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

FRIDAY, 4 JULY 2003

SYDNEY

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Friday, 4 July 2003

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

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

Terms of reference for the inquiry:

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

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WEIR, Pastor Warren Richard, Director, North West Community Care Inc. 683

Subcommittee met at 9.27 a.m.

ADAMS, Ms Kathryn Anne, Manager, Professional Services, New South Wales Nurses Association

HOLMES, Mr Brett, General Secretary, New South Wales Nurses Association

CHAIR—Welcome to this inquiry into long-term strategies for ageing. The committee appreciates the value of both grassroots experiences and systemic analysis of existing trends and programs. Today's witnesses will provide a balance of local and systemic issues for the committee's consideration. I remind you that the evidence 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 a contempt of the parliament.

The New South Wales Nurses Association has made a submission to the inquiry and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Holmes—Yes, I would. That New South Wales Nurses Association represents over 48,000 nurses across New South Wales. We are the state branch of the Australian Nursing Federation as well. So we are connected throughout Australia through the Australian Nursing Federation.

Nurses work in all areas of health in our coverage, in the public hospital acute sector, community health, private hospitals and the aged care services. Ageing persons come into contact with nurses in all of those sectors. Our public hospital system has frequent contact with aged persons and with the ageing community. A small proportion of those aged persons are in our community. Approximately five per cent ultimately need high-level aged care residential services, formerly known as nursing home care.

Since the review of the aged care legislation in 1997 there has been an attempt to try and remove the recognition that persons residing in aged care facilities require and need nursing care. Attempts to remove even the word 'nurse' from the legislation have been made. That ignores the reality of our aged care system and the people within our aged care system and particularly in the high-care facilities.

Those persons in the high-care facilities are there because they have a multitude of medical and mental health disorders which make it impossible for them to be cared for in their own homes or to be self-sufficient through their latter years. They require expert nursing care and they have a multitude of medical problems. Those medical problems require specialist nursing care. I believe that looking to the future, as the Intergenerational Report attempted to do, we need to be very aware of the need for a nursing work force available and ready to care for the most frail aged of our community. I have grave fears about whether, with the current process that we are in and in the current regime of provision of funding for aged care, we will be able to see that in the future.

Here in New South Wales we have lodged a claim in the state Industrial Relations Commission for a 27 per cent increase for nurses who are working in aged care. We have had to

do that because right now there is an 18 per cent differential between what a registered nurse or an enrolled nurse can be paid in a public hospital compared to what they can be paid in an aged care facility. That amounts to more than $140 a week on base rates. If we are to see an aged care service for those most frail aged in the future, then we have to ensure that there will be nurses willing to take on the role of caring for our most frail aged.

There is also within the low-care sector, formerly known as hostels, the provision of ageing in place, where we see people who would normally be transferred into the high-care facilities, or the nursing homes, ageing without adequate levels of nursing care or qualified nursing care. Their care is being left to untrained individuals or people with qualifications at the level of certificate III. That is unsustainable if we are to ensure that they have a safe level of care. They also have a multitude of medications and care needs that need to be supervised, overseen and provided by nurses.

I believe that the federal government has to look to the future and properly fund aged care services so that it can provide for the provision of care by qualified nurses, paid a reasonable rate of pay and certainly in the situation of being able to be paid at the same rate as their public hospital colleagues. They do the same level of work; they have the same level of responsibility in caring for our most frail aged.

Outside the aged care sector, community health nurses and nurses in the acute public sector provide care for our aged citizens. I believe those services will need to be increased quite significantly to be able to maintain the philosophy that people should remain at home for as long as possible. I do not believe that the programs that are currently in place are sufficiently resourced to ensure that episodal care—for instance, short-tem care requiring community nurses—is properly available to our aged citizens.

Reports from our members who work in community health indicate that, in areas such as Blacktown, they do not believe there are sufficient resources available to provide the full range of care to the community clients. Many community clients wait extensive periods to receive that care. Whilst that is a state health responsibility, the Commonwealth ultimately has a responsibility for the provision of care and the provision of funding to state health.

There are a number of areas where nurses play a very important role in the provision of health care and in health promotion for our ageing. The community nursing sector prides itself on having as one of its major philosophies the need to promote positive health care and the wellbeing of the community, including the aged.

We draw attention to our submission and ask that the committee take our points into consideration, recognise the contribution that nurses make to the wellbeing of the community and, particularly, look to the future and the need to ensure that we will have an adequately resourced nursing work force to care for our frail aged. Whilst a small percentage—between five and seven per cent—of the community require the services of our high-care aged facilities, those services mark the quality of our community and the quality of care that every person in Australia should be entitled to.

CHAIR—Thank you very much for your submission and also for your opening statement. I would like to ask you a question about the submission. On page 3, you said that the funding is

currently based on the notion that the aged care sector is supported accommodation with some care services. The Myer Foundation recently made a recommendation that there should be three funding streams—one based on the hotel type services, one on the care services and the third on the capital. Firstly, do you have any comments on that? Secondly, I would like to explore the notion of using the community hospitals funding model and how you see that operating.

Mr Holmes—The three levels of care—you mentioned hotel type services, care and capital—are certainly issues that need to be addressed. The reality about the hotel style services is that we would call those the hostel arrangements. Obviously, people need to be financially well-off to enter many of the hostel arrangements. The situation is, of course, that many people have to sell their homes and use their assets to move into that area. The other issue is that, as I have mentioned, many people then start ageing in those facilities, and there is a variance between the numbers of those hostel or hotel type services which are connected directly to an aged care facility or high-care facility. The philosophy about ageing in place sounds very nice—allowing people to enter the hostels and then being able to provide hotel type services to them. But there are many instances where, because of that very facility and the way that they are currently being operated, persons ageing in place are being put at risk. Their nursing care is not adequate, in my opinion, to ensure that they have the same standard of care that they would receive should they be in a high-care residential aged care service or a nursing home. That is because of the funding model and the fact that there are relatively few qualified nurses employed in those hostel areas as a direct result of the funding.

In terms of care, there certainly needs to be real growth in the availability of care area. The issue of the availability of nursing home beds or high-care beds has a direct impact on our public health services and on all our members who are in those acute care services where beds are being taken up by people waiting for those high-care facilities. That means that people are held up in emergency departments and there is a slow flow through the health system of those particular residents because of the need to wait for that high care. There is clearly an extensive time frame for some people to find suitable aged care facilities. Many people talk to me about the quality of care facilities. Many of my staff members have had the experience of trying to find aged care facilities for their relatives and they find it very frustrating. You would not be surprised that my staff members, many of whom are nurses, are well able to assess the sort of care they see being provided in aged care facilities and many of them are not impressed with a number of the facilities. Nurses in those facilities are working as hard as they can to provide the care but without, I believe, sufficient resources to do so.

The issue of capital is a very important one. The Commonwealth has increased its standards and has a program of demanding higher and higher standards for the care of residents. I would say that it is a very nice concept to have one- or two-bed rooms to care for aged care residents. But that has a direct impact on the ability to provide nursing care. As nice as it may be, it makes facilities very large without any real increase in the number of nurses available to care for those residents. So we have nurses running from one end of very long corridors to the other end, trying to care for those residents in their rooms. If we are to increase the standards and ensure that aged residents are provided with dignity and privacy then we also have to accommodate that in a real way in terms of the number of nurses that are available. You cannot nurse whilst you are on rollerskates. Many of you have seen funny movies about nurses on rollerskates but the reality is that the workload in aged care facilities is such that if you stretch buildings out and stretch

nurses further then it breaks somewhere. Someone falls over. It is the residents who ultimately lose because nurses cannot get to every need of the residents.

CHAIR—What about the community hospital?

Mr Holmes—The point that we are making there is that the residents in the high-care facilities have multifunction disorders. That is, they may be demented, they may also have a gastrointestinal difficulty, they may have a cardiac difficulty and they may have a respiratory difficulty—all in the one resident, the one patient. These people are patients in nursing homes but legislation has provided and thinking has been that they must be residents in their homes and that it is a home-like environment. Well, it is not really a home-like environment. They are being provided with expert nursing care and deserve to receive that expert nursing care.

The philosophy and the funding mechanism seem to say, ‘It’s just people being cared for in a home-like environment.’ Well, it is more than that. With respect to the level of care that those people require—gastrostomy feeds, IV therapy, tracheostomy care—it is a subacute level of care, chronic care, that needs to be undertaken, along with the immediate issues that arise when ‘chronic’ becomes ‘acute’. Public hospitals are now running programs in order to take expert nurses into the aged care facilities to administer specialist medications, to either oversee the administration of intravenous therapies or enteral feeding or to teach the aged care nurses the most up-to-date of those therapies that would normally be undertaken in an acute care public or private hospital. So those services are being moved into the aged care facility without a number of supportive backups. They expect the nurses in the aged care facility to carry out the same role that the nurses in the public hospital facility are carrying out, yet they say to them, ‘Sorry, we can’t afford to pay you at the same rate; you’re not worth as much.’ That is the message that our members feel is coming through.

You also have to ensure that if you are providing that sort of high level of care, you have sufficient numbers of staff to be able to oversee it. Whilst we welcome the programs, because they provide benefits to the aged residents in not having to be shifted to public hospitals and go through that awful trauma, they add additional burdens in the aged care area. Those additional burdens need to be recognised and corrected. If you are going to provide higher levels of acute type care, then you need to increase your staffing availability. I do not believe that has been properly recognised in the funding mechanisms that are currently available.

Ms HALL—Thanks for your excellent submission and presentation. I have a few questions that I would like to ask. The first one moves a little bit away from your submission. Yesterday we heard from the New South Wales government. They presented a very strong case to us that there were a number of people that were waiting within the public hospital system for aged care beds within the high-care, low-care sector. From the nurses’ perspective, could you validate this one way or another? Also, what are the implications for nurses—and I know we are talking about the aged care sector here—within the health care system generally?

Mr Holmes—The reports from our members certainly endorse that submission by the state government and the health department. Our members frequently report that there are a number of patients in the public hospital area awaiting placement in the aged care sector. As I said earlier, it backs up right throughout the system. Because those beds are occupied, those people cannot be discharged. When a hospital has to close its emergency department to all except

emergency entry, the system is to try to discharge as many people as possible to make room at the front door for those people to flow through. The aged people waiting for high-level care cannot go anywhere. That means other acute hospital admissions have to be pushed out earlier. That has an effect on the whole system, right out into the community, where community nurses are then forced to look after patients with higher levels of acuity.

Those stresses and strains have an impact on our members and, I believe, have had an impact on the ability of health systems to retain their nurses. The level of frustration that occurs when you cannot provide the proper level of care that you have been educated to provide leads to nurses—professional people—saying, 'I can't bear this any longer; I will simply walk away, because it is safer for me to walk away than to come back every day stressed out about not providing the proper level of care. It is easier to say "I've done my bit" and walk away.' We have to change that. There is certainly an impact from having 700 or 900 beds every day occupied by people who should be residents of aged care facilities.

Mr MOSSFIELD—Thank you for your presentation. I want to ask you to expand on some of the comments that you made in your submission. One of the very telling points you made, which impacted on me, was that the aged care system is isolated within the health care system. What is the impact of that?

Mr Holmes—What we are trying to identify there is that the acute hospital system and community system try to work as, I suppose, a system flowing patients through. The aged care system, obviously, is in a different organisational mode. It is run by either not-for-profit organisations or the private, for-profit sector. The interrelationships between the two, I believe, are fairly poor. There certainly is room for improvement in the communication and the interaction between our acute and our aged care sectors. Kate, could that be explained any further, or have I covered that?

Ms Adams—I think you have covered that very well, actually. The aged care system is quite a different system to the public and private hospital system.

Mr MOSSFIELD—Would there be any advantage in restructuring the health care system so that both the hospital system and the aged care system come under the same umbrella and are treated equally?

Ms Adams—We believe so. We believe that older people should be treated in the same way and have equal access to and equal opportunity for health care services as everyone else in the community.

Mr MOSSFIELD—You could even say that there is more need for medical treatment in an aged care establishment where, as you have said, individuals have multiple medical conditions. If a person goes into a public hospital, they go in for a specific reason, a specific purpose, which is treated, and then they are out. There would appear to be a greater need in the aged care system for medical services.

Mr Holmes—We certainly believe that there is an increasing need for high-level nursing care in the aged care sector. Of course, nurses need backup and support from medical staff, but the majority of the care is provided by nurses. In the future we will see, hopefully, aged care nurse

practitioners who will be able to provide the on-the-spot, high-level care that currently frustrates many aged care nurses. One of the real challenges when aged care nurses actually need someone to come and assist or provide medical cover is getting assistance from a GP who is otherwise engaged in their own practice. That is where aged care nurses really have to show their expertise; they need to shine in being able to handle what are sometimes critical situations without the sort of medical backup that they would have available if they were working in an acute public health facility.

Mr MOSSFIELD—In your submission you made the comment that the Intergenerational Report gives emphasis to medical services at the tertiary phase of the problem and rather dismisses preventative services. What is the long-term impact of that happening?

