does have to be organised pretty much on an individual level with the agreement of the doctor. When doctors get really busy, it is sometimes difficult to maintain as good a track of those events as you might like. I think that is where practice nurses can come in. Certainly, some of the home reviews and the aged assessment reviews that go on are quite useful as far as helping to maintain and monitor medication usage.

Ms HALL—I have a couple of simple questions I would like to ask you. What is the RRAMA classification here?

Mr Spence—The RRAMA classifications are 4 to 7 in the division area. Coffs Harbour is listed as a RRAMA 4.

Ms HALL—What area does the division cover?

Mr Spence—The Mid North Coast Division of General Practice covers an area from just west of Dorrigo, south to Stuarts Point and north to Ulmarra, which is north of Grafton. That area has a population of approximately 122,000 and is serviced by a GP work force of approximately 120 at any time. The GP work force was alluded to earlier. On a full-time equivalent basis it may well be brought back to approximately 90 to 95 full-time equivalent GPs in that work force.

Ms HALL—You stated that the GP to patient ratio in Coffs Harbour was one to 2,300. What would it be across the whole of the division and—I will choose an area that we were talking about before—Bellingen?

Mr Spence—From recollection, Bellingen is running at a GP to population mix of one to 1,300 approximately.

Ms HALL—What about Macksville?

Mr Spence—Macksville is about one to 1,150, and this fluctuates from month to month because the work force has been moving. It is approximately one to 1,800 at Grafton. We found that Coffs Harbour appeared to have a much lower ratio—

Ms HALL—Which is surprising.

Mr Spence—until recently, when we reviewed the data and looked at the time GPs spent on subspecialty areas and other areas not classified as general practice, and that nearly doubled the full-time equivalent GP to population ratio. That may be an explanation for why general practice

in the Coffs Harbour area has a waiting period of three to four weeks, and a number of GPs are closing their books to other patients.

Ms HALL—That was one of the questions I wanted to ask you. What is the average waiting period for a doctor's appointment across the division?

Dr Peck—I probably could not absolutely, accurately answer that.

Ms HALL—What about for your own practice?

Dr Peck—In my own practice, for a routine appointment it would be three to four weeks. We always try and keep three or four appointments a day for people who ring up with a crisis. We would generally be able to fit them in, so we try to make provision for that. But if you rang up and wanted your blood pressure review or you had a sore foot or a sore ankle, you might be waiting three to four weeks. My experience with my peer group of GPs is that they would have a similar waiting time.

Ms HALL—That really has an impact for the public health system, too, doesn't it, when people cannot organise an appointment?

Dr Peck—Absolutely. We have a very good after-hours service cooperative that works between 6 p.m. and 9.30 p.m., but that does not always help people who need to be seen during the day. I am sure it throws a huge demand onto the accident and emergency department.

Ms HALL—It would have to. I suppose that, because of the shortage of GPs—and you made the point that it is an area of high need: you have an older population, a high Indigenous population, and it is also a poorer area—the socioeconomic factors lead to a greater demand on health services. There seems to be a pretty well-established correlation there. Because of that and the demand on your services then that would also act against doctors bulk-billing in the area?

Dr Peck—Certainly. Bulk-billing is always a bit complicated. There are a lot of GPs who choose not to bulk-bill because they want to maintain control and autonomy over what they do, but I think the majority of people would not be bulk-billing for financial reasons. Our practice, as I think most doctors do for work in special areas caring for patients with special needs, in palliative care or people who are housebound, does bulk-bill. It was always traditional that, for people in nursing homes and hostels, a lot of doctors would bulk-bill, but I know there are a few GPs who are starting to think about moving away from that as well, so there are a lot of pressures against bulk-billing. But I think the main one is really just the adequacy of remuneration, to be fair.

Ms HALL—You have just mentioned another area that I am very interested in—that is, providing GP services to residential care facilities. What changes need to be put in place to make that more effective and work better from a GP's point of view?

Dr Peck—I think it is fair to say that, traditionally the GP will follow their patient to wherever the facility is. I suppose in our area that has been a little bit tricky in some instances because there are a lot of patients from up north—say Woolgoolga or Red Rock—who end up in residential care in Toormina or Coffs Harbour and geographically that makes it quite difficult.

From that point of view, it is very difficult to economically justify a 45-minute drive plus a 15-minute visit to see one patient. So that makes life a little difficult.

Ms HALL—What about the adequacy of consulting rooms and access to technology and things like that; is that an issue?

