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

TUESDAY, 24 FEBRUARY 2004

BROKEN HILL

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
http://parlinfoweb.aph.gov.au

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Tuesday, 24 February 2004

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

Members in attendance: Mr Cobb, Ms Hall

Terms of reference for the inquiry:

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

WITNESSES

Subcommittee met at 8.45 a.m.

CHAIR—I declare open the 17th public hearing of the House of Representatives Standing Committee on Ageing as part of our inquiry into long-term strategies for ageing. I thank everyone for attending today and apologise that we are running slightly late. I have apologies from several committee members who will not be with us today. Before we commence, I will just mention a few things for your general information. The inquiry into ageing has been going on now for some 18 months, and was due to be brought to a close at the end of last year. When I became chair of this committee, I spoke to Jill Hall, whose electorate of Shortland is on the edge of Newcastle and covers part of the Central Coast of New South Wales, and I was a bit surprised that the committee had never been off the coast. It had been to Sydney, Melbourne, Brisbane, Perth and the Gold Coast and that was about it. Quite obviously, for someone like me that was not terribly good, and Jill agreed with me.

We have since been to Alice Springs and to Darwin about a month ago, and without doubt the issues are somewhat different. I expect what we hear today to be not too different in some ways to what we heard in Alice Springs in particular. Obviously in the Northern Territory ageing is a very big, specific cultural issue—for so many full-blooded Aboriginals culture is a very big issue for ageing there. Also, we have a large Indigenous population in my own electorate of Parkes and in western New South Wales generally, and it is a very big issue, but probably not such an enormous cultural issue as it is in the Northern Territory. However, we are dealing with that.

The report of this inquiry will be tabled in parliament in around May or June of this year. The inquiry is actually about ageing in all its forms. It is not just about aged health and aged care; it is also about the social implications and what people expect in retirement. This government and future governments will use the evidence of the inquiry to determine what legislation they may introduce and what policies they may use over the next 10 years or so. Obviously we do have a more ageing society, and already there have been some rather interesting side-effects identified during proceedings.

This hearing is focused on remote, rural and Indigenous aspects of ageing. Today we have four witness groups appearing before us, which include respite care services, rural medical health, ageing specialists and local, state and federal government organisations. The witnesses have been grouped into four categories: medical specialists; aged care providers; local, state and federal government organisations; and Indigenous organisations. Roughly speaking, we have allocated 40 minutes per group.

This inquiry represents formal proceedings of the parliament and is recorded. Witnesses are accountable for what they say because this inquiry does represent a formal hearing of parliament, so it is well not to stray too far from the straight and narrow. I call our first witness group.

[8.49 a.m.]

FLECKNOE-BROWN, Dr Stephen Crisford, Consultant Physician; Chairman, Medical Staff Council; Director of Clinical Training, Broken Hill Health Service

MENZIES, Dr Rosalind Frances, Director, Barrier Division of General Practice

CHAIR—I welcome you both and thank you both for giving us your time and expertise today. Obviously this is not an inquisition but rather for you to help us know what we need to know: specifically, rural and remote medicine for the ageing population—in this case in Broken Hill and the surrounding regions. I do have to remind you that this is a formal hearing of parliament and you are accountable for what you say, although I would not get too worried about that. I invite you to make opening statements, and then we will move to questioning.

Dr Flecknoe-Brown—I am very grateful to you, Sir, for bringing the hearing to Broken Hill and to you, Ms Hall, for coming all this way. I think the best thing I can do—no doubt you have done your homework—is to outline a few things that will put in perspective the comments of the people who are to follow in this hearing. The first thing is obviously what you have seen already, Ms Hall: we are a long way away. Our nearest hamlet is 100 kilometres from here, our nearest city is 300 kilometres and our nearest capital city is 500 kilometres away. That means we have to be pretty self-sufficient in what we do, not just in the daily challenge of providing medical care that Ros and I face but in all of the aspects of providing care for the ageing population. If you run out of nursing home beds, you cannot put them in the next suburb. If a person gets too sick to be handled in Broken Hill, you have to be ready to ship them that hour by fast plane to Adelaide.

The other thing that I want to emphasise is the historical aspects of life in this city that have led to certain unique characteristics, as I see them—that is, from the perspective of having spent five years in Broken Hill. This city was settled in the late 1800s and the people who are now in their 70s and 80s were mainly born here, as were their parents and grandparents before them. They are not about to leave, and why should they? There is another factor which people are becoming increasingly aware of throughout the country: because of the progressive contraction in the local economy, our property values have not risen the way they do in other parts of Australia. So the asset base on which these elderly people are retiring is shrinking by comparison with the rest of the country.

The third important factor is the fact that as our older people age in situ—who often enjoy remarkably good health into their 80s and 90s, by the way—their children and their grandchildren have moved away seeking other opportunities elsewhere. So the usual extended family network that you see is not as strong here, although it is pretty strong. Certainly the volunteer spirit and the tendency for people to look after the frail aged in their homes, whether they are relatives or just neighbours, is quite an outstanding feature of life here in Broken Hill. But the fact is that, as time has gone by, the elderly have got older and have had less to depend on from the usual informal networks.

There is another factor that should be brought to the formal notice of this committee—that is, it is hard to attract professionals at all levels to Broken Hill. That is not unusual; it is a country-wide phenomenon in rural Australia. We who live here and work here cannot understand that; we think we have the best lifestyle we could possibly have. But it is very hard to interest young doctors, young nurses and even accountants, lawyers and so on. The expertise is thin on the ground in getting people who you need to offer the support that is necessary to look after people as they get older and frailer. That means that we have a large number of frail or becoming frail elderly people in Broken Hill compared with most other parts of Australia, and we have fewer and fewer who can look after these elderly people whilst they remain in their homes. Hospital is just the wrong place for a frail elderly person to be.

I have the list of patients that I handed over to the incoming physician yesterday. Over half of the 27 patients that I handed over to Dr Qasim are in a bed specifically because they are either waiting for a nursing home bed or because home services that could allow them to manage at home have not been made available at that point. I do not want to overegg the pudding, but there is a big problem here in Broken Hill in terms of being able to get support to help a person stay in their home, which I think is by far the most important priority. When they can no longer manage in their home, I do not believe the formula that has been applied here in Broken Hill is realistic or fair to the town to allow the frail and elderly to live with dignity and comfort in some sort of residential care facility.

Dr Menzies—I represent the Barrier Division of General Practice, of which I am one of the directors. As a general practitioner, I have been asked to comment on issues on aged care in Broken Hill. There are three main issues I would like to comment on. The first relates to the availability of beds. The elderly are either independent, in a hostel or in a nursing home. In Broken Hill there are not enough beds in hostels or nursing homes, with the greatest shortage being in low-care and dementia beds. People who cannot quite cope at home and just need minimal supervision are often waiting a long time for a low-care bed to become available. Their mental health may deteriorate if they are not mobile and they therefore live a very isolated existence. Carers, including relatives, friends and home care services, often carry a large burden.

Existing home care services can sometimes not keep up with demands. Elderly spouses of less independent people may carry a huge burden, with their own health deteriorating as a result. Because of the shortage of low-care beds, fairly independent people sometimes unfortunately go straight from home into a nursing home, where they can be surrounded by high-care residents, for example, patients with dementia. This is not ideal. If there were more nursing home beds, more people could be transferred from hostels when appropriate for their needs, hence freeing up beds for more independent people. This would partly solve the problem. Another effect of not enough nursing home beds, as Dr Flecknoe-Brown said, is that chronic care patients, particularly dementia patients, are taking up acute-care beds in our 88-bed hospital.

The second issue is that the town does not have a geriatrician. Health care of the elderly is a specialty in itself. There are differences when looking after the health of an elderly person, for instance in the use of medications, the care of patients with dementia and the care of patients with very limited mobility. Dementia is a complex health problem, and often GPs do not have the skills to give optimum care to these patients. There are currently 10-11 full-time equivalent GPs in town whereas, going by the recommended ratio of 1:1,200, there should ideally be 16. We are hard pushed to meet the demands of patients who actually come to our surgeries and,

although some of us do visit the nursing homes, I do not believe we provide optimum care to those nursing home patients, because of time constraints. I personally believe that a geriatrician is one of our biggest needs.

The third issue is really a phenomenon which has been touched on, and it impacts on the first two issues. That is, the proportion of older people in Broken Hill is particularly large, as many ex-Broken Hill residents are returning here as retirees. The problem of their care is compounded by the fact that often the younger members of their families have moved away, so they are unable to care for them.

CHAIR—Thank you very much. You just mentioned the fact that it is very hard for GPs in the town to give due care in aged care situations. It was put to us yesterday in Dubbo that nursing homes would possibly be better off having doctors on retainer rather than relying upon the ordinary GP, because mostly it is not life and death issues for which doctors are required at aged care homes, so they tend to be put at the bottom of the list. It tends to be the last thing that is done in the day. Would you see any merit in that—assuming the aged care facilities could afford to do that? They might be better off having doctors who are on retainer rather than relying on visiting GPs.

Dr Menzies—Personally, I think I would rather see the existing GP services supplemented by a geriatrician's input.

CHAIR—Do you think that geriatricians act in a one-on-one sense now, or do you think they are more likely to oversee general physicians who are dealing with older people? Are we likely to have enough specialised geriatricians to deal with our aged population?

Dr Menzies—I do not know the answer to that, but I think ideally their skills are best applied very much on a one-on-one situation with the patient.

CHAIR—In other words, the problems of the aged require specialisation rather than general GPs?

Dr Menzies—I think we need both. Every person needs a GP, but if an elderly person could have the backup of a review by a specialist every now and then, with general practice care in between, I think that would be ideal.

CHAIR—In Broken Hill, I think there are actually only about 10 GPs.

Dr Menzies—There are between 10 and 11 full-time equivalents.

CHAIR—And that is around one GP to 1,900 people—which is way over the norm.

Dr Menzies—Yes.

CHAIR—And I suppose the aged care homes would suffer more than most areas there.

Dr Menzies—Yes, I think so; because they cannot get out and about.

CHAIR—They simply cannot cover them.

Dr Menzies—Yes.

CHAIR—Is the locum situation possible here, or is it impossible?

Dr Menzies—To help the GPs?

CHAIR—For the GPs, yes. Are you able to access locums—I assume from Adelaide—or not?

Dr Menzies—It is very difficult to get locums, but sometimes we manage. And they come from all over the place.

Ms HALL—Thank you. It was very interesting to hear what you had to say. Would you know what percentage of the population is, say, over 65 or 75 in this area?

Dr Menzies—No.

Ms HALL—Okay. Maybe we could find that information out. It would be useful. Do you have a geriatrician fly in and do consultations?

Dr Menzies—No, nothing at all. When I first came here, eight years ago, there was a geriatrician who would come for two weeks and then go away for two weeks. That seemed to work, but that has not happened since about then.

Ms HALL—So you are really in one of the worst positions that this committee has heard about. We were at Dubbo and they have one that visits, and even in the Territory they have got people who come in and out. Are there any GPs who have some training in the area of gerontology?