Mr Holmes—Obviously, we believe that if preventative health care, which is largely provided through community programs, is not successful then we will end up with a larger proportion of our ageing community requiring high-care residential services in the future. The other important point I would like to make is that the generation which is heading into ageing also has a much different expectation of standards of care. The baby boomers have certainly experienced higher standards of living and higher standards of health care than some of the people who are currently in our aged care facilities, so the expectations are rising. Let me say that the baby boomers who currently have parents or relatives in aged care facilities are demanding higher standards of care and higher standards of practice, but I believe the aged care sector is without the ability to actually meet those expectations because of fairly restricted funding which does not allow sufficient staff to provide the standard of care that people expect. It is very noticeable to many people who have a relative in an acute public hospital situation. Then they notice the dramatic decrease in the number of qualified staff available to care for their relative. So they see this conundrum of acute public hospital care and then they go with their relative to the aged care facility and find that that is not available. There is only one registered nurse on night duty to look after their aged relative, with four to five assistants in nursing, if they are lucky. You might have 60 residents and one registered nurse on night duty. The levels of care that are available are quite dramatically different to what you would receive in the public hospital system. We believe very strongly that just because you are aged does not mean that you should expect, or should be expected to accept, a lower standard of care.

Mr MOSSFIELD—The committee has heard in other evidence that it is difficult to attract people to work in aged care. Is that the experience of your members? If so, what can be done to overcome that problem?

Mr Holmes—Absolutely. Interestingly, the aged care employers do not want to share with us just how bad the situation is but our members frequently report that for many shifts they are totally dependent on agency staff to provide the registered nurse cover. Aged care facilities are having to pay very high agency fees and high costs of agency care because of the difficulty of recruiting qualified staff. As I said earlier, as we go into the future we will suffer an ageing aged care work force. We point out in our submission that the average age of an aged care nurse is 54. That means that we have less than five years to turn that around to ensure that we actually reduce that average age to ensure there will be a work force.

Aged care nursing is one of the hardest and heaviest types of nursing that you can do. There are many very dedicated aged care nurses who carry on past 60—some even work to 75, we

have found. It is truly amazing that they can carry that workload. For the future, we need to see that aged care nursing is a viable part of the profession to enter. Currently that is not the case. If you expect people to take a $140 pay drop to go and work in the aged care sector, then do not look at the new generation of nurses. Unfortunately, or fortunately for them, young people these days look at the need to provide a house for themselves and education for their children. The idea that you will sacrifice yourself and your take-home pay to go and work in an area that you may love is not going to be sustainable in the future.

Our current work force in the aged care sector may well stay because they feel so committed to their residents and they are used to where they are at. But, if we look to the future, we have to have a system that is able to compete with both the private sector and the public sector to encourage qualified nurses to enter, and that properly rewards AINs. I think many people would be shocked to know that assistants in nursing who are providing direct care for all of the bodily functions of these aged residents are paid $2 an hour less than someone who puts a can of beetroot on the shelf at Woolworths. I do not begrudge any of that money to those shelf stackers, but assistants in nursing currently are not properly valued by the aged care employers. Ultimately, they blame the federal government because of the funding levels for that situation. You cannot expect people to go on forever accepting those tragically low rates of pay—$12 an hour for an AIN with four years of experience. It is a tragedy, because, in terms of relative rates of pay, they are providing care and taking responsibility far beyond that situation.

Ms HALL—Referring to the figures that you have in your submission—and you have touched on it with Frank—in the public sector, the average age of nurses is 44 years and 92 per cent of those are females. The average age of nurses working in aged care is 54. What percentage of those would be females?

Mr Holmes—I would say that it would probably be about 96 per cent or more. I would make the comment that males in nursing tend to gravitate towards the acute, high-stress situations, either in emergency departments or ICUs and those sorts of high-tech areas or high-stress areas, or to education or management. I would have to recognise that males are disproportionately into management positions and those high-tech areas. Relatively few of the aged care nurses are male. There are a number of assistants in nursing who are male, but there are relatively small numbers of males in the registered nurse category and often they end up being managers.

Ms HALL—Of course, this has implications for men who are living in both low- and high-care facilities where their care is constantly provided for them.

Mr Holmes—That is right, and the ideal situation is a proper match of both male and female nurses, because people, as they age, become more sensitive about who is caring for them. It is sometimes beneficial to have a mix of sexes in your nursing staff so that you can meet the needs of residents.

Ms HALL—Yesterday, the state government talked about the need for aged care to be one of the components of the Commonwealth-state health care agreement. What would be your position on this, looking at the implications it would have for funding and aged care within the states?

Mr Holmes—Without knowing whether they were saying we need to have one system of funding, or control of health and aged care, I cannot fully answer your question. But in my

opinion, with the Commonwealth providing aged care and the state providing health care, the reality is that aged care overlaps health care so much now that there needs to be some real discussion about how we will take our services forward in the future. I know that the philosophy is that ageing is not necessarily about being unhealthy. I can only speak from the perspective of a nurse—

Ms HALL—That is what we would like.

Mr Holmes—I think that most nurses are frustrated by the funding schism between Commonwealth and state and the fact that it is funded totally differently. For instance, aged care nurses are totally frustrated that they are under a whole different funding arrangement to the state nurses. Unfortunately, many nurses do not understand that it is two different systems and that that is why we have, at the moment, a great difference in the rate of pay and conditions of work. Those two different arrangements frustrate nurses. Whilst the Nurses Association recognises the history of that, many of our members do not understand it and are entirely frustrated by the fact. Many in the community also do not understand the difference in the funding mechanisms between the public hospital system and the aged care system.

Ms HALL—Many nurses have said to me that they find the RCS very difficult. They believe that the recording, the bureaucracy, the red tape that accompanies the aged care system is a disincentive—as well as the pay structure—and that it takes nurses away from what they see as their primary function. Would you like to comment on that?

Mr Holmes—The RCS has been reviewed, and we welcome moves to improve the situation, but nurses do indeed talk about their level of frustration with the RCS. Nurses in the aged care sector are in a unique situation in that they are almost entirely responsible for ensuring that there will be enough funds for their residents, through the RCS. But the RCS is not a nursing tool; it is a funding tool that nurses are forced to participate in to ensure that there will be money and nurses to look after the residents.

It is quite common to find that registered nurses—the highest qualified nurses in aged care—spend most of their day between two tasks: the administration of medication and the filling out of RCS documentation. The amount of time that they actually have available to assess patients and direct and supervise their care is limited. They constantly have to spread themselves between those two tasks and overseeing the care that is being provided by the assistants in nursing—the enrolled nurses. They find that very frustrating: the time that RCS takes, the numbers of hours that they need to expend on RCS documentation and the frequency of having to do that.

Many nurses talk about a much simpler system where residents are assessed on entry and then there is an understanding that they will be deteriorating—ageing does occur in these facilities—and, if people require additional care, there should be times that they can identify that and time for that increased funding to arrive. They are frustrated by the constancy of some of the RCS that they are doing. Nurses, along with the Nurses Association and the Australian Nursing Federation, have put many submissions to the government about the RCS funding. I understand that the minister has recognised that frustration and that some moves are being made to improve the situation, and I certainly hope that we will see a much more nurse-friendly system that can be used to ensure that aged care facilities are properly funded.

The Nurses Association has been very clear. We do not believe that there should be an open chequebook to aged care providers. We believe that the care that is provided should be acquitted and that aged care providers have a responsibility to use taxpayers' money appropriately. But we also believe that that money should be properly spent on provision of care. Ever since the change to the aged care system, many nurses have harked back to the accountability of the previous CAM/SAM funding arrangements and said, 'God, it was a nightmare, but it was so much better than what we have now. We could actually know that we would be guaranteed that a large proportion of the money that was being spent by the Commonwealth had to come into nursing hours or care hours.' That is no longer the case and nurses are certainly frustrated by that.

Ms HALL—This question is about the age of the work force and attracting younger nurses to aged care. Under the current system in New South Wales, when a nurse finishes university training they can get a 12-month internship, or whatever it is, within various sectors. Firstly, what percentage of those graduates will turn to aged care—do you have any figures on that? Secondly, putting aside the fact of that wage disparity—it goes without saying that that is an enormous disincentive—what needs to be done to attract more graduates to work within the aged care sector? What other incentives and initiatives could be taken to make it more attractive for graduate nurses?

Mr Holmes—Kate, do you have any idea of the figures?

Ms Adams—I do not have any idea. It is a very small amount of new graduates who would be attracted into the aged care sector. In fact, there is a group that runs an aged care career pathway program, and I think they have something like 11 new graduates across the state who are keen to get into that. With regard to new graduates, we at the Nurses Association have an undergraduate network of students who talk to us about their concerns. None of them are keen to go into aged care for varying reasons. One reason is certainly the money but another is their clinical placement. Often they do that in their first year, but they should do it again when they have more knowledge, I think. They are often used as extra pairs of hands and everyone is so busy that they do not have a really good clinical placement. If they could be supernumerary in those positions it would be better. The nurses in aged care are probably just run off their feet, so they cannot provide a good placement to students. So graduates are not attracted to the aged care area. Also, a lot of them are attracted to the bells and whistles of new technology et cetera. I think some would be willing to go into aged care if they were nurtured through, but they need people to encourage them. Nurses themselves need to be more mindful of those nurses who work in aged care and not denigrate them by saying it is a second-rate sort of nursing—which it certainly is not; it is a very high speciality. I think it should be encouraged in the new graduate population and the undergraduate population. Students should study it a lot more at university; that would certainly be an incentive.

Ms HALL—Would nurse practitioners working within the aged care area be an incentive?

Ms Adams—That would be a great incentive, because they could see there would be a career progression other than a management progression. They need to see that there is a clinical pathway for them.

Mr Holmes—I will add to that. The career pathway within an aged care facility is relatively limited compared to the opportunities within the public health system. As you also mentioned, in

the public health system many of the hospitals run new graduate programs, which are 12 months of supported education and rotation around units of the hospital, many of which rotations the graduates select themselves as they try to ascertain which is their area of expertise. I have also had reports from aged care directors of nursing who say that they do not want first year registered nurses in their facilities for safety reasons—safety for that registered nurse, who could be rostered on to look after up to 60 residents on night duty or to oversee four, five or six assistants in nursing. The expertise that is needed to do that is developed over time.

Whilst it will be very difficult to get many new graduate nurses into the aged care sector, I think we do have to, as Kate said, promote aged care nursing. It may be that many enrolled nurses who are currently converting to their registered nurse qualification through the university system would be very good candidates to work in aged care because of their previous experience in nursing. They certainly start out in a better situation than many new graduates who come from university without any previous nursing experience. So there are groups of nurses who could be eligible to go in there.

We have to make aged care a viable area of the nursing profession, and we can only do that if we can stand it on an equal footing and say, ‘You can go and work in aged care without taking pay cuts and with the expectation that you will be provided with education and support and that there is some sort of career structure for you.’ Currently you can be a registered nurse, or what is called an assistant director of nursing. In large nursing homes, you might look after a number of units, wards or whatever they call the residential parts of a large nursing home, or you might be the deputy director or director of nursing. It is scary to see that sometimes registered nurses with as little as five years experience get promoted to be directors of nursing. That is an example of the lack of experienced nurses prepared to take on the very difficult roles of managing those nursing homes, ensuring that there is sufficient funding through the RCS and overseeing care by a large work force of less qualified people.

CHAIR—Thank you very much for the evidence today. I wanted to ask you some questions about making ‘aged care nurse’ an attractive subspecialty, but I think you have responded to Ms Hall’s questions. Is there anything further you would like to add?

Ms Adams—I do not think so.

Mr Holmes—Thank you for your time.

CHAIR—Thank you very much.

[10.21 a.m.]

AGYEPONG, Ms Bernadette, Generalist Caseworker, Blacktown Migrant Resource Centre

ROSS, Ms Irene, Manager, Blacktown Migrant Resource Centre

CHAIR—Welcome. 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 a contempt of the parliament. Do you have any comments to make on the capacity in which you appear?

Ms Ross—Bernadette Agyepong is the generalist community settlement service worker covering Blacktown and Penrith. Prior to this, she was the Ghanaian worker in the Sydney metropolitan area.

CHAIR—Would you like to make an opening statement before I invite members to proceed with questions?

Ms Ross—Thank you. Blacktown Migrant Resource Centre welcome the opportunity to have an input into this inquiry. We hope that this inquiry will facilitate the development of more coordinated, inclusive and responsive aged care services to meet the diverse needs of our aged and ageing population, particularly those of culturally and linguistically diverse backgrounds from smaller populations, including the more recent arrivals with a wider gap in culture settling in Australia today.