Dr Peck—I think that is always an issue. It is difficult often to consult with patients. Most of the time when I go to a nursing home, we do take the patient back to their room, but often those rooms are shared. There are issues relating to confidentiality, to privacy, and as much as we try to maintain that, having the curtain pulled around you is not always completely adequate. So I think from that point of view, yes, some extra facilities in those places would be good.

Ms HALL—Do you have any particular concerns that relate to the care of older people in the community and access to services by older people in the mid-north coast?

Dr Peck—There are a few issues. Obviously, they are much less mobile, so they are very dependent on family, friends and services like community transport, because most cannot afford taxis. The public transport system in this area is not particularly good, which is understandable the way the place is spread out. So just getting access is a problem for a start.

As far as access to services is concerned, the hospital here is a bit remote and people have trouble physically getting to the building. Then there is the actual ability to access the services that are here, such as physiotherapy, occupational therapy and podiatry. Those services are extremely thin on the ground and it is very difficult to get an appointment. The public system has a six- to nine-month waiting list for podiatry, as I understand it—I may be wrong on that. So the difficulty is to try to get people to access these services outside. There are quite a few private physiotherapists and a couple of private podiatrists, but they all have to make a living. There are charges and expenses related to that. So there are a lot of problems—as much for the carers, as well. We haven't even got to those yet.

Ms HALL—Definitely. The issues relating to carers are enormous. What strategies does government need to put in place to address the issue of GP shortages, which you have identified as one of the issues in this area—particularly relating it to your area? What strategies need to be put in place to improve access to services by older people and to improve care of older people?

Dr Peck—I think this is a lovely place to live. I do not know why more GPs don't want to come here. The work is very satisfying. The difficulty is to attract particularly general practitioners. You need to make it attractive for them to come. I do not think the financial issues relating to what they get paid here is so much of a problem. I think it relates to spouses—spouse working environments, spouse needs, and education. The whole social infrastructure relating to spouse employment and further education is something you need to look at in urban areas. The medical schools are trying to work the other way by trying to attract rural students so that people are more likely to stay in rural areas. That is obviously a very good idea. It will take a little while for that to fully take hold.

Ms HALL—Can I ask where you grew up?

Dr Peck—Melbourne.

Ms HALL—That goes against it, doesn't it?

Dr Peck—It does a bit. Actually, there are a few Victorian GPs up here. I think this place has a lot to offer. It is just that it is very difficult for us to market that out there to the general population. Having medical students come and see the kind of work that gets done here and the variation that you can have with that is very important—not to mention the sunshine and the surf, if that is what you are into.

One of the main problems the aged population have in accessing is transportation. That needs to be looked at. As a community transport system it works reasonably well here. The problem is being able to physically get people from point A to point B without placing too much of a burden on the family—a lot of whom are working. These are the sorts of costs we don't ever really fully consider. We just say, 'Come down next Tuesday at two o'clock' and everyone has to rearrange their lives to do it.

Probably a much greater emphasis should be put on getting community based services working. The hospital system is encouraging people to early discharge and have care in the home, which is always much more practical anyway—better for everybody. The infrastructure services—domestic nursing, home care, home help and even Meals on Wheels—seem to me to be becoming more and more difficult to access, and I think that is a big problem.

CHAIR—In your submission, which is part of the broader ASLaRC submission, you talked about community and allied health services, that there is not enough of them to appropriately support enhanced primary care. Do you think there is a provision to employ, say, something like a community pharmacist who can actually do medication review in smaller rural centres? Is there a need for something like that?

Dr Peck—We discussed that when we were looking at putting in a submission for a project to run a domiciliary medication management review. It would seem to me that having someone appointed outside the loop, so to speak, say a pharmacist, would be quite a good idea. It always seemed to us a bit of an issue to have one of your peers reviewing what you do and basically either being seen to be critical perhaps or just being seen to provide something that you do not provide. We felt that there might be a bit of natural resistance to that, in having one pharmacist saying, 'We provide the service but your pharmacist does not want it or cannot.' I think having someone outside would be quite a good idea.

CHAIR—Someone from outside might work, yes. As there are no further questions, I thank you for your submission and also for your evidence today.

Dr Peck—Thank you for inviting us.

CHAIR—I thank all the witnesses who appeared before the committee today.

Resolved (on motion by **Ms Hall**, seconded by **Mr Hartsuyker**):

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.