Dr Menzies—We all have our undergraduate training.

Ms HALL—But no specialised training?

Dr Menzies—No.

Ms HALL—Is there a shortage of allied health workers? I suppose that is a pretty silly question.

Dr Menzies—As in?

Ms HALL—As in occupational therapists, physiotherapists, speech pathologists—professionals who could work with elderly people and help them in the rehabilitation process. Could you also tell me a little bit about the rehabilitation services that are available for older people in Broken Hill? I do not think we have been given that picture.

Dr Flecknoe-Brown—All of the services that you have referred to come out of the base hospital and, at any time, we are at least one down in every department that you could name. In relation to physiotherapy, occupational therapy, speech pathology and dietetics, we are always running at least one down on the number that we should have. Because of the way this city is set up, all of the community support services are coordinated almost exclusively from offices in the hospital, so we are pretty well aware of what is going on around the community as well. We know that not just are there not enough people to do the work but there is certainly not enough funding to finance the number of hours that people need to be looked after in their home. It is almost impossible even with lay helpers, let alone providing domiciliary nursing time and physio and occupational therapy rehabilitation in the home.

There is a rehabilitation unit that has two arms to it: one is the outpatient section at one end of the hospital, which has a hydrotherapy pool and a fairly advanced gymnasium—again, it would be lovely to have enough physiotherapists to have it used to its capacity—and the other is an active rehabilitation program within the hospital for in-patients. We do not have a rehabilitation specialist. As Dr Menzies pointed out, we do not have a geriatrician either. Our only contact with geriatricians is through a video link with Concord Hospital in Sydney, which is used—Deb Jones will be able to confirm this—roughly once every fortnight, but it may be more often than that. That is a useful service, but it is no substitute for a warm body.

Ms HALL—Do you have any of those other specialties flying in and out, or is it all telemedicine?

Dr Flecknoe-Brown—Not rehabilitation or geriatrics, not at all. Most of the other specialties are covered by fly in, fly out people from Adelaide.

Ms HALL—What is the waiting time for assessment by the ACAT team?

Dr Flecknoe-Brown—Most of the time it is the ACAT 'person'. For various reasons, my understanding is that there is one full-time person and one part-time person on the Aged Care Assessment Team.

Ms HALL—What are their backgrounds?

Dr Flecknoe-Brown—They are both trained nurses with advanced experience. I am not sure if they have additional credentials. The waiting time for an ACAT assessment in the hospital is two weeks. I presume it is longer in the community, but other witnesses will be able to give you a more precise figure on that.

Ms HALL—If somebody is leaving hospital and needs a home modifications assessment, needs an occupational therapist to go and inspect the home, what is the waiting period for that and what is the ability to bring those modifications online?

Dr Flecknoe-Brown—The waiting time for a home assessment is usually less than a week. Our occupational therapist can usually visit within three or four working days. But, almost inevitably, the patient's discharge from hospital is delayed by about two weeks if anything more than very simple modifications are needed.

Ms HALL—My final question goes back to the number of people that you have in the hospital that are waiting for beds in residential care. Did you say it was half the total number of people in hospital?

Dr Flecknoe-Brown—I did, and there are a number of riders that I could make to that bald statement if we had the time. Basically, if you look at this list, I have marked 'b' for bed and 'h' for home care services, and you will see that half of this side of the list is occupied by that. Some of them have only just decided they want a bed rather than trying to manage at home and so have not been waiting very long, but others who are looking for that elusive category of low-level accommodation—a hostel or other accommodation that does not require a lot of care—in a nursing home are waiting for months.

Ms HALL—When one of your patients is discharged to their home, what sort of plan or program is put in place? What are the strategies that take place through the hospital to link that person into the appropriate services when they leave, with what is happening with their GP—although the GP is probably involved in the hospital process in Broken Hill, aren't they—and then to link them into home care, Meals on Wheels and all those types of things? And is there follow-through on that program?

Dr Flecknoe-Brown—In principle, discharge planning starts the day of admission but, in practice, that often becomes a little bit higgledy-piggledy because of other priorities at the time. We have a discharge planner and the Aged Care Assessment Team. The members of ACAT usually attend at least one of our weekly meetings on the ward. The frustrating thing is that you have to bring into play three different levels of government in order to discharge a patient who needs additional home care services. You need to get access to the Home and Community Care facility, which although it is funded by the federal government is administered by local government; you need to organise the Home Care Service of New South Wales, which is under enormous financial pressure at the moment—and that is a state government facility; and then you may be able to access an Community Aged Care Package, which is a Commonwealth-administered facility. There is a lot of juggling, a lot of blame shifting and a lot of cost shifting in that process. I think that we do our very best, but at the moment the Home Care Service of New South Wales have been told that they can only take on either two upgrades of level of care or two new clients—that is, a limit of two from either category per month—for the whole of Broken Hill and the surrounding districts. So if a person is going home and needs lay help in the home they will be waiting a long time.

Ms HALL—As part of this committee's recommendations, do you think that we should be looking at dealing with those issues of the fragmentation of services, the crossovers between the different levels of government and the blame shifting that is involved in the process?

Dr Flecknoe-Brown—I think so, but I think that could be one of the broader scopes of this committee's findings. It is not just in this area, it goes across the board in health care.

Ms HALL—Yes, that is exactly right. What about readmissions: do you find that there is a follow-through with these discharge plans or do you find that older people continue to be readmitted?

Dr Flecknoe-Brown—Regrettably, the answer is yes: there are far too many people who are readmitted just because the arrangements fell down somehow. For instance, if we cannot organise the discharge by Thursday morning, we have got that patient till Monday afternoon, because we cannot get new services into the home in those four days. And that is often the case with returns to nursing homes as well because the nursing home administrators are under such financial pressure that they have to plan their rosters and know how many people they have in to be cared for and therefore how many staff they need to put on. They need to know that on Thursday. So, there is one-way traffic between Thursday and Monday.

Ms HALL—Thank you very much.

CHAIR—I have one last question which arose out of something you said earlier in regard to the Community Aged Care Package. You said that you believe there is a shortage of beds of one kind or another. Do you think the main shortage is with in-home beds? Do you think we need more Community Aged Care Packages, which are in-home beds, or more nursing home beds?

Dr Flecknoe-Brown—I am quite convinced we need more Community Aged Care Packages. I am aware of the perceived shortage of nursing home beds, and that is partly because of the tightness of the formula. But there are a heck of a lot of people who could be looked after better in their own home and would like to be.

Dr Menzies—I do not have anything different to add.

CHAIR—Thank you both very much indeed. Would you be happy for the committee to seek more information from you in writing at a later date?

Dr Flecknoe-Brown—Absolutely.

CHAIR—Thank you again.

[9.17 a.m.]

CARTER, Mr Allan Keith, Chief Executive Officer, Southern Cross Care (Broken Hill) Inc.

COLBERT, Mr Andrew Lawrence, Manager, Shorty O'Neil Village, Broken Hill City Council

ROBINS, Mrs Dallice May, Chairman, Aruma Lodge Inc.

CHAIR—Welcome. I remind you that this is a formal hearing of parliament; it is recorded by Hansard. You are also reminded that you are accountable for what you say. Would you like to make an opening statement before we quiz your brains?

Mr Carter—Thank you for the opportunity of appearing before the committee. I want to briefly touch upon a couple of broad issues relating to residential care and how it relates to rural and remote conditions. The first issue is accommodation charges and their impact; the second, which was previously touched upon, is the disproportionate size of the ageing population in Broken Hill and how that affects the services that we provide for residential aged care. If you look at the history of aged care in particular, it seems to have revolved around a process of one size fits all. That would go back prior to the 1997 act under which we currently operate. When that act was introduced in 1997, the structure of accommodation charges followed that brief, I think, of one size fits all. I do not intend to touch on the move away, across the board, from bonds to charges. I think that has been shown to be not particularly applicable, and I would imagine that, sometime within the foreseeable future, bonds will again be addressed across the board in aged care.

I want to return to the theme of one size fits all. To construct a nursing home or any aged care facility at the moment, you would be looking at somewhere in the vicinity of $110,000 a bed. If you take that figure as a nationwide constant and the fact that bonds have no upper limits on them, you would expect the bond to be higher in Sydney than it is in Melbourne, which is higher than it is in Adelaide and so on. The bond difference between that $110,000 figure and the bond that is charged would reflect the cost of the land to construct the particular facility on.

The wheels fall off the one-size-fits-all model when you get into a community like Broken Hill, because you are still going to pay $110,000 a bed to construct an aged care facility—maybe more, depending on which figures you use and whether it is Adelaide costs or east coast costs. History would show us that bonds of less than $40,000 are the norm, which is a long way short of the $110,000 that it costs per bed to construct the facility, without factoring in land. Land is not a particularly expensive commodity in Broken Hill, but you still are not anywhere near putting the bricks and mortar on the ground with a bond of less than $40,000.

Compounding that problem is the fact that at Southern Cross Care—and I assume these figures would be fairly typical for the other providers in Broken Hill—we consistently run at 75 per cent or higher of concessional residents, whose asset levels are less than the current $28,500 limit, which means they are not in a position to pay a bond. Although we receive a daily

supplement as part of the federal funding, again that does not add up to a point where you are in a position to put $110,000 a bed into the construction of new facilities. The point that needs to be considered is that, if residential aged care is going to be a model for the next 40 years, then, when considering the capital requirements to construct these facilities, the one-size-fits-all model does not work and the special circumstances of rural and remote areas have to be considered.

The other point I would like to return to—and Dr Menzies and Dr Flecknoe-Brown alluded to this—is the fact that the high proportion of aged people in the population in Broken Hill has the effect that there is a lower number in the population here from which to draw staff. There are extreme recruitment and retention issues with staff in a rural community. The training of those staff is fairly expensive. There is a tendency to train somebody, have them for six months and then, as a family decision, they move to Adelaide, Sydney, or wherever it might be. So you are back on this roundabout of constantly having to recruit new staff from a diminishing basis.

There is also a second effect that comes from the diminished population of people in a rural community, and that is the fact that, where in Sydney or Adelaide there is family or carer support within the home and within the community, which means that the person can stay in their home for a lot longer, what is tending to happen within a rural community such as Broken Hill is that that diminishing family support base means that the pressure to move into a residential facility comes earlier, which again places pressure on us as residential providers. Support can come from the community. Obviously there has to be, for want of a better term, a way station. That happens to be the hospital, which creates other issues as far as the provision of care within the community is concerned.

Mrs Robins—Aruma Lodge Inc. is a hostel for aged care. I would like to congratulate the government on its initiative in looking at the long-term strategies for ageing over the next 40 years. I am hopeful that the information gathered here today serves to make a difference. I am speaking to you today with very minimal experience. I am really only speaking about Aruma Lodge. The background of Aruma Lodge and the associated moral and ethical complexities and the community feelings of ownership in the facility are important. The building is 24 years old and was originally built as a low-care facility. Aruma Lodge has over the years established itself as a highly thought of and unique facility for aged care residents of Broken Hill, and because of its beginnings has developed its own special culture. The citizens of Broken Hill feel a great sense of ownership towards the organisation.