It must be recognised that the smaller groups often can and do miss out on receiving services or services that are culturally appropriate to their needs. In general it is more difficult to provide culturally appropriate care to someone who is from a different culture and language to one's own. I am not sure how many services or facilities which are open to all, or are providing multicultural services, have information translated into all of their residents' specific languages and have language specific staff, food, music, activities and religious ceremonies as well as have their input into the client satisfaction surveys to see what changes are required within that facility or service. Indeed, due to lack of information, many residents do not know or understand their rights, and their families are equally unaware of what to expect from the services.

The withdrawal of financial assistance towards establishment of aged care facilities has meant that only those with money are able to provide for their own community. Furthermore, entry fees or contributions to residential care have impacted on the smaller providers as well as clients, and clustering has become more difficult to carry through. The reporting requirements have further eroded language specific staff in aged care.

Community care providers have similar problems. Community care also adds a further difficulty for people from culturally and linguistically diverse backgrounds in that they are confused by the differences between the same service types providing different services in different locations. The complexity of the HACC system and the lack of information to these

communities are precluding them from accessing services that they require. It must be said that these groups are not utilising services and are unable to shape services to include their needs, thus perpetuating the gaps in services, particularly for the smaller groups.

Recent consultations organised by the Blacktown Migrant Resource Centre for the New South Wales Committee on Ageing confirmed that gaps identified in the 1990s and previous to that continue to be the gaps in services today. There is and was an indication that the aged care system is confusing—that there was a lack of information, a lack of language specific workers, a lack of culturally appropriate food and a lack of services familiar with their customs and needs.

While services cannot meet each and every individual resident’s or client’s needs, there are some strategies that can be employed to address some of the gaps that currently exist for the present older generation, as well as for the future, irrespective of the aged care structure that will be established. The newer communities will require us to rethink what is provided and how to meet the aged care needs of these communities that are currently settled in Australia. Coordination and centralisation of some services must be examined.

A clearer pathway is required to the aged care system across all service types that are required by older people and the frail aged, including services that are provided by migrant services and agencies. There must be consistency in information, particularly for the same type of service, irrespective of location or of the service. A single service or an agency should be designated to develop and distribute standard information on aged care to all communities and groups, using various medium as appropriate. Information needs to these communities in contractual matters must be considered very, very seriously, because they are actually buying in or paying for services, so they have to have equal rights.

A weighting is required for culturally and linguistically diverse clients in facilities and services, to acknowledge the services’ requirements to use more time perhaps to get equitable outcomes for those particular clients. Interpreters should be freely accessible to all services and agencies that provide services to people in aged care from culturally and linguistically diverse backgrounds. A centralised funding allocation would assist in coordination as well as monitoring the use of interpreters across the services and locations, and would provide for a better planning system for interpreter services.

An agency or agencies should be established, to recruit and train workers for aged care services for the smaller communities, that could be accessible to aged care providers across the various services and various locations. The present Department of Immigration and Multicultural and Indigenous Affairs model—the Community Settlement Services Scheme’s small and emerging communities funding model—would allow outreach services to be located in particular areas, allocating workers to work with X number of services to provide language specific links from the community to those services.

Formation of community groups for the well aged should be encouraged by government to assist in the development of community spirit—or social capital development—within these communities as an assistance to the general community. This, in particular, is extremely important in maintaining the health and wellbeing of the older population. One example is post-World War II, when migrants who came here were actually in camps. Whilst many people may not have thought that the camps were a good idea, they facilitated the development of networks

across the various strata within the communities which worked towards achieving positive outcomes for the communities. Today people are processed very quickly, are located in the general community as sole islands and are therefore very much isolated and will not be able to look after their own as well as the previous older generation has.

Finally, engaging both the old and the new communities is critical in the development of new structures for improving present systems to accommodate their needs. Extra support will be required for the people who have come out here now who have had a longer trauma torture experience in camps overseas before they came here. This will require mental health services expertise; it will require looking at all the other services that will be needed in addition to what is provided today. Also additional changes are required in ageing and aged care work—or professions—to assist the care of our elders in the future, and I think these should begin in our schools.

At present aged care is devoid of workers from some community groups. When you are looking at providing services to somebody who is from a particular community group it is really not appropriate for the person providing that service to be from a totally different culturally and linguistically diverse background who does not understand anything that they really have to consider in provision of that service.

There is also a very low view of the aged care professions. Aged care is usually seen as housekeeping or cleaning. That is not a way to attract people into that profession, so we really need to look at that aspect. Also, if we are looking at changing the population's view, we have to look at schools taking on board the fact that ageing is part of the process, to change the images that we have today.

CHAIR—Thank you very much.

Mr MOSSFIELD—Can you give the committee some examples of particular multicultural groups which the migrant resource centre is providing specific aged care assistance to?

Ms Ross—Currently we are providing for four ethno-specific groups, with the Polish, the Ukrainian, the Maltese and the Filipino packages. We have multicultural packages which access Tamil communities and the more recent arrivals as well.

Mr MOSSFIELD—What about the Sudanese community? Are you doing anything specific in that area?

Ms Ross—We have workers who provide services to the small and emerging communities, which include the Sudanese, the Ghanaian and the Tamil. The Sudanese community is broken up, as you would know, into two sectors. The northern Sudanese are very much the community that is expected to speak Arabic, and the southern Sudanese speak African languages, which are new languages to what we are now working with. They also have traditional ways of providing care across both of those communities. If you had to use a model, it is very much like the Indigenous communities here today, because they have the elders who make decisions. It is about networks within the family that provide for those communities. But we have people who are coming here who have been out of education for 20 years or more and who have no understanding of what our standards are, even within the home. They are orientated to what a

fridge is and what it is for and how to use a toilet. So we have people coming here who are not familiar with what we take for granted as being our way of life.

Our service is looking at the whole spectrum of a family's needs. We can see that there will be a lot of challenges to providers in looking at how to provide for those people, particularly when men cannot provide for women and women cannot provide for men either. There is no way that a Sudanese woman would provide personal care for a male. Therefore, you are looking at specific groups having specific needs that have to be considered today, particularly when you have a large intake of females with special needs and I do not know how many languages there currently are—but you are also looking at people who cannot be provided for by our current systems.

Mr MOSSFIELD—I can see that it would create enormous difficulties for your centre to look after those people's interests.

Ms Ross—We have bilingual workers who are familiar with the communities from where they come from. They know what the standards are overseas. They also know what the standards are here. Therefore, their role is very specifically to look at what the custom is here and how we can actually integrate those communities into our community in a way that is acceptable, easy and not confrontational. We look at what sorts of mechanisms we have at the moment and work with services to make those services understand what the requirements are for these communities. So we very much provide training to the communities on how to work with these people.

Mr MOSSFIELD—Is there any liaising between the major nursing homes in the area catering for multicultural groups, which would appear to be quite well-resourced, and the people you represent?

Ms Ross—You will find that the newer communities are very few and far between in residential care. The majority of people who are in aged care at the moment are from the older migrant groups, and they are in a similar situation to the new ones in that they do not really have very much that is responsive to their needs, and the community does not participate. The workers at our centre can only link people to services. We do not provide services in those centres as such, because our funding deems that we cannot. So I think we need to look at how to bridge that gap.

As far as the nursing homes in this area are concerned, the people who are coming into these facilities are actually gathered from all over New South Wales. If there is a Hungarian nursing home, it would be people not just from this area who are located there but also people from whatever Hungarian group they can get. It is the same with the Germans and so on: their own communities bring them in. We do work with the general service providers through the community aged care program, with the aged care services association, to understand what sorts of issues there are.

Mr MOSSFIELD—You obviously have the current problem of ageing people and the services you must provide. Have you given any thought to the migrants who will age over the next, say, 40 years and what services you may be required to provide for them?

Ms Ross—Whilst I was saying people are very different when they arrive in Australia, unfortunately the impact of the Australian way of life changes their perception or changes their ability to provide for their own communities. Whilst today the new communities look as though they will be able to facilitate their own care, that they will have members of extended family who will provide that support—the uncle and aunties and so on who work towards that—when you look at the people who are trying to establish themselves here, both husband and wife will end up working. You will see these communities being pushed as to how much they can actually provide for their own families. I know there are some people at present who have some people in residential care, and it is a traumatic experience because their values are being challenged by their inability to provide for them. Some of them actually visit them daily to provide them with food and everything else because they are not getting that in the residential facilities. While it does look as though we will have changes, the changes will be that the perceptions and the religious backgrounds of the communities coming in will require us to do certain things that we would not have done in the past in that they will not have certain procedures done in the future that they have now. I will ask Bernadette to expand on that.

Ms Agyepong—As people are not used to asking other people to care for their aged, it is a challenge. There should be community education for people to understand that there is a need for them to put their people in care. People normally say, ‘We’ll look after them,’ but they do not receive the sort of care they really require. They leave them at home and go to work and that kind of thing, because they also have their own lives to lead.

Also, people do not really have the resources, because they are new settlers and they are fighting for their own settlement needs. This makes it really difficult for them to meet the care needs of their aged. People do not think of the aged in terms of preventive care back home in other countries. So the old people who are coming in are not used to preventive care, and that should also be emphasised so that people will age healthily and there will be less need for them to be reliant upon others to give them care. The fact that people are not used to being in boarding houses or being away from home, away from their nuclear family, makes it really difficult for them to accept that when they are old they should leave home and be cared for by strangers. They do not know about that and do not even understand, because people normally revert to their own languages when they are old, and it is really very difficult.

Ms Ross—I would like to add a little more to that. Many of the people who are arriving today are single mothers who have six or seven children with them. So there will be an inability to pay to get into aged care accommodation. Even now, we are having difficulty finding accommodation for these women, and this is not going to go away. If we are looking at facilities to be built, perhaps we will have to look at how to accommodate the styles required. I turn once again to the Indigenous models that we are always talking about. It is about a family nurturing its own, and they are going to be caring for their own. So there is that sort of commonality between some of the newer communities and those that are functioning at the moment.

CHAIR—What do you expect the differences to be with the current cohort of migrants as they age over the next 40 years? Do you expect any differences between that group of migrants compared with the current aged group?

Ms Ross—If you are looking at the smaller groups, I can see common bonds across the ones that we have now and the ones that we will have in the future. The same sorts of issues are

coming up for these groups. I believe the second generation working in the sector or in services that deal with aged care will be much more informed. For those that are not in any way connected to those services, there will be no understanding of the systems, unless it is cleared up and made much more streamlined.

The biggest thing that I can see is that we must have more services catering for the Muslim communities. In the past, irrespective of the religion, apart from the Jewish homes that used to cater for their own, the rest of the community tended to fit in wherever there was availability. We now have more communities that have very strong religious or cultural needs. That will make a difference to aged care in the future.

CHAIR—Looking specifically at Blacktown, the Sudanese community consists of a significant number of refugees, as I understand it. Do you expect this group to age earlier due to the trauma they experienced as refugees and perhaps the health care they may have received in their country of origin?

Ms Ross—The people that are coming out here under the humanitarian program already have problems when they arrive. They have been traumatised, they have been sexually assaulted, they have seen people killed, they have lost their parents, they have lost their families, they have lost their husbands and so on. The mental health care needs to be incorporated into the system now so that it does continue right across as they are ageing. As we know, when a person gets older, their memories become much more vivid and therefore those people will need to have a lot more services focused on mental health care needs. Assessments will be impacted on as well, for example dementia, if somebody does not know the exact behaviour of that community, they are assessing them according to their own norms, and people can be assessed incorrectly. Assessments may need to be looked at by mental health services rather than dementia care providers. For that group, you really need to look at having a more integrated system.

Ms HALL—Thank you for your submission. I am very interested in work force issues. You mentioned a little while ago the issues of males caring for females and females caring for males—mainly females caring for males, and the problems that creates for various groups. Would you like to expand on that?

Ms Ross—The work force has been a challenge before; it will be much more so now. We now have about 66 new groups. With the work force, we are looking at people who are not used to having male doctors; the family cared for them. For example, for women who had FGM problems, they had females to care for them. They will not go to a nurse in a hospital unless the nurse is from that background or able to speak that language and understand what procedures, religious rites or cultural customs they had overseas. Because they are not the same as the rest of the women here, these people will not be able to accept services from somebody who does not consider them to be normal. What is normal differs between some of the new groups and the previous ones.

I think we need to look at how we recruit males and females—how we make the nursing profession more glamorous or better paying, and give much more credit to the sector to encourage people to come into it. I also think that at the moment we do not have enough of a mix of workers from the various community groups. There are only a couple of communities that are very strong in the profession. For people with dementia, for example—especially if they

have been at war with the particular community group from which the nursing staff have come—it is like putting them in prison again. You have to be aware of what is the right type of service for that individual and ensure that it is provided by the right people.

At the moment, there is difficulty in recruiting. I think that community education and information are really important to encourage a greater participation by some of the smaller communities, it is about recruiting people—through workers like Bernadette—who are interested in working in the sector. We have done that through some community groups already. We need to get them trained and certified so that they can provide care to these people. Again, there is a different model required, not just nursing. A lot of them will not go into nursing, because they have been out of education and they have problems with English. We can look at what else we can to do to ensure that we have the right skilled people providing aged care in the future.