You might ask yourself, 'How is this relevant?' Enormous amounts of community money have been provided, and therefore there is a huge moral obligation on incumbent boards to somehow try to retain this culture and the sense of ownership as well as deal with the ever-changing times and changes to government ageing requirements. Unfortunately, it has become less about the level of care of our elderly and more about dollars and business, which means things are now weighted very much one way.

Difficulties associated with managing aged care facilities increase demands on staff, skills, training and the physical layout of the facility, and they have an associated impact on the ability of the facility to function. When ageing in place was introduced, it dramatically changed the face and functioning ability of Aruma Lodge. It is not hard to acknowledge that a purpose-built facility becomes far less functional when the signposts are moved. The problem is not often recognised until it is almost too late and the facility finds itself in financial difficulty. It creeps

with the ever-changing directives of government. Poor physical layout, which directly impacts on the care, is another problem. Getting around the building is a major staffing and care issue. Changes could be made, but that would require time, money and resources.

Staffing issues are—as Allan has already mentioned—retention, training, education and level of care. Costs associated with accreditation and having to pay to meet the mandatory standards also play a part. Accreditation is an enormous burden on an already cash-strapped facility, not just because of accreditation costs, but because of the documentation and preparation time—time that should be spent on what the staff have actually been employed to do; that is, care for the residents. Allan has mentioned accommodation bonds, and I am sure there will be much talk of them during the day. We of course have the same problem.

The last point that I would like to make is that there needs to be some sort of access to education, training and management skills to enable boards to meet the complex demands of the roles they find themselves placed in. Many of these boards are made up of members of the community and well meaning citizens, and their knowledge is very limited. Certainly, when they get into a situation like this, sometimes it is extremely daunting. Boards need some form of help and ongoing mentorship and some sort of access to training. Do not forget that most of these boards are voluntary.

For Aruma Lodge—and probably for a lot of other organisations and facilities as well—it seems that there is no room in this economic climate to stand alone. That is fairly sad because I do not believe that big is always beautiful. Aged care for Aruma Lodge is at a turning point, as I am sure it is at many other facilities across the nation. Government funding is not enough. Aruma Lodge has little option left but to seek a relationship with a larger organisation and, in doing so, we will lose our grassroots ideology.

Mr Colbert—Shorty O'Neil Village is a 40-bed aged care facility. I guess that, as you are at your last stop, a great many of the complex matters have been dealt with. I want to speak on a number of the issues around the inflexibility in the way the Aged Care Act is applied and how that affects a remote facility such as Shorty O'Neil Village, and the local community. I believe one major issue is that, when we are evaluated for numbers of aged care beds, we are in fact part of a much greater area that takes in Dubbo et cetera. In a way, it is almost offensive to families and the aged persons themselves that it is presumed that, should a bed become available in Dubbo, they should take that bed for their family member, which would entail 10 hours of driving each way. While we are estimating and our numbers are being based on that area, that is exactly as it is. For instance, if numbers in Dubbo—using your good home, Chair—are way over and we are under the recommended per head number, then that formula is not going to change in a great period of time, no matter what the demand is in Broken Hill. So I think that we need to be judged on bed numbers for accessible beds only. For that, I would not consider beds at the Wilcannia base hospital as being accessible either. If families have to travel great distances on the outback roads then that is not a suitable placement for an aged person.

Further to that, one of the other issues we face out here is the support networks that aged persons have, which Allan mentioned. The fact is that in Broken Hill older people have a great many fewer support networks of family and friends because of the migration out of the city. As low-care facilities, we are not funded to accompany residents to medical appointments or anything. If a person in our facility does not have a family member or a friend who is able to

take them to an appointment then they either get a cab out of the 15 per cent of their income that remains after paying their fees or go without seeing their GP. I would suggest that a number of people do that.

An issue that was touched on earlier, relating to the number of low-care beds, was the fact that perhaps a lot of this can be picked up by aged care packages. Particular to Broken Hill, and I think as you drive around you will see this, is a great many 100-year-old wood and iron buildings that are falling into the ground. To put packages into those and ensure the occupational health and safety of the workers attending to those packages would cause insurmountable problems in a great many instances. It is a fact that there are people living in Broken Hill in properties that ought to be condemned and are very unsafe, yet they cannot do anything about it because they could not possibly afford the renovations. They cannot bring it to the attention of the authorities, because they will be removed from their homes and there is nowhere to go.

Another issue that affects us greatly is the inflexibility around the licensed bed numbers. In Broken Hill it acts as a very discriminatory policy against aged couples. If there are two people in the community both requiring care, they have to wait for two people to die simultaneously in a nursing home to get a bed. Invariably this means one partner in one nursing home and the other partner in another. Or, as we frequently see here where dementia is involved—and this is the case for a number that I know of at the moment—one resident is in care in Broken Hill and the partner that they will never see again is 500 kilometres away in Adelaide.

At accreditation time, when a facility is examined it should be examined for its ability to supply an extra place. Our facility has 40 beds, but there are 40 self-contained units. I could have 80 couples in there, but at the moment I do not have one because of the formula. You could take both partners into the one licence you have available and care for the other one for free, which has happened and is happening, but facilities certainly cannot afford to do that.

Earlier the geriatrician was spoken of. We are very fortunate that we have workers dedicated in the area health service to establishing the geriatrician link to Sydney. It is extremely helpful, but I think that telehealth has its limits and there really needs to be a frequent visit on that part because there are some circumstances and situations, especially where dementia is involved, where a telehealth room at the hospital is not an appropriate place to conduct an evaluation of a client's needs.

On training, while we provide very good training here to the staff, it is the higher level of training that is almost impossible to access. ACS have only offered one training course in Broken Hill in the last two years, I believe, and therefore we have to look at flying people to Sydney every time to attend any sort of training.

Before I finish, one other point that was raised earlier by Ms Hall was about the linkages of services within Broken Hill. I would say we are very lucky: our isolation has taught us greatly, and every fortnight all providers of aged care meet, examine the ACAT list and discuss where people are at. That way we try to prevent people falling through the net. There is a great deal of dedication; it just needs a bit of support.

CHAIR—Thank you very much. Could I ask: how big is your waiting list, Allan?

Mr Carter—For high care it is not huge. I could not put a number of it—three or four at the moment. When I looked at it this morning, they were still awaiting ACAT assessments.

CHAIR—Low care?

Mr Carter—That is a difficult one to judge. The list is quite extensive, but when a vacancy comes up there tends to be a response of, 'Look, I'm not ready yet, but please don't take me off the list.'

CHAIR—That is pretty common.

Mr Carter—Again, I am not sure of the actual number, but I would think that it would be well in excess of 10 to 15 people. Whether they are ready to actually move into a facility at the time the bed is available is another issue.

Mr Colbert—I would say it is a completely different story for us. Let me describe the facility first. Everybody has their own home. They have their own front yard and backyard. All of their meals and nursing services are delivered into the home. As you can imagine, it is a very popular destination.

CHAIR—Do you have any high care?

Mr Colbert—We are a low-care facility, but we do manage high-care people.

CHAIR—You take them through?

Mr Colbert—Yes, we do age in place.

CHAIR—But everyone comes in as low care?

Mr Colbert—Everybody comes in as low care. Therefore, we have a very extensive waiting list. You do not need to ring the moment a unit becomes available, because people are aware when someone in the village has passed away and I will have family whose parents are down on the list phoning that day.

Mrs Robins—I cannot speak positively about numbers, but I know that we do have quite an extensive waiting list and that would be a mixture of people from the low-care level to the middle category range and perhaps even higher.

CHAIR—Allan talked about concessional residents. Do you all have concessional residents?

Mrs Robins—Yes, we do.

CHAIR—Does that mean that there are people coming in as low care that you are not taking any bond at all from?

Mr Colbert—The majority.

Mr Carter—Bond or accommodation charge for high care at the moment.

CHAIR—Do you make that assessment on the fact that they do not have a home or assets at all? On what basis do you make that assessment?

Mr Carter—There are definite guidelines within the act as to how you would determine a person's concessional status. But the peculiarity of a place like Broken Hill means that, even if the house does count as an asset, it is quite common that the asset total is still under the threshold, so that person can still be concessional.

CHAIR—The point I am trying to make is that 75 per cent is very high.

Mr Carter—Extremely high, yes.

CHAIR—Mr Colbert, is your organisation anything like that?

Mr Colbert—Yes.

CHAIR—Compared to Dubbo or Sydney that is a very high figure. It really shows that the level of property assets here is at least less than half of Dubbo and a fraction of Sydney. That is what it is based on, isn't it? Is it pretty much because of house values?

Mr Carter—Yes. I think it is fair to say with elderly people that the major asset they are going to have is their house. As an example, the low-care facility that Southern Cross operate has 27 beds. For those 27 beds, for the first time since 1997 we have actually exceeded $300,000 in bonds in total—that is not one bed. When I make comparisons with my colleagues in Southern Cross in Sydney, that would not be one bond, let alone a total for a 27-bed facility.

CHAIR—I think we heard yesterday that $98,500 is the average bond rate.

Ms HALL—Thank you so much. It is very interesting and it must be very challenging for you. You must be finding it really difficult to manage to operate under the current acts that are in place. I think that it is probably a tribute to your resourcefulness and ability and your commitment to the community that you actually do manage to deliver under such difficult circumstances. Can you fill me in on the types of facilities that operate within Broken Hill? Are there any for-profit facilities? I am sure that there are many that are not-for-profit. That in itself is a very big statement and supports what you are saying about the accommodation bonds and that you really need some organisation behind you to be able to survive in this environment. In regard to the staffing mix, would you like to give me a bit of a rundown on your ability to get registered nurses and whether there are any additional costs associated with that because you have to pay nurses to come in?

Mr Colbert—At the moment we are re-examining the role of the enrolled nurse in line with the changes that have been made to their ability to administer medications. Part of what we are examining is the long-term future of registered nurse availability in Broken Hill. In August of last year, our part-time registered nurse retired, and we have not been able to replace that person. So we have one full-time equivalent registered nurse for a 40-bed facility and are enhancing the enrolled nurse roles as a result.

Mr Carter—We operate two high-care facilities and under the act are required to have a registered nurse there 24 hours a day. We usually manage to cover that fairly well. There are times when it is particularly difficult, and from time to time we have actually had to have the managers of the facility come in and work a shift—the afternoon and night shift in particular—because there is no availability of registered nurses. A good example of where that issue leads is that we have one registered nurse on our books who is 74 years of age. She should be retired, not working. But for our purposes she fulfils a marvellous role, in that she is happy to work and we need those skills. We are very grateful that she is there and available.

The role within nursing homes or high-care facilities for enrolled nurses at the moment is not great. They could be of tremendous value to us if the restrictions on what they are allowed to do under the Nurses Registration Board et cetera were modified so that the skills that they obviously have could be used. Unfortunately, under current regimes they cannot. The majority of our staff involved in caring for residents are assistants in nursing. I would think that in excess of 90 per cent would have done the certificate III in aged care. That has obviously enhanced their skills, but I think is also an indication of the dedication of the staff that work in aged care. They believe that there are skills they need, that walking in off the street is not an acceptable starting point and that they need to go and get those skills. There is a very strong education program within the community for that certificate III in aged care.

Mr Colbert—All of our staff have the certificate III.

Mrs Robins—We have a 58-bed facility. Ten of those beds are in a dementia wing, therefore we need to have an RN—a registered nurse. We have one, but, even if we were able to access more, we would not be able to afford to retain that person, simply because most of our residents are in the concessional category.

Ms HALL—Do you have difficulty getting AINs as well?

Mr Carter—No, but they tend to rotate. As I said earlier, we get somebody, we put the time and the effort into training them and then, due to family decisions or whatever, they disappear or they knock on my door and say, 'Do you know anybody in Adelaide who might be looking for a PCA or somebody who has worked in aged care? We are moving to Adelaide.'

Ms HALL—Do you have that difficulty, Mrs Robins?

Mrs Robins—Not to my knowledge.

Ms HALL—Is your work force an ageing work force?

Mr Colbert—The average age of the care staff would be—I am guessing—in the mid-40s.

Mr Carter—Our staff are of a similar age and getting older.

Mrs Robins—I would say the same

Ms HALL—You did mention a little bit about the requirements for facilities with documentation, the issue of red tape and the requirement for you to record everything in great

detail. Does that have an enormous impact? Would you like to share with us a little bit about the RCS and how that impacts on your ability to provide care and function?

Mr Colbert—I do not attend the RCS, but I know it takes a significant amount of the registered nurse's time. I would not want to go too far into it, because it is currently under review and I am hoping that the new RCS will be much more user-friendly. It is not our biggest problem. I think accreditation is the best thing that could possibly have happened to aged care. It needs to be finetuned, but I think that is all about the accreditation process. I do not think the documentation—for me and for staff—is over the top; it is at its limits but, to cover our duty of care, I do not find it too unreasonable.

Mr Carter—With the RCS, I have not been in any way directly involved in the care and I can only make some general comments about it. To look at it from an administrative point of view, it rankles a little with me that the criteria for validation—I am not saying there should not be validation of any claim against the system—is how well you write the paperwork, and the volume thereof. Copious quantities of paperwork are required. Should you have a validator arrive for the RCS, you find that your care staff are spending more and more time on documentation and that is something which annoys them. They see their role as providing care to the residents, and they do not believe that sitting somewhere at a table writing copious notes about the care that was provided is maximising the care that they provide to the residents. The other side of that whole validation process in the RCS as it currently applies is that, when the validator turns up, the only thing the validator looks at is the notes. To us it seems incredible that, if the validator is a trained registered nurse, they cannot have a look at the care that is being provided on the floor, which would indicate the level of care required and whether or not the claims being made for that care are valid.

Mrs Robins—I would like to support Allan's statement.

Ms HALL—Have you had many of your residents reviewed and—in the clawback that we hear about—reclassified at a lower level?

Mr Carter—We are smarter now.

CHAIR—Everyone has been smarter on that one.

Mr Carter—The initial validation visit we had cost us a clawback somewhere in the vicinity of $100,000. One of the problems that arose that caused the clawback to occur—and this was in the early stages of the act—was that we had a friendly visit from a departmental officer who went through and briefed us on what was considered valid and how you did these things et cetera. When the actual validator turned up, the response was: 'You can't claim that.' Our response was, 'That's what your colleague said.' The validator said that she was wrong. We had set up our mechanisms, paperwork and systems around what we were told and it cost us. I think we have had, over the period of the current act, three or four validation visits. We have progressively done better in not falling victim to as much clawback as the first one, but we have lost money on all visits in varying proportions.

Ms HALL—Is it a problem that different validators look for different things and that there is no consistency?

Mr Carter—That is a part of the problem. But interpretation is probably even more of a concern than what is the flavour of the month in that particular area—for example, the focus of whoever comes out, whether it is RCS validation or accreditation. We all have our pet themes et cetera, and you can live with that. The thing you need more than anything is that the interpretation is consistent.

Mr Colbert—It has been at least two years since we have had a validation. Should one occur now, what are the implications of that very long period since the last one? In that time, there has been a new manager at the facility and we have lost one of the registered staff. There could even have been a new registered nurse working there and not used to the system. There has been no check and then, after this very long period, someone may come in and say, 'It has not been correct to this point.'

Mrs Robins—I have nothing further to add.

CHAIR—Andrew, you mentioned the ability to bring in a husband and wife in different circumstances. Simply adding more beds would not necessarily solve that; it is not going to make beds become available at the same time. Are you suggesting that, where you have a dementia and a low-care situation together, or a high-care and a low-care situation together, the government should make more provision for the partner coming into the low-care situation or the hostel? Is that what you mean?

Mr Colbert—If both of the couple qualify for low care, they have their own unit at my facility. There is no problem for me putting another bed or a double bed in that unit to house the couple. I just cannot do it because I need 41 licences to do it. I have only 40. So, unless I want to leave one vacant for a long time—and obviously the financial implications would be murderous—and wait until I got another vacancy, then one of those couples on the waiting list would have an opportunity.

CHAIR—So what you are talking about is a variation which has to be based on justifiably being used and then withdrawn when not necessary?

Mr Colbert—Yes. Should one of the couple either pass away or move on to another facility, then at that point you would be reduced back to your 40 licences.

CHAIR—The other question I want to ask all of you is in relation to the surrounding areas, be it Tibooburra, Menindee, Wilcannia or wherever. Do the surrounding areas have any particular effect on what you do? Do you make any provision for people from outside Broken Hill?

Mr Carter—Not in a conscious or deliberate sense. If somebody from Tibooburra, Menindee or wherever were looking for a bed, they would be considered along with anyone else. The allocation of that bed would be on priority and care need. I would imagine that somebody living alone in Tibooburra might have a higher care need than someone perhaps in Broken Hill. Historically, though, we have not had a lot of residents for the nursing homes, in particular, come from surrounding districts. They tend to mainly be sourced from Broken Hill.

CHAIR—Is that the same for you, Andrew and Dallice?

Mr Colbert—Yes.

Mrs Robins—We do have a few regional people in our facility right now. It is a very small number.

CHAIR—Do any of you have any Indigenous residents?

Mr Carter—We have three at the moment.

Mr Colbert—We have none at the moment.

Mrs Robins—I think we have three or four, but I am not 100 per cent sure on the number.

CHAIR—Do you have to make special provision for them in any way? Obviously, it is somewhat different in the Territory because there are many more cultural differences there. Do you have to make any different provision for them culturally or in any other way here?

Mr Carter—Not at the moment. There is less pressure on us as providers because of the CAC Packages that UnitingCare have and are running in the district at the moment. I think that is a far more appropriate model for caring for elderly Aboriginals, and they seem to be covering that fairly well at the moment.

Mr Colbert—I would agree with that.

Mrs Robins—I would just like to say that, in the lower care area, their cultural needs have to be addressed and therefore the staff need to understand their cultural needs. So an amount of training needs to be done there.

CHAIR—Is it something that the staff have to be trained to deal with?

Mrs Robins—Let us say that they should be.

Mr Colbert—I would say that usually—and we have had a number of people who come into respite—they have support workers. Those support workers come in and speak to the staff and inform the care plan. So it tends to be part of the care plan, which is applied to everybody who comes through. Once again, because everybody has an individual house, we obviate a lot of the issues.

Ms HALL—Mr Colbert, you handed some information to the secretariat about the 2001 census figures for Broken Hill. Would you like to put that on the record for us, please?

Mr Colbert—According to the 2001 census, the percentage of residents over the age of 65 in Broken Hill is 17.7 per cent—that is, 4,624 people out of a total of 20,269.

CHAIR—Thank you very much indeed.

Proceedings suspended from 10.01 a.m. to 10.21 a.m.

MILLMAN, Mrs Donna Patricia, Community Programs Manager, Broken Hill City Council

JONES, Ms Debra Maria, Manager, Aged Care Services, Far West Area Health Service

TREBILCOCK, Mr Anthony Mark, Branch Manager, Far West Area, Home Care Service of New South Wales

VICKERS, Mr William, Pension-Welfare Officer, Legacy; and Pension-Welfare Officer and Vice-President, Returned and Services League

CARTER, Mr Allan Keith, Chief Executive Officer, Southern Cross Care (Broken Hill) Inc., representing Aged Care Focus Group, Broken Hill

CHAIR—I welcome the witnesses. I remind you all that this is a formal hearing of the parliament and is recorded by Hansard. Witnesses are accountable for what they say. Would any of you like to make a short opening statement before we move to questions?

Ms Jones—The Far West Area Health Service covers 270,000 square kilometres, and we are the largest geographical area health service in New South Wales. I think the Sinclair report said that if you put every one of our population out to pasture, we would have about eight square kilometres each to graze on. That is a reflection of how sparsely populated the whole area of the Far West Area Health Service is. From a clinical management perspective, ageing for older adults in rural and remote settings over the coming decades raises many complex issues. Currently, the continuum of care for older adults is only as strong as its weakest link. The provision of quality clinical care means little if frail older adults and their carers cannot access functional support in the community. It is also lacking if older adults frequently re-present to the emergency departments due to poor clinical management or inappropriate discharge planning. If this continues to occur then we continue to fail those most at need.

The future needs of rural and remote older adults must be met with the same opportunities as their metropolitan counterparts have. Geographical location should not be a tool used to marginalise and rationalise resources. All initiatives must be underpinned by access and equity to resources. Current funding formulas are heavily weighted to population size. This obviously disadvantages sparsely populated areas. Although these areas receive additional funds based on isolation and population make-up, there remains a failure to acknowledge the depth of complexity confronted in some of Australia's harshest environments. Issues such as limited care options, distance, isolation, lack of access to specialist resources, poor health care statistics and the migration of younger cohorts to areas with greater employment opportunities must all be taken into account when discussing visions for the future.

Aged care providers in western New South Wales are well aware of the current gaps in service availability and are working as a cohesive unit to identify strategies which will address these issues in a manner that suits our populations, communities and environments. It is essential to highlight that growing old is a success story and that ageing and death are chapters of the life

continuum. By ensuring that aged care is incorporated into primary health care models, older adults can expect to age, and age well.

So as a clinician and one of those who will be 80 in about 40 years time—now I have give away my age—what do I and others who want to continue their life styles of the nineties in the 21st century expect? I expect: to have access to services as I require them and to have them delivered in a timely fashion; to have trained and skilled professionals providing care, whether that be acute care, community based care or residential care; to be safe within my community and protected when I am most vulnerable; to be an active participant in all aspects of my health care and society; and to have a streamlined continuum of care that is not fragmented by differing funding bodies, guidelines, ownership and limitations.