Ms HALL—Given that assistants in nursing are probably some of the lowest paid workers in the Australian community, and given that in areas like outer metropolitan Sydney a high number of people come from non-English-speaking backgrounds, do you believe that some initiatives need to be put in place to improve the status and the wage structure for workers employed in this industry?

Ms Ross—I definitely do. I think we need to look at proper remuneration.

Ms HALL—Also include in that how you think this should be done, and what should be done to increase the status associated with this kind of employment.

Ms Ross—It starts with government saying that these people are valued. Firstly, there should be an increase in income. The occupation should be seen as a profession rather than as just a housekeeper—and there is that perception in the community. I think that if communities are educated about the value of the sector more people will enter it. There are many different individual communities residing in rural and remote areas, so the same model I raised before can be employed there too. Outreach services could go out to those centres to provide some links. Health centres are also providing services there, and they could look at a bilingual educator providing that sort of link. Again, it is about recruiting from the community but with government overarching it, saying that it is valued and that it is something that the community really wants.

Ms HALL—Bernadette mentioned a moment ago how, when people age, they tend to lose their English and they rely on their first language. When this committee first started hearings, down in Canberra, this was a question I raised with some bureaucrats—how we cater for people from non-English-speaking backgrounds who are in residential care. It was put to me that it should be up to the family members to be the go-betweens between facilities and government and all those different bureaucracies and organisations that people have to deal with. What is your comment on that statement? How do people cope if they do not have families? What structures are in place and what structures need to be in place?

Ms Agyepong—That is not good enough. It is just passing the buck. They should rather look at ways of improving the system, because people are coming in—there is nothing we can do. They do not have skills, or they lose their skills. It means that these people are somehow being looked on as second class and therefore not requiring the same level of care as people from

English-speaking backgrounds. Even when families are able and do understand well enough to interpret, we should bear in mind that they have their own interests, which will override those of the client or the patient, and therefore family members are not the best people to use as go-betweens, mediators or advocates for these people.

There should be a system. If they do not want to pay for interpreters, they should recruit—promote the work, as Irene was saying—and get people from other backgrounds working in the field by having this sort of career pathway. You could start as an AIN, but then progress and become someone in future. That is also one way of attracting people, because you can work in the aged care industry for 20 years as an AIN and you will receive, from four years going in, $12 for the rest of your life. That is also something that is not worth while and attractive.

The job should be made attractive and we should get people from other backgrounds to take on the job as nurses in different capacities. Also they have these people like diversional therapists, who have therapy with them. Maybe some of them should have multilingual skills to deal with these people, because people really do feel at home and at ease and are able to enjoy whatever is being offered them when they understand you. Otherwise you will misinterpret what they are saying, and they will just keep quiet and sit there without understanding really what is going on. That will be very sad. We will be killing them before they reach their death, and that kind of thing.

Ms HALL—It is really isolating people.

Ms Agyepong—Exactly, and it is making it really difficult and frustrating. That is why people become aggressive. If they do not understand, and no-one seems to care for them, they use aggression to get their point across.

Ms Ross—If people think that those that are speaking a language other than English should have their families provide for them, are we going to provide that care free? If it is provided free, that is fine. There is a difference between what residents get, and what services are capable of doing. We have a sort of charities model—those for the poor, those for those that can provide and so on. Then you have those NESB groups that are going to be provided for free, because they are going to have a home away from home, people providing them with food and coming in and doing all the activities—washing and cleaning and so on. That is a different model, if that is the model we are going to adopt. But it is very much recognised that not everyone has a family and, irrespective of which country you come from, once you get older you do not plan for the future. You think in your first language; your first language is something that you reminisce in. The more you reminisce, the more you are away from people who can speak English, the common language—the more you forget the second language.

It does not matter whether we stop migration today. If the people we have here maintain a second language, this problem will continue. So we have to look at how the current system meets the needs and looks at the standards of care and how we monitor the data and record what sorts of services are provided and whether there are specific things that we need to look at or do. Maybe we should do something with clustering that is different, such as lower entry fees and such to assist to provide for so that we can provide for many more in a single facility.

It also then goes on to show that we need to train people who provide aged care services and look at the composition of management within those organisations so that there is a good mix of different understandings, different cultures and different ways of doing things so that we can do more than just tinker at the edges about developing something that is responsive. Let's face it: Australia is very diverse and the diversity is not going to go away. If we are going to do something we have to make sure that we are very inclusive of all Australians.

Ms HALL—Would you like to address the issue of isolation for older people from non-English-speaking backgrounds living within the community?

Ms Ross—Isolation within the services that are being provided or living within the community on their own?

Ms HALL—How do you identify those people living in the community who are not linked to your services or a migrant resource service and link in to them and ensure that their isolation is dissipated?

Ms Ross—With some we actually fall over them because people bring them to our attention, especially older people over the recent months.

Ms HALL—Is there a structure that governments should put in place to address this issue?

Ms Ross—Absolutely. With the newer communities now coming in, it is very timely to look at our structures and the system. That would begin with when people arrive and the orientation program. They then go into the longer term accommodation. You have the population data and movements—local government, Centrelink and the Commonwealth—even though people come into an area and then relocate to different areas.

There are measures that we can put into place. We know exactly how many are coming in and what sorts of community networks they have. We have people proposing people to come into Australia who are only very new themselves. They do not know the system, they cannot understand exactly how we function, but they are also supporting other people coming in. Those people are going to be isolated—little islands on their own. They are already saying that they can manage but I think the current system cannot provide for these groups.

When it comes to older people who no longer drive—and a lot of women in many of these communities do not drive—if there is no network in the community, it is going to be terrible. I think we are looking at local government and at other community groups taking on some of the facilitating and the community capacity building responsibilities.

Ms Agyepong—Centres where old people can come together and act socially have programs designed to help. The time comes when they take over and run the groups themselves. Those who know can inform others of what is happening out there and where people can go for help. They can also have people go there, including health workers and social workers, to help and educate them about the system and what is happening and what their needs are. We can also have community educators going into these places and telling them about ageing, what is happening to them and the sorts of things they can do.

This will help to break their isolation because it will give them some social activities. They can talk to each other and do things that are beneficial to them instead of stay at home by themselves when their children are not there. Some of those who live alone do not even see anyone for days on end. We will also be able to know what is happening with some of them and have services cater to these people. This will help to break their isolation and minimise the need to put them in residential care because they will look after their health, eat well and have some exercise. There are some light exercises that people can do with them in these facilities that will help them.

Unfortunately, these measures are very limited. We do not have centres. We have a lot of requests for rooms in our centre but we cannot cater to them because we do not have the accommodation. We also run groups for different people to help break the isolation and help them to mix with the general community and feel part of the Australian community that they are in. That is also a strategy that the government should look at.

Ms Ross—That is why I said earlier that we really need to look at services for aged care right across the whole sector, including migrant services. The families that are coming in have parents as well, therefore they come into the migrant services first and then they transit into the community. When we are planning for services we really have to examine all services that are currently provided that are linked to aged persons.

CHAIR—Thank you very much for your evidence today.

Proceedings suspended from 11.01 a.m. to 11.16 a.m.

McCALLUM, Professor John, Dean, College of Social and Health Sciences, University of Western Sydney

RUSSELL, Professor Cherry Lee, Associate Professor, School of Behavioural and Community Health Sciences, University of Sydney

CHAIR—Welcome. 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 a contempt of the parliament. Professor McCallum and Professor Russell, you have both made submissions to the inquiry, being Nos. 132 and 133 respectively, and copies are available from the committee secretariat. Would you each like to make an opening statement before I invite members to proceed with questions?

Prof. Russell—I would like to thank you for the opportunity of talking to my submission today. I have been involved in this field, both as a researcher and an educator, for more than 20 years and I had to think about which hat—researcher's or educator's—to wear when I was writing this particular submission. I decided that education was it because, whereas I have seen massive changes in awareness and action at the level of policy in relation to direct service provision and that kind of thing, over this period I have not seen comparable changes in approaches to educating the work force for an ageing population. It is all very well to have well-planned services in place, but services are delivered by people and if those people are not appropriately knowledgeable or skilled then it will not work as you intend it to work. Whereas the Commonwealth has taken a lead—quite rightly so—in areas of aged care, healthy ageing and all the rest of it, I believe that in a country like Australia it really is a matter for a federal government to take the lead in developing a systematic, coordinated approach to the educational needs of the work force. I am particularly aware of the health work force issues, but I do not believe that it is limited to the health work force. We are going to have more and more older people accessing the full range of public and private services, so there is going to need to be an understanding of ageing related issues across the board.

I am also speaking as somebody who, for this period of time, has developed and taught professional programs in gerontology, both in Australia and offshore—in Singapore. There seems to be a greater level of awareness in some areas of the Singaporean government of the importance of an educated work force. I know there has been a lot of discussion about the need to educate those who are at the coalface—AINs and those sorts of people are where most of the attention has been directed—but, from my perspective, it is extremely important to ensure that best practice is modelled from the top down.

It is extremely important that senior professionals are encouraged and supported to develop specific ageing related knowledge and skills. I know that, in Singapore, for instance, if you are a professional employed in the health department and you get a further qualification while you are employed, your salary automatically goes up the minute the award is conferred. I think that is a particularly interesting model to think about. But, of course, for systems like that to work there has to be collaboration between governments, industry, the professions and the educators. I think

that really only the Commonwealth is in a position to take the lead and set up an infrastructure that is going to work through some of these issues.

Prof. McCallum—Thank you very much for the opportunity to speak. I would like to thank the committee for meeting in Western Sydney, where my university is located. I am normally heading to Canberra or central Sydney for such inquiries. I do not intend to make a long opening statement, except to say that I am most interested not so much in multiplying up demography, which is the normal way we deal with ageing, but in thinking about the changes we need to make to our institutions and the way we do things, because we are a very different society.

I have thought about this and touched upon five themes in my submission. The first one is older workers. I think that is changing as we talk, but it needs a lot of attention. The short and perhaps glib way of saying what the issue is there is that the people who do not need to work can get jobs in older age and the people who do need to work cannot get jobs. That is a bit glib, but that is the essence of the issue put simply.

I think we need to talk about the dynamics of assets and health and care needs rather than the costs of ageing—that is, the dynamics of government support, personal income, private income and informal care. It is not a simple matter to do that, but I think we need to approach it. We cannot fix it by dealing with one part of it. I think we need to seriously rebuild community care. We cannot move forward in an ageing society without a better and smarter community care system. We do need to intervene to promote healthy ageing. By that, I do not mean just non-smoking, heart disease and cancer; I mean the care needs that people have as well, which would be around things like continence, depression, disability and so on.

Finally, I think that, at the end of the day, an ageing society has to do business and have economic growth. There are lots of opportunities in internal trade and business and in external exporting of aged care services. They are the five things I thought were the most important in terms of our thinking about the longer term and ageing.

CHAIR—First of all, on the work force issue, you have outlined some of the priority areas for increasing work force participation amongst older Australians. Do you have anything to add to that? What do you see as the priorities now?

Prof. McCallum—I think there is a clear priority about getting a better fit between the natural capacities and limitations of older people and the workplace, and there is very good European work from Finland about that. That is the first thing you have to do. There is an estimate from Finland that somewhere near 30 or 40 per cent of people over 55 are disabled by the way the work and the workplace are structured rather than by their own limitations. That is a really important part of it. I think we do need to look at the motivations as well. That has a bit to do with the social side of work and how work is organised, as well as the physical, ergonomic side of work. If we work on those things, we can allow natural forces of supply and demand to work.

There is perhaps one unintended consequence of this that would concern me. There is a labour shortage in some areas which is drawing young people from Western Sydney and from the fringes of Sydney into jobs downtown. That is very reasonable. I know from anecdotal evidence that recruitment firms are saying to major firms: ‘Don’t bother with these people; they’re too much trouble. Why don’t you get an older worker?’ That is anecdotal; I do not know how

widespread that is, but it is a logical way to go because we know the capacities of older workers are probably at a higher level of skill and they have a greater level of dependency than some younger people. I would be concerned if our fixing one problem creates another—namely, that we are not drawing in young people to jobs where they gain skills and life experience. If that is an unintended consequence, we need to deal with it and be conscious of it.

CHAIR—Professor Russell, at present what sort of exposure do the different health care professions give, in their education and training, to the issues of caring for and treating the older population?

Prof. Russell—Over recent years there has been a bit of improvement at the undergraduate level but, by and large, in my experience, ageing is still, if you like, a minority issue if it is covered at all. I get graduates into my programs; I also teach at the undergraduate level but my units are all electives. There is not a core component in the undergraduate streams relating to ageing. Human development apparently stops at about 45, if you are to believe the curricula in some of the undergraduate biology programs, for instance. But at the graduate level there are a number of courses—graduate certificates, master's degrees and so forth—offered by various universities around Australia; in fact there are quite a few. One of the difficulties in offering graduate education in gerontology to health professionals is that you cannot follow the traditional model of studying an undergraduate degree, moving into graduate studies, supporting yourself along the way and then moving out into a career of choice, because most younger people have not got the slightest interest in working in aged care. I do not know if there is much point in trying to tackle that in a big way.