As a clinician, I also have expectations. I expect that the far west will advance into clinical streaming for aged care. I would expect a multidisciplinary team specialising in ageing, not only in illness but also on how to keep me healthy and independent. I would expect prompt and appropriate assessment services. Aged care is a core element, as I mentioned earlier, of the primary health care model. I would expect access to health promotion and ongoing education. I would expect nurse practitioners in aged care and chronic care to be available in our emergency departments.

How do we achieve this level of care in rural and remote communities where resources are limited, recruitment and retention of staff a chronic challenge and access to specialist services a treat? From a clinician's or manager's perspective, we must strengthen our current partnerships. In the far west, we must expand on our partnership with Concord Hospital and go beyond access to geriatricians and psychogeriatricians via telehealth. We have the potential to rotate our staff through these metropolitan sites to enhance skills, training, education, mentorship and preceptorship. Once we have achieved a highly skilled, multidisciplinary team, we will then put this team on the road across the far west to offer support to our isolated communities.

We can move this team from larger sites because we will have nurse practitioners placed in emergency departments who will be capable of transitioning with complex aged care clients into acute, community and residential settings. We will have clinical nurse consultants located in our three sectors and clinical nurse specialists based at local levels. We will have a locally based nursing career pathway, which starts at high school with certificate II aged care and community care and progresses to certificate III, hopefully IV and then on to supporting bridging to registered nursing and onwards to nurse practitioner.

We as rural and remote practitioners must seed and sow bush nurses for bush communities. We must expand our comfort zone beyond telehealth and take technology into the homes of our more isolated aged. We conduct surveillance, management and support via web cams but we never forget that human contact is essential and that technology can only be a support, not a primary measure in providing care. We ensure all carers receive appropriate training and support and that when needed crisis respite is always available. As part of a team, we progress these initiatives in partnership with our community and residential providers.

These are some of the visions, but little can be achieved unless adequate funding is available. In essence, rural and remote aged care providers and consumers have the ability to achieve equitable, accessible and quality aged care. We will find local models of care to meet local

needs, but in doing so we also need state and federal support to overcome the restrictive barriers that currently exist. We also need additional funding so we can progress models of care.

Mr Carter—I will jump in here because I have not got a lot to say. I had my turn before. All I would like to say at this point is that I am here to demonstrate that in a rural community we can work as a cooperative. We understand there are issues for rural and remote communities and we also know that the only we can come up with any sort of solution is by joining across the whole spectrum of funding, care provision et cetera and working together towards the better outcomes that we can achieve in the area of aged care within the community. I would suggest that, with this committee looking 40 years out as to where aged care is going and the issues that surround it, the progress we are making as a group in focusing within the local community may be a model that has some application elsewhere.

Mrs Millman—I have been asked to attend today to discuss issues surrounding aged care services in the community. These issues were identified through interagency meetings with health and aged care services, ACAT meetings and HACC forums. I will go through the issues we have identified. There are limited secure dementia-specific residential places. Therefore, when the need arises, the existing services are unable to meet the needs of people with challenging behaviour, such as wandering et cetera, because of the limited services that are available. Often people with dementia are assessed as only requiring low-level care when in fact their needs are high due to their behaviours. There are limited resources and service providers in the more rural and remote areas, such as Tibooburra and Ivanhoe, and the costs associated with service provision in these areas mean that we are unable to buy services if they are not available.

The fact that there are limited private service providers reduces options of purchasing specialist services. There is reduced family support, as has been mentioned earlier, because family members are leaving Broken Hill or are ageing and already have work commitments, so we are not able to rely on them to assist in supporting their family members in the community. The provision of in-home palliative care support is not always available for people with high-care needs, due to the high costs associated with providing this level of support. Another issue is the waiting time for veterans' home care and assessment, which means it is not always available when required.

Regarding post acute care and the lack of short-term support options, sometimes these people do not fit into the HACC target group. As to uncoordinated discharges, previously we did have a discharge planner, and I know that the idea of discharges from the hospital back into community services was a lot more successful. We do have a social welfare officer based in the hospital to assist with patients with complex needs, but his time is often limited as well. There is also the increasing demand for low-level support, such as cleaning and gardening services, which has been mentioned.

CHAIR—Thank you. Are there any other statements?

Mr Vickers—I am here essentially to represent the service men and women and children involved in veterans' affairs in Broken Hill. Legacy, as we all know, has 133,000 widows. It is self-supporting; there is no government assistance whatsoever. In Broken Hill we are at the stage now where we are still holding 293 widows. That has varied from 300 to 270 over the period, but what is significant is that 240 ladies are over the age of 75. That tells us that we have a fair

number of issues to look after in the next five to 10 years. Of those, only six of them are post-World War II veterans—for instance, Korea and Vietnam—and another was a First World War veteran, so it is kicking up that we have not gotten through the age group of the Second World War yet and we still have Korea, Vietnam and all the conflicts that have happened since then.

CHAIR—Did you mean veteran widows or people who just served?

Mr Vickers—No, that was overall widows. The veterans are about 30 per cent, I think. At present we have no dependent children or disabled people, but that can go up and down as we progress through the years. What we have to look at now, as the World War II veterans pass on, is that we can expect the number of widows to increase over the next few years and then slowly subside after about the 10-year mark. It is going to be pretty hard, so I daresay Legacy in the future, with the draining membership and fewer people to look after, will most probably be looking at government funding somewhere along the line.

We think that in 2025 we will only be looking after around 80 people through the Legacy range, so for the next 20 years or so the number of people we have is going to drop drastically. On the veterans' affairs side of it, one of the things I would like to look at is the availability of transport—air, rail and bus—to get these people to specialist treatments in Adelaide or Mildura, whichever the case. At present we have 296 veterans on our books here.

Another problem that we are finding here in Broken Hill at present is the gold card. What has happened is that a lot these ladies and men have had a general practitioner as their doctor for 20 years, whereas in the last two or three years we have had a big amount of doctors that come into the city, are here for a short time and go. For instance, in the last two years I have had three different doctors in Broken Hill, whereas previous to that I had one for 15 years. Our elderly are finding that very hard to get around. Also, there are only a few doctors that are accepting the gold card nowadays for the veterans or for the aged people. This is causing a fair problem in Broken Hill. A lot of the doctors that do accept these cards are the ones that are coming in and out within a six- to 12-month period. So it is a problem we have to look at in the future.

Another major problem that we have to look at is our single returned soldiers. We are talking about people's wife dying or their husband dying. I think more so now and in the future it is the male person. What happens is that most times their wife has been their carer or assistant who has helped to get them around the town, to the doctors or whatever. When their partner falls off the planet, most times there is no-one to fill that void because most of the children have gone away and done their university course or whatever it is and they are not in the town to look after these people. We are finding at present that a lot of us are driving these people to Adelaide because it is about a four- or five-day turnaround to go down and back on the train. We have problems there; Veterans' Affairs will not pay the five days accommodation for one doctor's appointment in Adelaide. This is something that is increasing. The only transport we have here that goes daily is the plane. But then a lot of older people are frightened of the aircraft and the travel is restricted for them. If not for the goodness of some people like me or our RSL members taking them to Adelaide for this particular treatment and bringing them back, they most probably would not get it.

Also, there is nothing for them in the house. We have got HACC, we have got all of these people that do it, but a lot of these old diggers are pretty hard set in their ways. They will not go

out of their way to find assistance. Unless we know there is a problem, it is pretty hard. In the next few years we are going to have to do a fair bit of education with these older veterans to let them know what services are available. But there is not a problem until their partner goes on, and then they seem to be left in a dark spot.

Most of the Second World War veterans came home with a 'nothing wrong with me' type mentality. In the latter years, they have had their depressions, and their different things, but they are in the same boat—they will not come and ask for assistance. In that sense we have to start looking at more educational programs to come out to let these veterans know what is available to them. In Broken Hill we are pushing like hell through the RSL and all these other organisations to make sure that that is an area that is covered, but it is pretty hard if they do not know.

I think the next ten years is going to be a pretty hard area with the end of the Second World War veterans. As I said, they are nearly all in the seventies; some of them are even up in their 80s. We need to get a bit more assistance with programs to come out to let them know what is available through the Veterans' Affairs, through different organisations, through local hospitals and doctors—because once their wife goes, they do not seem to know anything, and it is a big problem.

CHAIR—That is true of most men.

Mr Vickers—Yes. That is the stuff that I am mainly interested in. If we can get a bit of assistance on those types of roles, I think we will be quite happy in Broken Hill.

Mr Trebilcock—To give you a profile, the far west area branch of the Home Care Service covers the Broken Hill LGA, the Wentworth LGA, the Balranald LGA, the Central Darling Shire and the unincorporated area of New South Wales. We currently service 532 clients from a variety of funding sources, which include HACC funding, community aged care packages, Commonwealth respite for carers, and the veterans' home care program. All the community service organisations in Broken Hill at the moment are operating at capacity, and that capacity is directly related to budget. All the services meet every week. We work very collaboratively together. We try and workshop through the clients who are referred to us to get the best outcomes for them. Just as a note on that, over the last six months the Home Care Service has received 122 referrals for service and we have been able to progress 62 of those to actually receive service.

It has been touched on before that, while we have funding being allocated on population group planning, it does not take into account the demographics involved in rural areas. Having contact with Wentworth and Balranald, I know they have the same sort of issue. We are in rural communities. The family supports that you would normally have in those areas move away for economic reasons, so the burden of care comes back to community organisations. The Orana far west area has received very little in growth funding for several years.

Some of the issues that come up continually—and this applies to the earlier submissions that you have received—relate to blocked beds in hospitals—

CHAIR—Sorry—blocked beds?

Mr Trebilcock—Blocked beds—that is where people are inappropriately in hospital beds. In the ideal world, if we had sufficient funding, we could provide service to those people but, unfortunately, at the moment that is not the case. In a lot of ways, if you are looking at what will happen 40 years down the track, I believe that this area and similar areas are quite possibly already there—we are at capacity and there is very little room for growth. Because people's life expectancy is now longer, when people come into community services they tend to stay with that service for a lot longer than has previously been the case.

CHAIR—Thank you. What is coming through very strongly in Broken Hill is probably a little different to what we have struck elsewhere. It is probably the opposite of Dubbo, for example. Here, the rest of the population is moving out and all the older people are staying. Listening to what people are saying, the families are no longer here, whereas I would say it is the opposite in Dubbo and those areas—people are moving to centres where there is support et cetera. Here, you are telling us that the relatives are going and leaving the older people behind, which has its obvious problems which Bill and others have addressed. I think the medical profession pointed that out earlier. If I am right, what you are saying is that it puts a far greater strain on aged care or the services that apply to them, because the community services do what the family would normally do, even if transport is the only issue. Tony, you said that you are able to deal with roughly half of the referrals you get.

Mr Trebilcock—Yes.

CHAIR—Are you basically talking about the Central Darling?

Mr Trebilcock—No, I am talking about the overall branch and, as I said, that covers Broken Hill LGA—

CHAIR—You are including Broken Hill in that?