Most of the people who come into my programs are already working in the field. They have fallen into it in one way or another and have discovered that they like it. They realise that their preparation has been completely inadequate because it was hardly touched upon in their undergraduate programs. For them to then come and do postgraduate work entails a huge sacrifice with very little reward. They are normally working full time. They have to study part time and often they have families as well. At the end of the day, in all probability there will be no direct rewards for them at all in terms of promotion, advancement, increased pay or anything like that. They do it because they are genuinely committed to providing better quality care.

I must say too that we experienced a huge decline in numbers when fees were introduced for postgraduate course work in the early 1990s. We have now seen the numbers picking up again since PELS—the postgraduate equivalent of HECS—was introduced. These kinds of things are very cost sensitive. People who work in aged care are not big money earners, by any stretch of the imagination. I personally argue that, for courses in really sensitive and critical areas like this, there be some kind of recognition through fee relief, scholarships or what have you that would address that cost issue.

Also—and I believe you have heard about this before—there is an absence of a clear career pathway in the field of gerontology, which does not offer the same incentives as other fields for people to pursue further education. If you can get a job with no specific education in gerontology, which is what happens now, why would you bother? If it is going to be that difficult for you, why on earth would you bother? If I were a kindergarten teacher I could walk into a job as a director of a day care centre for older people. Why should I spend two years of my life and

$20,000 getting a further qualification? Of course, that means that the services that are being provided are not necessarily appropriate, which is inefficient and probably ineffective.

CHAIR—Professor McCallum, in the comparisons you have done between Australia and Japan on care preferences, do you attribute the differences between the two countries to cultural difference? Do you think that using an asset and health dynamics approach would assist in any way in managing the ongoing funding of support for the ageing population?

Prof. McCallum—The differences are historic and cultural, with a stronger preference for family care in Japan because it has been a rapid developer from an agricultural society where family have the primary responsibility. In that sense, Japan would be like some of our immigrant communities, where there is a strong preference for family care, perhaps in part induced by some of the issues of language and culture in entering some of our mainstream facilities. Thinking about the dynamics of assets and health is very important when you are looking at a country like Japan and comparing it with Australia. You have to think about whether the family resources are there to do the job. Japan has discovered that they are not and introduced long-term care insurance from the end of April 2001.

On the other hand, we in Australia could say: ‘How do we maintain the levels of family support we have, which people genuinely are prepared to provide? How do we maintain them by genuinely supportive community services?’ It is not just a matter of saying: ‘Goodness me, Australian society is ageing. How many more residential care beds do we need?’ My point is that we need to think about the whole mix of things. It is not a simple mechanical process; it is an organic mix we are looking at. The sort of inquiry you are engaging in is a better way than sitting in a back room and multiplying the numbers of people we expect to grow old. It is instructive and it does deliver that sort of message.

Ms HALL—Going on from that, you say that the common approach to looking at an ageing society is looking at what it is going to cost us as a community and there are areas you have identified. If we were to push the envelope, open the parameters and look at things in a more global way, are there some opportunities that could link to perceived costs? Isn’t there a way that we could look at turning it into an economic advantage, as opposed to an economic disadvantage?

Prof. McCallum—Certainly. Somebody’s cost is somebody else’s job, so there is a positive. If you are better at the management of service delivery then you have an intellectual property that is valuable both internally in Australia and externally if it is something that works. So that is the idea of exporting and helping with services, and there are markets around that.

The cost equation is something that one really needs to be careful about because, if we simply change the rate at which people aged 55 to 64 years are employed, then we shift the costs dramatically. If we change the way that pharmaceutical benefits are delivered and paid for, we shift the costs. Costing in health was the main driver in the Intergenerational Report—the majority of the health costs were pharmaceutical benefits driven.

If there were a cure for Alzheimer’s disease, then costs would change dramatically in terms of residential care. More practically, and perhaps more realistically, we know we can reduce costs of care without necessarily a reduction in quality, from some very detailed work in British

Columbia. We know that we can shift the cost by getting the community care mix going better. So that is the first thing: we can provide that level of care for some people in the community, without a noticeable reduction in the quality of care, at a much reduced cost to residential care. That is simply because we are not paying the accommodation costs.

Ms HALL—I was going to ask about community care next. You might like to expand on that at this point to save me going back. You also mentioned the RCS; you could include that in your answer.

Prof. McCallum—If we are going to maintain the publicly funded levels of services that we need to service an ageing population, we need to think about how we deliver services. We cannot simply multiply up high-cost residential care in relation to building costs and the relatively high costs of services without rethinking the way we do it. That rethinking is not something I would believe to be cost driven but something in which we need to start with what people want, and there are very good examples of this sort of innovation coming into the system in various parts of Australia.

Generally speaking, people do not want to go into a residential care facility. Oftentimes it is a good idea if they do, particularly if you are the carer, but generally speaking they still do not want to go. That is something we can work with. There are new technologies in community care and there are new aids and appliances in a different sense of technology that we can use in the community that can deliver that care. We created the Home and Community Care system in the late 1980s, and it was a tremendous advance in community care. It is now generally regarded as being far too disparate and far too uneven in the way that it works. It is something that needs to be rebuilt and rethought.

Ms HALL—How would you rebuild it?

Prof. McCallum—There are some fundamental principles—namely, that it needs to be organised around major regions and connected with the other services in those regions. We need to understand that there is a lot of wastage between a hospital system that is not well connected to an aged care community system and an aged care residential system, and a primary health care system and whatever else—a local government system.

These are not easy issues but they are areas where very significant cost savings can be made by better interaction between those systems and dealing with inappropriate things. A very simple example would be in the western area of Melbourne, in the area health service carve-up, where they have the highest rate of admissions of older people who are 70-plus of any area in metropolitan Melbourne. They also have the lowest coverage of Home and Community Care services. That is trying to put in graphic terms: if you do not do one thing, what do families do if something goes wrong? They go to the hospital for emergency care or whatever. We need to get those balances working a lot better. I was part of the Myer Foundation's '2020: A vision for aged care in Australia' group last year, and that is what we put in. What I have said is exactly the same as in the Myer 2020 vision.

Ms HALL—When we are looking at costs, the provision of home and community care, community packages and residential care, to what extent do you think the funding of health and

aged care impacts on the provision of those services, given that funding is part Commonwealth and part state, and what do you think you should be done to address that?

Prof. McCallum—It leads to a fairly predictable political debate, and advantage—or at least people thinking there is advantage—in cost shifting of various kinds. At least people think they are cost shifting, even if they are not, and it is a good political debate. I think we have to move forward with this by concentrating the funds that deliver services to older people within large regions. Certainly that was a position put in the Myer report as well. We need to think about the way the money works. I would support a position where the subsidies follow the client, where the person has an assessed need and there are certain things that they can do. The service system has to meet those needs and there is a flexibility in the way the system does that. We should be thinking about a clear difference in need between care needs and accommodation needs.

Ms HALL—Like the UK system?

Prof. McCallum—I think the UK talked about this without really dealing with it. Their inquiry into long-term care advocated a separation of those two, but it has not been acted on as seriously as one might have thought if that recommendation were to be followed up. But, yes, I am talking in terms of the report on long-term care in the UK. I think where there is a public responsibility is to provide care, and where there is a capacity for difference and private funding is in accommodation. That is politically very difficult at the moment, but in the longer term we are going to have to deal with that issue or we will hit limitations on our capacity to fund the services people need.

Ms HALL—Professor Russell, looking at education and educating the ageing work force, and in particular looking at educating health professionals, those working within the health 'industry', what kinds of programs do you think should be directed at different levels within the health service? What do you think should be done to address the issue of age discrimination within the education framework? What do managers need to be educated in in relation to ageing and the aged clients within the health system?

Prof. Russell—That is a triple-barrelled question. I will see if I can remember it! The first part was about the health work force at different levels and what kind of education they need. I presume you are talking about the levels from AIN up through—

Ms HALL—To management or middle management.

Prof. Russell—First of all, at all levels, whatever educational program you offer has to be multidisciplinary. You cannot be discipline specific. You cannot be profession specific. You cannot just talk about biology. You cannot just talk about psychology. There has to be an understanding of the multifactorial nature of ageing and of what you are doing with older people. That means it needs to be collaborative educational development between a range of disciplines and professions. I think that is the best way to go.

If you are teaching people to work in a team—and I imagine you are hearing that aged care has to be based on teamwork—then people should be learning as a team as well, not just learning their own little bit of the job. When you go out into the world you are actually working with a

whole bunch of other people and you ask yourself: 'What do they do? How do I relate to them?' If the education can be multiprofessional as well as multidisciplinary, that is ideal.

I made the point before that, in any facility or service, evidence and one's own personal experience show that it is the person at the top who really sets the tone for what goes on in the rest of the place. We know from experience that, whether it is a school, a nursing home or whatever, if you get a new principal, a new don, there can virtually be an overnight transformation. How does that happen? I think it is really important that people who are undertaking those senior roles in care are encouraged, supported and required to have specialist educational preparation and are rewarded for doing so. We already have in place—whether they are working effectively or not is another question—expectations in the residential care field that continuing education will be part of the ongoing requirements for accreditation and so on and so forth. I think the single best thing you can do to ensure that that works, and works effectively, is to have a person at the top who knows what they are doing. Okay, that was the first one. The second one was age discrimination actually in education?

Ms HALL—Yes, discrimination in education.

Prof. Russell—Mature experienced workers going back and trying to get qualifications?

Ms HALL—Yes, but dealing with discrimination and students generally and how you address that, and I suppose how you eventually remove it from the institutions and organisations that deal with older people.

Prof. Russell—I imagine that you do not want my particular pedagogical model outlined here.

Ms HALL—No, we will not ask for that.

Prof. Russell—It is crucial in any educational program in gerontology that you address the issues of attitudes, stereotypes, myths, prejudices and so forth in a realistic and practical way; I think that is important. I think that it is about developing a curriculum around reflective practice—that is, you do not just get people to read the textbooks; you get them to apply things in real life and you get them to think and reflect on their own experience. That is what you assess them on, not on whether they can regurgitate the book but on whether they can see how that applies to a real life situation. So, yes, any educational program has to be based on those kinds of things. It is extremely effective: you can get people to think critically about their attitudes and what kind of effect negative attitudes have in their practice. In a well-designed program you can do that. What was the third one?

Ms HALL—I think you probably addressed the third one in your first answer.

Prof. Russell—Could I just add one thing?

Ms HALL—Yes.

Prof. Russell—You asked John if there are opportunities.

Ms HALL—Definitely.

Prof. Russell—We have developed an opportunity—and I think it is more generally applicable—through the development of international educational programs in gerontology. The South-East Asian countries in particular are becoming aware that their populations are ageing. They have not got the educational infrastructure at the moment to develop their health professional programs and their people are coming to Australia and other places for those programs. With Internet technology—putting programs online, which is what we are doing—and some offshore teaching, they are willing to pay for our expertise in gerontological education. It becomes a little bit embarrassing when the government that you are teaching is actually more aware of the educational issue than your own is.

Ms HALL—Point taken.

Prof. McCallum—With your indulgence, Chair, I will make two quick comments about education. The University of Western Sydney is the largest educator of nurses in Australia. We account for 13 per cent of all nurses in training in Australia and 25 per cent-plus of all nurses in New South Wales. Within a three-year generalist program, our nurses would do some parts on ageing. It is not possible to do more than that because it is a generalist program and everybody wants a bit of it—that's it. They would do a lot of ageing education around their clinical training but there is a critical problem with that because the experiences are sometimes quite negative or sometimes misinterpreted by younger people going into aged care facilities, so they will see some care management as being abusive when it is not and some as being abusive when it is. That is the sort of quality of care we have at the moment. That is quite difficult to deal with. The critical problem in that education is more the overall volume of nurses we have.

There are a number of things we need to do a lot better. We need to have better TAFE and university connections, EN-RN connections and work based education than we have at the moment, and those are some of the things Cherry was touching on. Getting back to my point, we also need better supported clinical, because it is the highest cost end of a university's operations and teaching. If you can support that better, people can work through the experiences that they have in ageing.

On a final point—and I know the Deputy Chair is aware of this—there are some new developments in teaching aged care subjects. For example, there is an Australia-wide approach to developing a public health topic on ageing, which I think is a very interesting approach—people can share and pool their expertise. That is a very positive development that we ought to think about doing more of.

Ms HALL—I have one more question. I realise we are running short of time; I actually have a lot more questions. In what areas—and you could both answer this question as it relates to research—do you think there needs to be more research in the area of ageing? Do you think that there should be a special stream of grants just for ageing so it does not have to compete with other areas of health?

Prof. Russell—My answer would be very simple. It reflects my own particular approach to research. We need more research where the relevant questions are being asked directly of older people themselves. I am one of presumably many people you are hearing from who are speaking for older people and attempting to represent their voices as best we can. But in my research over all these years where I have done studies that have taken a set of assumptions that have come

from excellent research by service providers, academics or whoever, I have taken these same questions to older people who are living through situations. The perspectives more often than not are quite different. I have done research, for instance, on social isolation—talking to service providers, talking to the old people that they are serving and asking what their views are on social isolation. There are very different perspectives. I have asked what is an appropriate residential environment for older people. Service providers tell you one thing: it should be as domestic as possible. What the older people, particularly the frail older people, like is actually more of an institutional hotel model, which is anathema to professionals.

So we need more research that is directly asking older people about their experiences, not hypothetical questions such as, 'What in the best of all possible worlds would you like?' or 'Would you rather stay at home or be in a nursing home?' Well, der! What are they going to say? That kind of research just gets buried under the numbers and the experts. But without that research, no matter what service you provide, if it is not actually meeting the needs of older people they will stay away in droves. We saw that in the seventies with senior citizen centres. 'What a brilliant idea!' we all thought. 'Let's give them clubs where they can all go and be with each other,' and they voted with their feet. They did not want that! So that was a very costly learning exercise. That is my answer: fund research that actually involves talking directly to older people.

Prof. McCallum—There are a number of priorities in our research mix that are not well covered at the moment. Let me express a prejudice. I represent the social public health and health services side of research, not the biomedical or clinical side of research, although I do that collaboratively with others. I think we have very poor health services and aged care services research. It is very undeveloped. That is true across the health sector, not just in relation to ageing. We have underfunded ergonomic workplace labour force research about older people. There was a burst of that around the late seventies and early eighties with the old Bureau of Labour Market Research. It fell in a rather large hole and has not scrambled up out of it yet. We need to get that kind of research going well. We are going to get genomics, proteomics and biomedical research related to that, whether we like it or not—and I do like it. However, that is enormously expensive research.

It concerns me that we probably know more about the genetics of ageing than we know about community care. I do not think that is an unreasonable statement to make. We have to think about that and work out how we can make that work better. Minister Kevin Andrews is considering what to do with community care at the moment. He does not have evidence to work with of any substantial kind in doing that. He will be relying on expert opinion; he will be gathering what he can internationally and flying blind to some extent in working that through. That is an unhelpful situation that we need to deal with.

The final question is about whether we need to quarantine some funds for this. I think everybody feels they are badly done by in research grant bodies like the Australian Research Council or the National Health and Medical Research Council. Every group says, 'We are doing terribly. They do not love what we are doing and they do not understand how good we are.' The bottom line is that it is a competitive process. Around 30 per cent of people get through NHMRC. It is tough. We probably have to build capacity in ageing research. It is not there. We have small groups who are all competing against one another. There are no economies of scale or

large capacity areas in ageing research. They have to be built. We need to think about strategies within that.

There are very large longitudinal studies we can do. In the shorter term, there are very large longitudinal studies that are already being done that cannot properly fund themselves to do that work, for which it would probably be possible to use public money to buy into to get quick results. In March there was a very good example of this in the journal of the American Medical Association in a paper by Lunney and others. It talked about the trajectories of decline in function near death. They simply went into existing longitudinal studies, got some work done in there and got the data out. That is a much more cost-effective model than waiting 10 years to see what happens with older Australians in some area. I am not going against that. I am just saying that we need to think smarter.

We do know a lot of things, but we do not know what to do with them. We do know about exercise and old age, but we do not know what works best for people who are 75 and over in getting them exercising. There is a whole field of intervention research where we need to find out what works. If we are to do that, we need to be strategic in the way we do it and we need to work in terms of the most effective best bets for public money. We need to think in terms of that public money being focused on areas like buying into existing studies—so you are getting a quicker return for effort and you are using the resource that is already there—and intervention studies so you can actually get a policy out saying, 'Yes, I know what to do to get older people to have stronger bones and not fall over and to get rid of their depression by exercise. I know the best way of doing that.' We do not know what to do at the moment. That is a possible way of dealing with it, but it needs to connect as a quarantine fund to the existing peer review bodies like ARC and NHMRC. There are examples of how you connect while quarantining the money.

Prof. Russell—I would like to add that I support the need for some kind of quarantining regarding ageing research. I make the additional suggestion that one of the most effective ways of building capacity of excellence among researchers would be to fund research scholarships for outstanding young researchers who might otherwise not even think about doing research on ageing, but with the attraction of a scholarship you might attract some of the best and brightest and they will stay on and develop the infrastructure further down the line.

CHAIR—Professor McCallum, I wanted to ask you about healthy ageing and the longitudinal study in Dubbo. I note that the research has generated an enormous volume of articles. What are the implications of your longitudinal study for policy makers? Have you drawn any conclusions about modifiable risk factors and interventions that work?

Prof. McCallum—We had a very good example of this. We compared Dubbo to Hawaii—in particular, to the Honolulu heart study, and found that there was better treatment of hypertension in the Hawaiian population, and that immediately went through to the GPs in Dubbo and I suspect it increased the use of some cardiovascular medications as well. I can focus this around some new areas. We have contributed to a strong international effort around cholesterol. At the beginning of this study we did not know what cholesterol did in older populations because older populations were never studied in the cholesterol studies. At the end of the period we now have a very good idea of how that works and how to manage treatment of that, so we have contributed strongly to that. I would focus more on disability, depression and incontinence. One of the variables we find that has a very general power of prediction across all service use and the

outcomes you would want to avoid in later life is a simple measure called peak expiratory flow, which is the force with which you breathe out. If you are in the bottom tertile, you have disability earlier, you use more hospital services, you stay in hospital longer, you are more likely to go to a hostel, you are more likely to go to a nursing home, and that is independent of all the other things that get you there. There is a sort of factor we can begin to work with.

If I could make a general point, I think we are relatively well aware of the general health factors—smoking and so on. We are less aware of the factors that create weak peak expiratory flow that are more disabling, create greater disability. We are less able to deal with depression in later life than other periods, and that is another generalist and powerful predictor. We know a lot about incontinence but we do not deal with it through our service system. So in terms of deliverables, they are areas that we can certainly work with. They are factors that lead to the worst experiences in later life for families and for older people.

I wanted to end on a positive note because it is often quite negative on ageing. We have found that alcohol is good for survival, particularly because it protects against cardiovascular disease. And it is not just red wine; it is actually any form of drinking. We are now doing new work which will be reporting publicly next month, which shows that it also predicts against nursing home admission, and that is because it protects against dementia. So, Chair, in terms of some of the things that work in later life, they are not necessarily things that involve you having to stop doing what you like or having to do more of what you do not like. Some of them can actually be just living well socially and maintaining the enjoyment of things that are actually good for you.

CHAIR—How do you define moderate alcohol consumption?

Prof. McCallum—It is one to seven drinks per week for women and about 14 to 28 per week for men. But on many of these variables there is actually a dose response effect. We are dealing with survivors in a population; those ill effects of alcohol have been sorted out earlier in life, so those results should not be taken to apply to younger people, where risks of violent deaths and suicide related to alcohol are quite high.

CHAIR—Did you look at any difference between wine and other forms of alcohol or did you find no difference?

Prof. McCallum—Yes, we did look for that and there was no difference. In reading the international literature on this, it does seem to be related to alcohol per se rather than to the type of alcohol intake.

CHAIR—Lastly, I want to ask you about the exporting of aged care services. It sounds like a great idea. What sorts of obstacles and impediments are there to exporting these services?

Prof. McCallum—I think that business expertise needs to be developed in the people who have the ideas and knowledge in aged care services. Some people in those areas are very good at what they are doing and are, to some extent, giving away their ideas. That is a generous activity, but it is not necessarily in their or their organisations' interests. That is the first thing. The second thing is that, as in any form of business, it is not easy in many cases to do the deals overseas. In particular, people who are not experienced in that area and who have a welfare orientation to what they do need a lot of help when they are doing this sort of business overseas. I would add

the point that I think it also depends on a lot of government-to-government contact—and I am thinking particularly of Japan—which is needed to open doors and give the right marketing and impetus so that people coming from Australian organisations can have access to that market and talk that through. But, certainly, the Australian Embassy in Japan and Austrade have a high priority on developing those areas in Japan and in many other Asian countries.

CHAIR—Thank you.

[12.07 p.m.]

MARGRIE, Ms Linda, Macarthur Home and Community Care Development Officer and Facilitator of Forum, Macarthur Aged and Disability Forum

CHAIR—Welcome. I remind you that the evidence 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 a contempt of the parliament. The Macarthur HACC Forum has made a submission, numbered 19, to the inquiry. Would you like to make an opening statement before I invite members to proceed with questions?

Ms Margrie—First of all, thank you very much for allowing me to come and give evidence to the committee. One of the things that we looked at in our submission, and I think this probably overarches everything we would like to say today, was the commitment of inclusiveness within the sector. The Macarthur HACC Forum has recently changed its name to the Macarthur Aged and Disability Forum because we realised that, out of 110 members, only about 30 per cent of those were actually HACC funded. The rest were aged workers within health, residential care, community aged care packages and Commonwealth respite centres. I think it is really important to look at that in the local area. One of the things that we find very frustrating on the ground is the different programs and the way they interact. We talked about that in our submission.

The other thing, looking at it holistically, is: how can the community sector work better and how can we use what we have better? I think it is really important, before we start throwing money at a problem, to look at how we can do what we do already much better and how the community can still retain ownership of that. Unless that local community owns its services and looks at its community as a whole rather than as a branch of something from outside, those strategies and innovations are capped—they are coming from the academic level, because it is the only area where they can get in, rather than from the ground.

I would also like to talk today about how we can build that capacity and how we can encourage volunteering—everyone knows that volunteers are becoming harder and harder to get. How are we going to do that over the next 20 years? I would also like to look at the Home and Community Care program, where it has come from and perhaps where it needs to go so that it can increase that capacity.

CHAIR—You have raised an issue that the committee has heard a lot about—that is, the need to streamline the administration of programs for community care. Do you have any ideas on that?

Ms Margrie—What we looked at were the number of programs, duplication, eligibility and access, data collection—all those types of things that under-funded services are wasting resources trying to do. The Commonwealth, through Minister Kevin Andrews, has recently put out a new strategy for community care. That seems to be getting a very good response on the ground. It is a good start and it is broad enough to encourage discussion, which I think we were all very happy to see. Quite often the policy comes down from on high with, 'There is the

answer and now we're going to implement it.' The community care sector is seen as a frustration or a problem that gets in the way of that implementation. This paper is quite different in that it looks at trying to lead the discussion forward and being interested in what is coming from the ground and in the innovation. So I think that new strategy is a really good first step; it is long overdue and it is very refreshing to see it.

CHAIR—Would you like to see a model like HACC or the community aged care packages? What sort of model do you think we should have for community care?

Ms Margrie—I do not think we need different models. I see community aged care packages as something that could have been provided within HACC if we had looked at the program we had and expanded it. I guess that is one of the frustrations that we have, and I do not know whether it is between Commonwealth-state relations and funding or whatever. On the ground we just see a new program pop up, and it is another set. That may be an easy way of getting around the state and the Commonwealth not putting in the right amount of money each and those sorts of arguments, but on the ground it creates more problems.

When the Home and Community Care program came into existence it worked extremely well. But we have to remember that, when it came into existence, de-institutionalisation of people with disabilities had not happened; matrons kept people in hospitals until they felt safe enough and happy to go home; there was no early discharge and there were no changes in the way in which the sectors supported each other. In days gone by there was a lot more cooperation between health and community care, probably because there was not such stringent accountability methods. We were all probably breaking the rules but, when push came to shove, if a client needed something we somehow bent it to get it.

Nowadays, everyone is so concerned about their budget bottom line that quite often that blocks issues. A perfect example in Macarthur is when we started a temporary aged care service. It was recognised that a lot of people in the area were falling through the gaps between discharge and the picking up of community care services. HACC was never designed to be an emergency service. It was designed for people who say that an elderly relative is getting frailer and that they might need someone to help mum with the vacuuming. It was not a case of, 'Right now—I need personal care tomorrow.'

We looked at those issues and we successfully got funding for a Home and Community Care program that accepted people who are 65 years of age and over. They had to be HACC eligible. They were assessed and put onto an eight-week program. Those eight weeks allow the Home and Community Care service to do their assessments, to be fed into those clients and for them to be able to be redirected to Home and Community Care. When we looked back over six months we discovered, which we all thought was very exciting but which we cannot seem to get anybody else excited about, that 40 per cent of those clients did not need Home and Community Care after the eight weeks. One government department says, 'You didn't do the assessment. They probably weren't HACC eligible.' Well, yes, they were. When they were in hospital we thought they would need ongoing maintenance care. The other side of government, the Commonwealth, says, 'Hang on, that looks like it's post-acute care; what's HACC doing funding that?' We could not get past this situation of 'that program shouldn't be doing it' or 'this program shouldn't be doing it' and generate some excitement that we had just saved money in HACC that would have been ongoing.