Mr Trebilcock—Yes—Broken Hill, Wentworth, Balranald, the Central Darling and the unincorporated area.

CHAIR—So that is Tibooburra right through to the Central Darling. When you say that you are actually able to put half of them on the books, do you mean that for half of them you simply did not have the resources or could not process them?

Mr Trebilcock—We did not have the resources. It becomes a prioritisation issue. You have to be able to provide care where there is the greatest need. We have to look at what the greatest need is and make a decision based on that, and those issues are purely budgetary.

CHAIR—Do you make any distinction between an assessment that involves Tibooburra and one that involves Broken Hill?

Mr Trebilcock—We are actually funded for community aged care packages in the Central Darling Shire. With aged care packages you can average across, so we are able to service—

CHAIR—So to some extent you are able to make that area-specific?

Mr Trebilcock—Yes; those packages are specific to the Central Darling Shire.

CHAIR—What about the unincorporated area? It is really only Tibooburra, isn't it?

Mr Trebilcock—Yes, and we do provide services in Tibooburra.

CHAIR—Do you have community aged care packages for Tibooburra?

Mr Trebilcock—No, we do not. We actually utilise our HACC funding for Tibooburra.

CHAIR—Deb, you mentioned emergency departments. Could you enlarge on that. You were asking for specific services to be available in emergency departments. What is that about?

Ms Jones—In a lot of bigger metropolitan sites we have what are called ASET teams, which are like an emergency response team that is aged care specific. There is a geriatrician, a psychogeriatrician, allied health and an ACAT delegate—a core team that is capable of responding to aged care complexities when they present at an emergency department.

CHAIR—Can you give an example?

Ms Jones—When an 80-year-old who perhaps has diabetes and a chronic respiratory condition has an exacerbation of that condition at home and then presents at an emergency department, with also a little bit of dementia on board, you can imagine the complexities for a busy emergency department in trying to deal with that situation. There might be difficulty in communicating with the client, who may come in solo without anyone there to provide information. There is a medical issue and you cannot get a good history on it and you cannot determine the symptoms. From my perspective, the reality is that in the future there will not be enough geriatricians to go around. Last time I spoke to Concord Hospital there were about three geriatricians there. So, unless there is a huge turnover of geriatricians out of the system, we are very unlikely to have a full-time geriatrician in the far west in the near future. What I am looking at is what is likely and what is feasible. With the advent of nurse practitioners increasing across the area, having a nurse practitioner with aged care and chronic care experience based in the emergency department would open up the door to a more complex assessment being able to occur, and there would be greater potential to link back into the aged care providers to see if the person needs to be readmitted or whether we have the services that can respond to the needs of the community.

CHAIR—It seems to me that what you are talking about requires a pretty detailed patient history in order to be dealt with in the first place—emergency situation or not.

Ms Jones—Luckily for a lot of rural communities, a lot of people are already known. So you tend to have the smaller community approach where in a lot of situations you know who is coming through the door.

CHAIR—You also mentioned bush nurses—I assume that is what you meant—which when I was young saved more lives than doctors did. There are not any bush nurses as such out in the communities at the moment, are there?

Ms Jones—I was generalising across enrolled nurses, registered nurses and nurse practitioners. With our current recruitment and retention difficulties we do call on agency staff who may be metropolitan based.

CHAIR—So you did not mean bush nursing in its proper sense but simply nurses who happen to be in the outback?

Ms Jones—Yes; but in referring to 'bush nurses' I am talking about people who grow up in the bush and providing them with an opportunity to train at a more local level. At the moment most of them have to go to metropolitan sites to train. We have limited numbers of enrolled nurses. I am talking about offering a pathway to entice our students into a nursing career. I think the average age of nurses in the far west is about 47, and so our work force's population is an ageing one as well. To us, it is a matter of having bush people who are quite comfortable living in bush communities and who are used to the culture, the harshness and the isolation. It is very important to provide opportunities for those individuals to access a nursing career without forcing them off to Dubbo, Sydney or Newcastle, where they will get a taste of the big life.

CHAIR—In other words, you want the training that now occurs in Dubbo to occur in Broken Hill.

Ms Jones—The only real weakness we have currently is with our EN training. We can provide training for certificate II and certificate III through TAFE. But for training in certificate IV, EN training, we can provide for only very limited numbers. We can now also provide bridging to registered nursing; that is supported in the far west as well.

CHAIR—I have a general question which can be answered by anyone who wants to have a go at it. Basically, HACC is well funded through various sources and delivered more or less by the state and local government. Do you feel that there needs to be a lot more cooperation with it, or do you feel that it battles on reasonably well as it is?

Mr Vickers—From my experience with the HACC centre through my involvement with the veterans, it has been very good; but I think we need that other role through which additional assistance can be given. HACC has certain areas through which its funds can come, just as we have certain areas through which we can get money—from Legacy and other areas. However, I think HACC is more of a second line: 'If we can't get them through the system, we'll poke them through to HACC.'

CHAIR—It is a safety net.

Mr Vickers—It is a safety net for the veterans community, yes.

CHAIR—Can anyone else comment on HACC?

Mr Trebilcock—I think HACC funding works very well. In this area all HACC-funded organisations work very closely together; as I said, we meet weekly. I would hark back to growth funding and population group planning. It probably sounds a bit hackneyed but, while HACC looks at population group planning—and it looks at it on the basis of a local planning area rather than a local government area—you almost have the same inequity that I believe Andrew spoke

about earlier with nursing home beds in Dubbo as opposed to what you have on the ground in an area where there is an identified need.

CHAIR—I am trying to get away from the health care issue, because you are a more general group than most. In this local community what do you think people who are retirees might expect—and I am not talking about people who need aged care or health care—or deserve to expect out of retirement that they are not getting? We have come across transport services as being something that aged people obviously need—and I do not mean for health reasons; I just mean for general reasons, be it from here to Adelaide, just around town or whatever. Apart from transport, what do you think people expect that government in particular but perhaps the community also will have to look at providing which might be different here in Broken Hill to how it is in Sydney—or even if it is not different? What do we expect out of life?

Mr Trebilcock—One thing that happens as our population ages is that a lot of our services are operated with volunteers; that volunteer base starts to shrink and your volunteers become your clients. So we are probably looking at having some form of enhanced funding to be able to provide those services that we currently run with volunteers. Whether or not that is done through an expansion of some of the Centrelink arrangements that are now in place, I can see that as being an issue down the track—and it is probably more specific than general.

CHAIR—Do you mean the sorts of services that are provided by Broken Hill Inc.?

Mr Trebilcock—No; through Centrelink and mutual obligation. Perhaps that will need to be enhanced or some form of funding will be needed to supply services that we currently operate with volunteers. I am talking specifically about things like food services and neighbour aid services. This leads to the lower levels of care. It may be simple things like Donna and we as a group have identified: the first types of services that people need to access—simple domestic assistance and yard maintenance.

CHAIR—I accept that. You are talking about an extension of what HACC does, in other words, in some way or another.

Mr Trebilcock—Yes.

CHAIR—Do we have to do more to try and bring different forms of entertainment to a place like Broken Hill? Just for a moment, rather than canvassing the care situation, I am trying to get to what people's life expectations are—what makes life worth living.

Mr Carter—If we look at the model 40 years out, I think that residential aged care as we see it now will not be around then. What we have to determine and get to is the elderly being able to access affordable housing to which services can be brought in an efficient and cost-effective manner which allows them to maintain their independence. There are all sorts of service issues—transport and things like that—that go with it. But I think there is an overwhelming trend or desire that you see even now with people who we would say should be in residential care but do not want to be because they see that as being the end of their independence; there is a certain finality to it. I see the underlying issue 40 years out as being affordable housing that is user-friendly to care providers so that the person can remain independent and have services brought to them.

Ms Jones—Like I have said, being one of those who is going to charge rapidly into the next 40 years, with grey hair, I want increased options with work force participation as well. We heard earlier someone saying that they have a 74-year-old RM. I do not know whether at 74 I will still want to be out there doing the hard yakka, but I want there to be that flexibility if I feel I am still capable. I may not be able to do the hands-on, but hopefully I will have with me a wealth of wisdom and experience.

CHAIR—Basically, you think we should think pretty hard about retirement age or the compulsory retirement age and that sort of thing.

Ms Jones—Yes. The other thing is key roles in community. Just because I am old does not mean that I suffer from senile forgetfulness or I will develop dementia. Hopefully, I will be one of those who are healthy as they age—if I ever give up smoking—and I will be able to then remain an active participant in society and what occurs. So they are some key issues too.

The entertainment issue is a big one. As I have said, we will bring with us our wants of the nineties and the early 2000s, and technology is a key point. I will want to have access to the Internet if I do not have it in my own home. I will want to be able to access multitechnology that is coming on board. Then there are basic entertainments—it might not be singing along to Slim anymore—and getting that sort of stuff out here: to get art galleries' exhibitions still coming out here and, obviously, to make all those facilities accessible too.

I watch my mum now getting up a ramp; she walks with a tripod walker. She experiences the greatest of difficulty in accessing the entertainment centre, even though there is a ramp. I will want to go swimming but, if I have arthritis, I will not be able to get in and out of the pool. If I am unable to climb up and down the steps or up and down those horrible little silver ladders, I will then be eliminated from doing any sort of aquarobics unless I do it in a specialised pool at premises belonging to a health service. They are the things we need to start looking at as well: basic access for conditions that will be quite common.

CHAIR—Thank you very much.

Ms HALL—I think you have answered that question really well. I was wondering about the recreational activities and options for older people who are living in Broken Hill now and about what needs to be looked at for the future. Going back to the medical type issues, you have talked about the accident and emergency department. I understand that in Broken Hill the accident and emergency department is very busy. You have a shortage of GPs; does that contribute to that department being so busy? Also, do the GPs in Broken Hill bulk-bill; and, if they do not, does that also contribute to that department being so busy? What are the implications of all of this on older people presenting at accident and emergency departments?

Ms Jones—Even though the emergency department, under triage, receives a lot of category 1 and 2 patients, which are the emergencies or acute presentations, it still experiences a lot of GP type presentations, which are flu, urinary tract infections and sore ears—and I am not being derogatory about our current GPs, who have obviously stated that they are working at full capacity. They are like the rest of the aged care services locally; we are all struggling at full capacity to try and provide ongoing services and to keep accepting new people on to our books. But I do think that that is a contributing factor.

Ms HALL—Does bulk-billing occur in Broken Hill?

Ms Jones—Some of the GPs continue to bulk-bill and some do not.

Ms HALL—And there is the problem with the gold card, which is also very interesting. With older people presenting at hospitals and occasionally probably going to a GP, is there a problem with the monitoring of medication and with ensuring that duplication of medications does not occur? Sometimes perhaps an older person will take a generic medication as well as a brand name medication and that will contribute to a person getting quite sick.