Many of our clients are leaving hospital and getting HACC for the rest of their lives. Let's face it, when you are getting the care it is very nice. HACC does not reassess every eight weeks; we may reassess once every 12 months or if there is a change in the client's circumstances. We feel that a gateway into the community care system, introduced in a temporary way, really can save a lot of funding at the other end. To move on from that, we are now trying to fight this being defunded from HACC, and trying to get that 40 per cent of funding through health so that we can say, 'Look, we have got the mix.' But that innovation seems to have been blocked. That is where we are talking about Commonwealth-state relations. Those innovations need to be grabbed hold of and moved forward. In the temporary program, the other thing we were trying to do was to allocate funding upon exiting the program rather than upon entering—which also seemed like an idea that was a bit too hard to grasp—because we do not know, until they leave, whether they are going to need ongoing care or temporary care.

I do not think the model matters so much as what you do within the model. Home and Community Care has worked well but we also have to remember that part of the target group are people with disabilities. In an ageing population, people with disabilities are ageing as well, so we have other issues to look at. Sometimes people talk about whether we should split ageing from people with disabilities. To me it does not seem advantageous to do that, because there are so many basic maintenance services that people with disabilities need that are the same as HACC. Why provide a Meals on Wheels service for aged people and a different Meals on Wheels service for people with disabilities? It does not make sense. But we have to acknowledge that the commitment to a person with a disability may be for 50 years whereas, in the early days of HACC, clients came into the system, moved into a nursing home, passed away and then the money was reused. We have an ongoing commitment to people with disabilities which I think needs to stay within the discussion on our ageing society, because people with disabilities tend to age earlier. Ageing is not a date; it is a process. If as a community we want de-institutionalisation, which I think is wonderful, we have to pay for it. We have to provide those support systems in the community.

Ms HALL—I am pleased to see that you identify the issue of the state and the Commonwealth and the conflict that is created, the need to address it, the need for better communication and for the development of a seamless system. I think we would all agree that, wherever we go, it appears there are some problems created there. Can you tell me—and I suppose we were just talking about one of these projects—the implications of the competitive tendering process and the setting up of pilots, and of the refusal of governments at all levels to fund those pilots on an ongoing basis even if they have proven to be very successful? Can you also tell me how the limit on the period for which projects are funded effects service delivery?

Ms Margrie—The competitive tendering process seems to have become a little saner than when it was first introduced about four years ago, when everything went to competitive tender. For example, in Macarthur a need came up for one-off assistance for clients where, for example, they had been away for a fortnight and needed someone to come in and clean the fridge—that type of thing. All we needed was $10,000 locally. We were going to share it between the existing neighbour aid services. Competitive tendering was introduced and, all of a sudden, $60,000 was funded to a large organisation to do it which then changed its priorities and moved the money. It was just ridiculous. Now, on this year's grid, we have another $15,000 for one-off maintenance. That was competitive tendering gone mad. It was a case of 'It has to be costed, so anyone can go for it.' Now there seems to be a rationale more of 'Can we build it into the service system?'

There are more direct allocations, and only for large amounts of money or new types of services is that competitive tendering occurring.

I still think that within the community sector we have to weigh competitiveness up against what we are losing. Are we losing cooperative community sectors because of that competitiveness? It has taken us a lot of time in Macarthur to try and keep encouraging groups to share their best ideas. The ones that do it best are the small local agencies that have been operating on shoestrings for years and years and have had to share good ideas to make their projects work. Some of the bigger organisations that come in perhaps have—and I am not saying they should not have—a business plan for their organisation that covers the state, and do not have that commitment to local area issues. They can quite often look at that sharing of ideas and think, 'Hang on a tick; that gives me an extra tick on my next submission if I can come up with that innovation.' I think we have to be very careful about that.

The Community Options model seems to work extremely well with the private sector agencies being brokered by a non-government agency. That way there is that monitoring of a service that has not, I guess, got profit as the motivator, and it enables that use of the private sector. I am talking about things like domestic assistance. With the amount of money that is funded for workers to provide a basic service—say, vacuuming—what type of different service would we get if that were from a private house cleaning service monitored by a non-government organisation? Is there a way that we can save money with those types of things so we can put that money back into the care that involves quality-of-life issues, the understanding of ageing, those types of things that are very important to the practical side? Is there a balance that we can make there?

Ms HALL—What about the pilots?

Ms Margrie—I think pilots can be extremely valuable as long as they are placed in the community in strategic locations. We need to balance up how things work in rural areas and metropolitan areas, how things will work with people from non-English-speaking backgrounds and people in ATSI communities, and those types of issues. The problem is that, if it is a great success in an area, there needs to be that commitment to carry it on or else we set up false expectations in our communities and the next pilot we run may not work—not because it is not a good idea but just because everyone has been burnt once and does not want to get involved in it a second time. It can cause a great flurry of excitement—like what happened with our temporary aged care—and then a big 'hang on, this is what we were thought we were trying to prove'.

It needs to be done with an acknowledgment that, if it is working, there does need to be that commitment afterwards. Otherwise, perhaps we could look at issues around what we have already. We seem to have everything already. We have transport, meals and personal care. Maybe we could run pilots within the system we already have rather than create something outside that system—create a new service. Perhaps you could create a new arm of an existing service, so it can still be seen that that service is there after the pilot is finished. Do you know what I mean?

Ms HALL—Yes.

Ms Margrie—So you have that connection still back to the community and that feedback. That may work better. What was the other one?

Ms HALL—The time limits on projects and having to reapply for funding.

Ms Margrie—It is important for services to look at development. It is important for services to have some guarantee that they are going to be there in another four years, because that gives them the commitment to keep working in the area. If it is a core service, there need to be recurrent grants, but in the recurrent grants there needs to be proper monitoring. The HACC national service standards came into play. That has changed the way a lot of services operate, and for the better. Every service I have met said, 'God, it was a pain in the neck, Linda, but, God, I'm glad we did it.' It was really good. I feel comfortable now that the service is not about personalities. It is not who is on your management committee this year. It is not whether I am the coordinator or somebody else takes over. We have a structure that can sustain us. How that monitoring is does is really important.

While we do need monitoring from funding bodies, we should also have peer monitoring so we get a view of how that service is interrelating with other services. Are they returning phone calls? Are they cooperating with common assessment and things like that that we do not get from a policy manual? We need the qualitative side not only from the consumer saying what they think but also from the other services in the area about how much of a team player that service is. When services do not come up to scratch, we need to be harder about defunding. Everyone knows that services very rarely get defunded, because we do not want the bad press. But how long do you support a service that is obviously not working, and what damage is that causing in the community? Sometimes you need to bite the bullet and, if you do, you do it hard. You do not leave it dragging on for many years.

Ms HALL—My next question is about the adequacy of services within your area. What is the waiting time for the provision of services and how many people are falling through the cracks simply because you do not have enough services and the demand outstrips the supply?

Ms Margrie—Most services in our area have a waiting list. Services that operate with volunteers seem to be able to cope better than those that do not. Obviously for Meals on Wheels who are putting in one more meal and going an extra street it is not that much of a change, whereas services such as frail aged day care centres have waiting lists. All our day care centres have waiting lists at the moment—some 30, some 10—probably for the first time since I have been there, and I have been there nine years. I have been a worker within home and community care for 13 years. We are now reactive instead of proactive. HACC services are operating in crisis, and our clients are becoming higher need all the time. A lot of service providers are frustrated that we can no longer do that preventive work. A client once said to me, 'You used to help people before they broke their hip, didn't you?' And I thought, 'Yes, we did. We did try and get in there and do the bathroom before you fell over and broke your hip.' But more and more those clients are becoming higher need.

This is where the different programs come in. There are people getting CACPs—an ACAT assessment—that are only getting three hours worth of service a week. I have a suspicion that they are in a CACP because they could not get home care, not because they need hostel level care. In community care, there are probably people on whom we are spending more than would be spent if they were in a nursing home. We have clients in HACC that are on the books to go to nursing homes but cannot get in. It is about being able—and I think this is addressed in the new strategy—to look at that basic level of care and make sure that people can move through the

system. What is happening is they are getting to a certain point and it is becoming a bottleneck. Those people are staying in the system and becoming higher and higher need, while the newer clients that are coming on cannot get in.

CHAIR—Is there anything further you would like to add?

Ms Margrie—The issue around looking at communities and how they are changing is really important—how you are going to create that volunteer mentality and keep that within your community with a volunteer base that is smaller and smaller. Some services have utilised the Work for the Dole program wonderfully, and there is scope for that, but that is usually in areas where those people are supervised. We have to be very careful about why people are volunteering to our agencies, obviously for client safety and things like that.

Eligibility is one of the big things that keep coming up. In our area we run a central information service—a 1800 number. Unfortunately, Macarthur has two 1800 numbers because of the competitive tendering process, but we will leave that. The big questions I am asked are: 'I could not get that service but I am on a disability pension. If I am on a disability pension, why can't I get the service? If I am on an age pension, why can't I get the service?' One of those issues is eligibility for those pensions. Maybe one way we can address that is to look at the pensions and try to link them to some sort of eligibility so we do not constantly have to explain, 'Yes, you are disabled enough to get a pension but you are not disabled enough to get your lawns mown.' Why? Perhaps that could facilitate entry into a system.

With regard to funding into the future, first of all we need to look at what we do better. As I said, the new strategy has a lot of commendable things. We need to really move forward on that. But other peak bodies have talked about an age and disability levy and whether that is appropriate. I really do not think people mind paying taxes as long as they know what they are used for. I have an objection to paying a tax and then not being able to get what perhaps that tax was paid for. That really needs to be looked at. I know that, as governments, everyone hates introducing new taxes but if we want to provide a high quality aged care system—and hopefully I will become aged, and any of us could become disabled tomorrow; when we walk out we could get hit by a car so we have to ask: do we want to be able to provide that care?—maybe we are going to have to put in some extras to pay for that.

CHAIR—Thank you very much.

[12.32 p.m.]

RIPAMONTI, Mr Paul Henry, Administration Manager, North West Community Care Inc.

WEIR, Pastor Warren Richard, Director, North West Community Care Inc.

CHAIR—Welcome. 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 a contempt of the parliament. Would you like to make an opening statement before I invite members to proceed with questions?

Pastor Weir—Thank you for the opportunity to address the inquiry into long-term strategies into the ageing of the Australian population. North West Community Care is a non-profit community organisation based at Stanhope Gardens in the north-west area of Sydney, adjacent to Parklea Markets and the fast growing, rapidly changing new release areas and new estates that are developing in the north-west. Our focus is on people and the development of community in these new estates. We have a triangular concept of facilities, programs and facilitation. Our focus is on bringing people together in an atmosphere of trust and friendship rather than fear, worry and frustration. Our concept is a very positive one and we have a very forward-thinking focus on the community. We are the actual community developers; we are the facilitators. People are community and our concept is that people build community as well. As facilitators, the success of long-term sustainability is in building those models that empower people to own and be loyal to their own community.

We are very optimistic about the future. We are not driven by negative attitudes, worries or concerns about the future; we are driven by optimism. We are confident of the future and the things that are happening in our society and in our world as well. We get back to the change that is happening. It is a rapid change right across the whole spectrum of society today, with management, technology, food production, medicine and science changing dramatically. People are now even saying that in some of our research we are finding that even our physical appearance in 20 years time will be changed as well. For me, it is probably a good thing but we will not go down that pathway too far! But those are the sorts of things that are happening right across the whole spectrum of our society. Things are changing; social fabrics are changing. Fifty per cent of marriages in Australia end in divorce. The implications or the resulting effects of that particular issue lead to a whole host of social issues, such as long-term permanent rentals, affordable housing concepts, policies et cetera.

Baby boomers' attitudes are also changing. I believe that the baby boomers are not looking forward to retirement and there is a new concept and new thinking amongst them. The lifestyles that they are espousing are quite different from our expectations of 20 years ago when we had an education, a career and a retirement and superannuation package. Even the superannuation system is of concern to many. Because we are at the coalface, we see attitudes changing dramatically amongst the baby boomers. They are saying, 'I want to contribute and stay a part of this, and I want to see some long-term strategies.' The other day someone quoted to me a line

from a famous ‘Rolling Stones’ song: ‘I hope I die before I get old.’ If we think about that line for a moment, we can see that there is a lot of meaning and positive attitude in what we are on about.

A Monash University professor recently said that change is happening so quickly that, in the next 17 years—from now until 2020—we will see the same amount of change as between the Roman chariot and the Stealth Bomber. That is the sort of change that is happening. Also, thinking is changing dramatically and that is where the challenge is for us today. Our research is suggesting that thinking will change and traditional models will not be the same for the ageing population of Australia. New models will come on board, some of which we have been able to take on board and present here today. That new thinking encourages us to step out of the boat, move out of the square and look towards the new models that are coming about.