Ms Jones—I suppose it comes back to preaching to the converted too. In Broken Hill we recently supplied education, which was funded through the Department of Veterans' Affairs, on wise medication management for older adults. We ran four sessions, and the first two were wonderfully well attended; about 40 elderly people attended both initial sessions. So I think there was a need for that information to be delivered out there. Also locally we have a consultant pharmacist who now does medication reviews. He works closely with our general practice division here and he also works closely with the Department of Veterans' Affairs. He will actually review everyone.

I think it is very similar to what Bill has said. Until someone is in a pickle, they do not know that these are the potentials. I think that is an area that is perhaps lacking in our education, right from preschool through. We should be trying to instil in our preschoolers an acceptance of ageing and death as part of the life continuum. Western society is not very good at accepting that the end outcome will be death. I think somehow, right from very young ages, we have to look at teaching, training and supporting people in looking at growing older healthily as a pinnacle of life's events.

In relation to medications, one of our health service providers said that they went into an elderly person's home the other day and brought out about four or five Woolies bags of tablets, which were from prescriptions that had all been filled over the last six months. That is an enormous amount of medication for someone to have. So obviously people are slipping through the net in a very big way, and I think it is a really hidden issue. I also find it interesting that a lot of research has been done on the side effects of taking five-plus medications but not very much has been done on the adverse effects of not taking five-plus medications. So whether or not there is some benefit in limiting or expanding our use of medication, that has not yet been set down hard and fast.

Ms HALL—My next question picks up on what Mr Vickers was saying about getting people to use services. How do you manage to locate a person who has not been known to you? There must be many older people out there who really need some of the services that you provide but, until they reach a state of crisis, do not present at A and E or wherever.

Ms Jones—I think I may have stated that this was one of the primary issues considered by the aged care focus group. When we first came together we had to sit down and discuss how services worked, how well we were gelling, where gaps were and where we could progress to in the provision of aged care services. Whether it was through a lack of knowledge or a lack in individuals seeking knowledge prior to a crisis occurring was a noted issue for all of us.

One of the thoughts thrown around and which we are now acting on is to look at radio commercials or having one of the aged care departments doing a 15-minute presentation prior to what I think is called *Marketplace*, to which a huge audience of our target group listens. We are looking at providing, during the 15 minutes beforehand, information about what is out there, what is happening in aged care and what services are available—and then accompanying that with *BDT* ads in the paper, where you would showcase a service a week. But even then it would be very interesting to see if we actually do make people stop and think.

I am quite impressed with some of the medication ads that are now on TV—the lovely man who mixes all his medications up in the blender and has them bubbling out. I think that actually sells a very good message and it sells it with humour. It sells it in a very novel way. We keep hitting people with hard and fast bland information but, because people are so overloaded with a lot of information all the time or because they are ageing, they tend not to remember a lot of stuff. We have to present it in a much more novel way to make people sit up and pay attention to what we have got out there.

Ms HALL—Thank you. If a person needs crisis respite care in Broken Hill is it a possibility?

Mrs Millman—It is. Through Broken Hill City Council I manage the Commonwealth Carer Respite Centre in this area. We provide crisis respite care with a carer focus, but once again, if we are talking about people with dementia, if there is no family or carer involved, then usually the residential facilities with respite beds are full up to six months in advance.

Ms Jones—Donna just raised a very pertinent issue. Donna's services are geared at carers. We have that big fall-through where we have frail elderly people living alone who do not have a carer. They are automatically eliminated from accessing any service that is funded specifically for carers. You then have someone, without a carer but with a need, who is not suitable for that service.

Mrs Millman—Quite often we will have a husband who is caring for his wife with dementia and he becomes chronically ill as well. He will end up in an acute care setting and there is no place for his wife because she may have special needs.

Ms HALL—Are there any day care centres?

Mr Trebilcock—Yes. There are two day care centres that operate in Broken Hill. I can only talk to you about the one that is auspiced through the Home Care Service. That is a dementia specific day care centre. We operate that five days a week.

Ms HALL—Tony, you said that half the people that you assess were provided with services. What happens to the other half?

Mr Trebilcock—We work as a collaborative group to try and get the best outcomes that we can. As I said, we have to prioritise the service. There will be people that we cannot help. That is an acknowledgement that we have to make. It does not always sit well with community service providers that we have to say no.

Mrs Millman—People that have needs at the lower end of the scale—where they are not able to manage their gardening or their house cleaning and washing—are often referred to another community service and the person with the highest need will be dealt with before the person with the lowest need, so they will just wait in limbo until they can get picked up.

Ms HALL—Does this manifest itself in a person who could have been provided with lower level services at one stage presenting further down the track in a crisis situation? Is it the situation that, while they may have been able to maintain their home and live independently in the community before, they are ending up in residential care because there were not the services available at that early stage to help maintain their independence?

Mr Trebilcock—I could not give you any statistics on that. When somebody is told that we are unable to offer a service at this time, they are also told that, should their needs increase, they will need to re-refer and then it will be looked at again. That mechanism is there to enable us to look down the track so that, if someone's needs do increase, they become a higher priority.

Ms HALL—Would anybody else like to add anything on that?

Mrs Millman—I believe that, if we were able to assist people at the lower end of the scale, maybe we would be able to identify as their needs increased, whereas people might not be so keen to identify that their needs are increasing. I think that would be a way of identifying that increasing need.

Ms HALL—Basically the question is: do you think early intervention works?

Mrs Millman—Yes.

Mr Trebilcock—Absolutely. In the ideal world, if we could help everybody, if we could intervene at that level, it would certainly make a difference. Then you could progress somebody through the different levels of service.

Ms Jones—One thing that none of us have touched on is the issue of elder abuse and the complexities associated with that. In the far west we tend to deal with a lot of very complex elder abuse issues and that generally falls back on our aged care assessment team delegates, who are already now being overwhelmed with complex aged care cases without having issues of abuse on top of that. In the systems that surround the reporting and the actual applications to the Guardianship Tribunal, we have remote workers in remote communities having to put their name on application forms to the Guardianship Tribunal and then the tribunal or the person who is reporting it having to hand these documents over to the alleged abuser with their name and contact details on them. We are putting our staff at risk. We are not doing any justice in making staff feel really intimidated about following through on that process.

Mr Vickers—The people we are talking about in the homes have the services available because they know of them. Where I come from, most of the older gents and widows do not know what services are available in the town. They are sitting back and not coming forward to get those services or the information about them. Last year we ran two meetings at the RSL and had Veterans' Affairs up from Adelaide. That was brilliant. Maybe 60 people came. They have a rough idea of some of the services, but a lot of them are still in their houses and do not get out of

them at all, mainly because they have not got a carer or the information required to get assistance. We are finding that more and more as they get older.

CHAIR—I have one last question which comes out of listening to you for the last half-hour. In my time on the committee and in my own experience, the cooperation which you have talked about is a bit unique. What prompted you to do it? It is not that common to see a group like you cooperating to the extent that you have. How did it happen?

Ms Jones—As has been mentioned on two prior occasions and as Andrew mentioned, our residential care providers and our Aged Care Assessment Team already established meetings once a fortnight and our community based providers also established meetings once a week. So we already had the foundations; we already had various well-established open communication channels between all services. Issues were raised by the Broken Hill Health Advisory Council in relation to their concerns about limited access to low-care residential facilities. As a group, instead of saying, 'All right, we will just jump on this bandwagon,' we decided to call all key players in aged care together to find out if we were missing things right at the very beginning which were precursors to people seeking low care at an inappropriate time or sooner than they should have. That is where it began.

We asked all key players to come together and, of course, we had no refusals. Everyone was quite keen to get on it. Once we started talking, we then unearthed a multitude of other issues and strategies that might be of use in providing a comprehensive streamlined aged care service while taking into account that we are still very restricted by our funding guidelines in what we can and cannot do. One of the things we are looking at is making sure that, if we do sit down and say, 'We think a new model may work for us,' the federal government will hear about it.

CHAIR—I imagine it has made your budget go a bit further too, or be more effective.

Ms Jones—This is what we are hoping. But you then start touching on funding arrangements like coordinated care trials, as they have done in health or with the MPSs, when you start looking at aged care. Because we have such strict guidelines, it is very hard for us to pass people over each other's barriers—without doing it a bit covertly—to try and ensure that someone gets the service. It will be interesting to see how we overcome that.

CHAIR—Thank you all very much. We have gone badly over time—and I apologise to the next group—but it has been very valuable.

Ms HALL—I move that the submission from Mr Bill Vickers and the submission from the Menindee Health Advisory Council be received.

CHAIR—I second the motion.

[11.15 a.m.]

DEBONO, Mr Stephen Joseph, General Manager, Lower Western Sector, Far West Area Health Service, representing Maari Ma Health Aboriginal Corporation

DWYER, Mr Terence Michael, Manager, Maari Ma Primary Heath Care Service

DOYLE, Mr Ricky Leagh, Facilitator, Menindee Health Advisory Council

BELL, Mrs Nyoli Merle, (Private capacity)

CHAIR—I welcome the witnesses. I draw your attention to the fact that this is a hearing of the parliament and is recorded by Hansard, so witnesses are accountable for what they say. Thank you very much for appearing today. I apologise for us running over time. Would any of you like to make a short opening statement before we move to questions?

Mr Doyle—The Menindee Health Service facility serves an area including the town itself and smaller pockets of populations at Sunset Strip, Copi Hollow, Menindee Lakes Caravan Park, Tandou Farm and numerous pastoral properties. The catchment population is approximately 800. A third of the township's population is Aboriginal, with a 19 per cent Aboriginal representation throughout the entire catchment area. The Menindee Health Advisory Council has consistently campaigned for an appropriate health facility to address the needs of all of the community, in particular the aged and disabled. Currently in Menindee there is no in-patient facility offering aged care accommodation of any form and no respite care for aged and disabled persons.

The Health Advisory Council recommends the following requirements for aged persons in Menindee for the current and foreseeable future: a multipurpose service providing six beds, four of which are to be permanently designated for aged care and/or respite care for the aged and disabled, and two of which are to be designated for observation of patients; four home units for independent living, established over the next five to 10 years; an aged day care program and purpose room incorporated in the multipurpose service; financial assistance for socially disadvantaged families attempting to care for aged family members—for example, structural changes to bathrooms and that sort of thing; and maintaining and expanding as necessary the in-home services currently being provided in Menindee.

Health advisory council members have actively pursued these health issues with both state and federal government representations, as evidenced by the correspondence items we have enclosed with our submission. Please refer to the attached appendices. Correspondence in August 2001 from the Minister for Health and Aged Care to Mr Tony Lawler, the then Commonwealth MP, stated:

... a Multi Purpose Service program is a joint program where the Commonwealth pools flexible aged care funding with the State health service funds in a manner most appropriate to the operating realities of small rural health and aged care facilities. The program works best in small towns that cannot maintain a stand alone aged care facility and where integration of the services is the most sensible option to allow sustainability of the service. Importantly it is designed to

help communities whose catchment areas is such that the call on the aged care services is uneven or sporadic. The cashing out aspect provides certainty in funding, irrespective of the actual call on services.

This comment was made in reply to Mr Lawler's direct representation to the minister on Menindee's behalf after visiting in 2001.