We have had some discussions about the needs of the future and where these needs have to be addressed. What are people asking for and what are they suggesting that they will want in the future? These things include security, to be valued as people, to be respected and to be given opportunities to contribute. They want loyalty to and an ownership of the society and community they live in. Eventually, they will need care and support as well. Our strategies focus on four or five new concepts. We have been putting them in place and working with them over the last three years and we have a model for their implementation. I believe it is time to move to new models and a new thinking in implementing them.

What we are suggesting here today is that we should get back to the core of the issue, and these are the strategies we propose. There is some new thinking about what our communities should look like. The concept of multigenerational estates is coming on board in some places. Our research indicates that, within a whole cross-section of the community, new estates are being established that are multigenerational. Young children, working people, professional people and also elderly people are being planned for, are contributing to and are being part of these new estates and communities. An integrated, caring community is a model that we could set up, establish and prepare. It is already happening in some parts of the United States. As a model, we could put together 2,000 residents in a new estate, with independent living units, rental accommodation for the over-50s, pension housing, nursing homes, a hospital or medical facility and a hostel, all of which could be planned and shared.

Some of the outcomes from this integrated, caring community are very strategic—a whole host of agencies are looking at them. The outcomes these multigenerational estates aim for are mentoring, sharing, caring and harmony in community. There is a lot of disharmony out there, and a policy that governments are now professing or looking towards is harmony in community—bringing together, rather than isolating. We are proposing the full integration of people into a caring community. We believe that the multigenerational estate will be very functional in the future in Australia.

We are proposing multigenerational communities or estates. Facilities that are innovative and open to community resources is our second strategy. We are facility based. We are keen to put facilities into communities for a whole range of issues, such as resource centres, leisure learning and recreational activities that would enhance the quality of living within the estates. Our model looks towards having a facilitator to build community, to run community events and to initiate a

quality of living, an excitement and a positivity, and that is happening in several places that we are working in.

Sustainability, affordable housing and planning are the other strategies we are very interested in. We believe this committee is strategic in planning for the long-term needs of Australians. In terms of planning that is strategic and holistic, our concept is bringing together. We work with inter-agencies and organisations that are doing a fantastic job. Our concept is to bring them together and have them interrelating in very much a caring and strong community.

North West Community Care is not money driven or focused on resources; rather, we have a real desire to work with people and to bring people together. Over the last three years we have had some strategic organisations such as Landcom, the Department of Family and Community Services, Winten Property Group and Mirvac trialling some of these innovative ideas for community facilities and putting in a facilitator to build community—to initiate I should say: we are not the builders of community—they are there to facilitate the building of community.

Some of the interesting things in the new estates are tennis courts and swimming pools, and a clubhouse type situation where people can come and meet together. There is a direct link role there for a facilitator to play. Community ownership of these facilities is another dimension that needs to be explored further as well because that ownership of, and loyalty to, community brings about a sense of goodwill among the residents within these estates.

Thank you for the invitation to share our vision and some of our strategies. We are facilitators and we are at the coalface. We do not work from a centre based model. We are out there and we take welcome kits; we are out there meeting people at their doors when they move into their new homes throughout these estates. So we are at the coalface, and the challenge to all of us is to consider the new and the fresh rather than the same old traditional ways. There are new models appearing, and more will appear. I would like to quote from a document from the Maryland Department of Aging, entitled ‘Strengthening Maryland communities the intergenerational way’. It states:

In a message announcing the theme for the 2002 Older Americans Month Observance, Assistant Secretary of Aging, Josephina Carbonell writes ‘We must work to ensure health and human services reach across generations where we have young people working as volunteers to assist our elders and, at the same time, we have older adults working with youth. Stronger multi-generational programs result in stronger individuals who are more connected to their communities. Stronger individuals result in stronger communities and stronger communities create a stronger nation.’

CHAIR—Thank you very much. What do you see are the key factors to building social capital over the next 40 years? How do you think that will enhance the experience of those who are aged and ageing?

Mr Ripamonti—’Social capital’ is not a term that we are endeared to, but I know what you mean. We like to look at people as people. Listening to some of the other speakers today has been interesting because, as Warren said, we are at the coalface so we talk one on one with the young people and the elderly.

It is amazing the wealth of information and abilities that these people have, particularly the elderly. It is a shame—you go into a nursing home, for example, and you talk to people there

and, granted, there are a certain percentage of people who unfortunately are demented or incapacitated, where they simply need to be loved and cared for, but there are others that may simply be physically incapacitated. They may have a wealth of knowledge mentally, but they have no way of sharing that and no way of feeling useful. One of our principles, whether the person is 10 years old or 100 years old, is to make that person feel that they are useful and have something to contribute to society.

Part of our strategy in doing that is, as we said, to have facilities, programs and facilitation and, in the middle of that, to also have events. The events are also geared to bringing people out so that they rub shoulders with one another in an atmosphere where they are not really too worried about the fears of the day. They are not worried about whether they are going to be blown up or whatever. They can just relax. In that relaxed atmosphere, they share things that they would not normally share otherwise, and so a bond is formed. That is what we class as community.

It is interesting: when we look at what is happening with the ageing population, we immediately think of the aged but, when you think about it, the 10-year-olds are going to be 50-year-olds, and so it is not simply the aged, it is the moving of the whole spectrum of age groups through. One of the challenges that we have in what we are doing is to ask: 'What sorts of facilities do we need? Where are these peaks going to occur and what are the types of programs and leisure learning activities that are going to be best suited to whatever the peak groups are?' That includes multicultural and all the rest of it. That is a challenge that we have ahead of us—to make sure that the community is integrated rather than disintegrated. We see today that we are living in the middle of the result of what I would class as disintegration of community but, as Warren said, it is fantastic to have this opportunity to input some of this back, because we see the thinking of the government changing. We see the thinking of the developers changing to an attitude of integration. To us, that is very encouraging.

Pastor Weir—We find it very strategic that organisations such as Landcom now have community development built into their triple bottom line reporting. The social component of their work—care of community, the building of community—now is just as important as the economic and environmental. We have people like the president of the residents association in Stanhope Gardens saying: 'I wouldn't like to live anywhere else. I have these things happening. It is such a great community to live in.' They are so excited about the future. This lady is probably in her mid-60s and she is so excited and wants to stay where she is for as long as possible.

We also take to communities some of the values and events that we have known growing up—the fireworks spectaculars, the Christmas carols, the teddy bear picnics and things like that. They are so well received and people say: 'My! This is just so fantastic. Now I can introduce my children to them and they don't miss out on the things that we knew and took for granted as young people.' I am sorry—I get a bit carried away. My wife said not to waffle too much today!

Ms HALL—I would like to understand a little bit more about your organisation. I see that you are an incorporated not-for-profit charitable organisation. Are you funded under any other organisation? Tell me a little bit about how you came into being. I can see that you have this strong community development focus, that you are going out there and visiting and trying to

build the capacity of new estates and developing areas, but I still do not understand really who or what you are.

Pastor Weir—North West Community Care originally was under the umbrella of the Uniting Church. However, we were invited to stand alone in our own capacity. There are people that have a heart for community, and we have a membership base of around 30 people. We have 12 staff on board. We are a not-for-profit organisation.

Ms HALL—Do you get any funding through the Uniting Church? Do they still support you at all?

Pastor Weir—No. Our funding comes from people who have come to us, such as Landcom, which is a government instrumentality. Winten Property Group, a private developer, came to us. They wanted to be at the cutting edge of society in building communities; they did not want to walk away from the kerbs and gutters and leave the community of people on its own. They came and asked, 'Can you trial this concept with us?' So we have taken out the welcome kits and held community events. We have set up a residents association for long-term sustainability. We had a call recently from another developer who wants to set up a similar office in Brisbane. We have people asking us to facilitate growth in the community.

We have a Christian fellowship at Parklea and the North West Christian fellowship at the new leisure centre in Stanhope Gardens. North West Community Care is a stand-alone community organisation for the purpose of bringing people together and facilitating the building of community. It has no other agenda than that. Under that umbrella, we have a registered charity called North West Helping Hand. One hundred per cent of the money from the fellowships is donated into Helping Hand. It is a registered charity open to public contributions. We meet the needs of people in necessitous circumstances all over the north-west. If they have a need and we have the resources, we bless them and encourage them in that way—no strings attached and no questions asked. Donations of food, furniture and other things are coming in all the time, and calls are coming to us all the time for support and help. Where we are able to help, we do so—without any discrimination whatsoever on race, colour, creed or religion.

Ms HALL—Your organisation has really come out of the fact that, in Sydney, the development of new estates has skyrocketed.

Mr Ripamonti—Warren touched on the fact that when North West Community Care were under the umbrella of the Uniting Church, they got to the point where they said to us, 'We really do not want to run this anymore.' The way that came about was that Landcom had decided to take the initiative and do something different when people moved into new estates. They devised a little welcome kit with local information and a few freebies in it. The idea was to go and meet these people. The other part of that was to run events so that when they came in they would generally have somewhere to go. They were the two aspects of the initial program.

When they said that they did not want to run with it anymore, we took it up. We had had a look at it and then Winten came along—they had some other developments out there—and since then Newbury, which is under Mirvac. They said that they could see the effect that it was having. Not only were we going to meet people at the door, with the kit; we were asking people what their needs are, how many children they have and what we could do to help them. We were

pushing the ‘bubble’ out a bit. We decided that we would collate all this data, so we set up our own database. We found that, as we started reporting on this, Landcom started pushing us for more detailed reports. The whole thing seemed to get a life of its own.

Winten then asked us, ‘What are you guys like at developing residents groups?’ Warren had already been with Glenwood and Stanhope Gardens, which are now flourishing in their own right. Highlands Ridge is in the embryo stage of launching out and doing its own thing. We have been pushed into not only delivering welcome kits—which we are also refining and improving all the time—but making people feel welcome and as though they belong somewhere. There is nothing worse for a family coming from somewhere else, as we have heard earlier, than feeling like they are in a distant land and that nobody is around and nobody cares for them.

Someone might suddenly turn up at the door and say, ‘Here’s a kit to make you feel welcome. Let us know if there is anything we can do for you.’ They say, ‘That’s fantastic.’ In that kit are contact names. We are involved with both agencies, at Blacktown and at Baulkham Hills. We interface one on one with each of those agencies. We make it very clear to them that if we can do anything to assist them, we will do it. If somebody needs an aged care person, we say, ‘Here is the best one to call in this area.’ We act as an intermediary in that way as well. That also is growing. Even as we speak here today, it is blossoming and growing because of people’s need. It just goes on.

Ms HALL—Living in a new estate can be an isolating experience.

Mr Ripamonti—Particularly if you are the first one in there.

Ms HALL—Yes. You have new homes that are usually quite expensive. Generally speaking, you have younger families. Both people may work. Then there is child care and all the other associated issues. With an ageing population, it is not only about providing services to older people, it is also about creating a community or society for families and children where we can reverse the impact of an ageing population. Do you work on behalf of residents to address child care needs? I am sure that transport needs and the provision of services are big issues in the area you cover.

Pastor Weir—There are a host of issues. The work is exciting. I will refer to some events. For example, there is an open invitation to our events. You can come with no strings attached and enjoy—build relationships with your neighbours rather than not know who they might be. You can meet them together. We had more than 5,000 people at the fireworks spectacular the other night, and 10,000 people at the Christmas carols. We will have a teddy bear picnic with Humphrey B. Bear in a few weeks, and there will be 600 to 800 preschool children together. We have had bus trips up to Berowra Waters, where we have chips and pavlova for the senior citizens. In these new estates we find people who have not been out of their homes for months. We have found a degree of isolation among some of the ethnic folk in the community, particularly the older generation. We have been able to bring them out, have a good time and meet their new neighbours et cetera. It is all about family and enhancing the quality of life in these new estates. There are problems and issues within new estates. As I said earlier, our concept is a multigenerational approach to planning—that is where we want to go next. With this planning issue, you people are in strategic positions to influence policy. That is why we were

keen and excited to be here today—to be able to plan some of these new estates that are caring estates.

Ms HALL—And age friendly components to the estates, as far as housing and access to services are concerned.

Pastor Weir—Exactly. I will take up that point about transport. Last week we were able to negotiate with Busways new express services from the new estates of Kellyville Ridge, Newbury, Stanhope Gardens and Glenwood into the city and into Parramatta. As we see needs at the coalface, we are able to go to those people and say, ‘The residents association support us 300 per cent and we support them 300 per cent.’ We write the same letters to make differences in the community.

Mr Ripamonti—We do not necessarily do all the work.

Pastor Weir—That is right.

Mr Ripamonti—We try to encourage facilitators. We stay as far as we can in the background but every now and again we have to go to the foreground but we still try and get them to do as much of the work as possible.

Ms HALL—It is about community empowerment.

Pastor Weir—That is right. It is about sustainability and empowering people. It is their community; they will own it if you can encourage and facilitate them.

CHAIR—Thank you very much for your submission, for your evidence today, which we appreciate, and for what you have added to the committee’s deliberations. I wish to thank all witnesses who have appeared before the committee today.

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

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.

Subcommittee adjourned at 12.59 p.m.