Menindee and its environment need a multipurpose service with home units and aged day care for the following reasons. We are geographically isolated, with the nearest hospital being 110 kilometres away. Unfortunately, we had the distinction of being ranked second highest on the social disadvantage scale within New South Wales, excluding Sydney. Currently, we are only serviced by a primary health care facility with no acute beds. We have an ageing population: as at 23 February 2004, 21 permanent residents living at Sunset Strip are aged 60 years and over, with a further 15 permanent residents aged between 55 and 60 years. As at 18 February 2004, four permanent residents of Menindee have been forced to reside in other towns' aged care facilities, a further two residents are awaiting placement, seven people need respite care—the closest respite care being available in Broken Hill—the health service has 5,200 active patient records, and community nursing in the Menindee area regularly visits 55 people, all of whom are aged or suffer a chronic disease.

Menindee has in operation an extremely successful Meals on Wheels program, which currently serves just 10 residents and often serves up to 19. This service could be used in conjunction with our proposed aged care services. Menindee Homes for the Aged and Disabled has five existing homes, the majority of which are over 50 years old and were formerly Water Board houses. All homes are permanently occupied and there is a waiting list for future tenants. The homes will soon need major refurbishment or alternative accommodation will be needed. The building site chosen for a proposed primary health care facility would accommodate expansion to a multipurpose centre and the additional home units. The chosen site is central to the town and adjacent to the existing Menindee Homes for the Aged and Disabled. Members of the Aboriginal aged population have already experienced the pain of separation from family members, so it seems extremely insensitive to separate them from their families again in their declining years. Menindee Health Advisory Council feels very strongly that circumstances in the Menindee area are exceptional and that greater consideration should be given to that fact. Whatever future actions are taken, the aged and disabled persons need to be treated with the dignity and respect they deserve.

Mr DeBono—I am the General Manager of the Lower Western Sector of the Far West Area Health Service and I am employed by Maari Ma Health Aboriginal Corporation under a fairly unique arrangement in which an Aboriginal organisation manages mainstream health services for a large sector of New South Wales. The communities in the lower sector, starting from north and moving south, include Tibooburra, Wilcannia, White Cliffs, Ivanhoe, Menindee, Wentworth, Dareton and Balranald. Only three of our facilities—Wilcannia, Wentworth and Balranald—actually have in-patient beds. There is a total of 50 beds in the sector, 34 of which are designated for nursing home type patients—long-stay and mainly fairly acutely ill people.

Mr Dwyer—The Maari Ma Primary Health Care Service in Broken Hill provides a primary health care service primarily for Aboriginal people in Broken Hill. We have 2,600 people on our database, of which probably 1,500 are permanent and 1,100 are casual. Despite the best efforts of health providers, Aboriginal people are still living 20 years fewer than non-Aboriginal people,

taken across the nation. Aboriginal people are generally sicker at a given age than non-Aboriginal people. This is the burden of disease or chronic illness. It means that a 50-year-old Aboriginal person generally has greater health problems than a 50-year-old non-Aboriginal person. Aboriginal people need access to culturally appropriate aged care facilities. We have to take into account the mobility of Aboriginal people and their extended family situation. This might mean that an Aboriginal person will be visited by 20 or 30 people at one stage. We need to take into account Aboriginal people's affiliation with and love of the outdoors and traditional food. If you are an Aboriginal person and have eaten kangaroo every week of your life, you should expect to be able to eat some kangaroo in your old age.

CHAIR—Thank you. We have two people here specialising in Aboriginal aged care and one specialising in general care in an area that has a very high Aboriginal population. My first question is to all of you, and you have touched on this, Terry. We have recently been to the Territory, where the cultural differences are absolutely enormous. Can you enlarge a bit on what you think are the different requirements for aged care for Aboriginal people as opposed to the general population? I cannot believe they are quite as distinct here as they are in the Northern Territory or Northern Queensland or a lot of Western Australia. I think it is much more integrated here than it is over there. But what do you see as the primary issues?

Mr Dwyer—I understand what you are saying because I have worked in the Northern Territory and with traditional Aboriginal people, and it is different in western New South Wales to how it is in the Northern Territory. I have often thought about the differences. I think the extended family is still very much a factor in western New South Wales, in the same way as it is in the Territory. Other factors are probably the things that I have touched on—the affiliation with the land and the lifestyle, and the mobility of Aboriginal people around western New South Wales. Often there is an ebb and flow, usually around funerals. The rites of passage for Aboriginal people are still quite marked, and probably the most important thing is the funerals. There is a funeral in Walgett today; people can see it is very topical. There will be a lot of people moving towards Walgett.

If there is a funeral out here in western New South Wales, if there is one in Wilcannia, we will notice that in the way we do business: there will be quite a few vacancies, people missing their appointments. And the reason, if you ask why, is: because there is a big funeral in Wilcannia, so there are a whole lot of people going up to Wilcannia. That is about keeping kinship ties and it is about socialising but it is also about rites of passage and saying goodbye to a member of the Aboriginal community—those sorts of things. In the Territory a funeral can take a week. People put a week aside. Politicians ring up communities to see whether or not they can go out to a community. They want to know if there is a funeral on out there because, if there is, it is a waste of time going out because no business is going to be done for a week. It is not like that here, but it still impacts on the way things are done.

CHAIR—My experience, just in my time, is that there is a very high proportion of the Aboriginal population that moves, whether it is between here and Wilcannia or Bourke or wherever it might be. Do you think that has particular implications for the aged—do the aged tend to move with the rest of the family?

Mr Dwyer—I think they tend to move with the rest of the family, up to a point. We do not have a lot of aged Aboriginal people, mainly because of my first point, that Aboriginal people are living 20 years fewer—

CHAIR—It has the same effect to an extent, even if it is at an earlier age, doesn't it?

Mr Dwyer—Yes. We have a couple of people who are wrestling with those issues now. They are Aboriginal people, they are 60 or 70 years old, they are in the extended family, they cannot really be taken around easily and there is a lot of conflict within the extended family about what should happen to them—whether the family should persevere with them or whether they should be put into a nursing home. If we are looking 40 years down the track, these are the sorts of issues that we should be looking at: how we are going to design aged care facilities to cope with Aboriginal people? If we health professionals can shorten that 20 years—and we would like to think that we can—then there will be more Aboriginal people seeking aged care facilities. That was my third point: they need to be culturally appropriate. If you have an extended family, they all might want to come and visit this person, and that might mean that you have got to have somewhere where 30 relatives can come. Maybe they want to cook a kangaroo, so you might need an area down the back of the garden somewhere or what have you so that they can actually do that.

CHAIR—We saw that at Alice Springs.

Mr Doyle—Can I just reiterate what Terry said about the extended family? I feel that a lot of Aboriginal families would be very reluctant to put their elderly in an aged care situation. I speak from experience; my wife is Aboriginal. Her grandmother is 83 years old and she is living with one of her daughters because she does not want to go into aged care.

CHAIR—What we have seen a fair bit is a lot of reluctance to go. A lot of them seem to go until their health improves and then, the minute their health improves, they want to come back; then, when they get crook, they go back again. The other issue we found with the providers up there is that a proportion of the people simply cannot stand it and want to come back. Most of them, after about three months, settle in very well but there is a proportion who do not.

Ms HALL—It is fair to assume that the Aboriginal communities that you service are more socially and economically disadvantaged than other communities in this area, and we have already heard this morning how socially and economically disadvantaged the whole area is. So you would have very specific problems with being able to find suitable accommodation in residential care because they would be basically at the bottom of the group that gets access and has assets. The social and economic disadvantage is also linked to the chronic health problems that exist within the community. Are these issues putting extra stress on the services that you provide? Have you come up with any creative ideas to deal with older people in the communities that you represent? And have you got some very strong advice for us in looking at things that will work?

Mr Dwyer—As a manager of a primary health care service, our focus is very much on trying to deal with the health of Aboriginal people. We are focused on chronic disease; aged care is not our core business. We are looking at the overall population and trying to reduce the effects of chronic disease and turn around the 20-year shorter life expectancy of Aboriginal people. When I

do a search of our database and look at the Aboriginal people who are over 55, it is not a very long list compared to the rest of the database.

Ms HALL—They have special needs and probably greater needs than the rest of the population in Broken Hill. How do you address that? And what should we be looking at to address that?

Mr Dwyer—What we are doing from a health point of view is trying to implement enhanced primary health care and Medicare item numbers. We are looking at doing health assessments on Aboriginal people over 55, case conferencing and that sort of thing. In terms of accommodation, that is not really my field.

Ms HALL—Would anyone else like to add to that?

Mr Doyle—Just out of Menindee there are three or four Aboriginal health workers who go out into the community and visit the elderly in their homes. They feel a lot more comfortable about doing that than having to be brought to the nursing service and that sort of thing.

Ms HALL—So there is a greater role for Aboriginal health workers to work with older people within their community?

Mr Doyle—Yes, I think so.

Ms HALL—That is a positive recommendation for us, and it probably coincides with what we heard in the Territory as well. What about palliative care? Is there any palliative care being provided in Menindee or through your health service?

Mr DeBono—No, there are no inpatient beds in Menindee.

Ms HALL—Even within the community setting?

Mr DeBono—Yes, there are some. It is very low-key. If someone gets to the sharp end, that person would have to come to Broken Hill, for example. We do not have palliative care specialists in those small facilities.

Ms HALL—I suppose that getting palliative care, per se, is very difficult within the whole Broken Hill region. Finally, could you tell me the current problems that the people who attend your services, or those within your communities, are experiencing and what government should focus on?

Mr Doyle—One of the things that we have a problem with in Menindee is that there are no choices for the aged. They either have to stay where they are and put up with their ailments or they have to be shipped to Broken Hill or somewhere else to an aged facility. They do not have any choice. It belies their dignity that they have to be uprooted from their community and environment and be taken to Broken Hill. They cannot get people to visit them. There is not a regular service coming in. For that reason, it is just one of those things. A small aged care facility in Menindee would be more appropriate to our town.

Ms HALL—Like the one you detailed in your submission. What about HACC programs? Do you administer any HACC programs?

Mr DeBono—No, not through the health service anyway.

Ms HALL—Would you like to be able to have some Aboriginal specific HACC programs that you could administer? Would that help?

Mr Doyle—It would, yes.

CHAIR—Is there a bus between Menindee and Broken Hill for aged people, whether they be Aboriginal or otherwise?

Mr DeBono—Yes, there is a daily bus service.

CHAIR—Daily.

Mr DeBono—Except for Saturdays and Sundays.

Mr Dwyer—The central issue for us would be chronic disease and how it shortens people's lives and impacts on their quality of life. One of the things that I believe government could do would be to run health promotion campaigns. It is quite some years since the 'Norm' or the 'Life. Be in it' program. Those sorts of things impact on chronic disease. Campaigns like that not only help Indigenous people but also help non-Indigenous people. As the population ages, things like diabetes and the effects of smoking and alcoholism are really going to impact not only on the length of a person's life but also on the quality of it—what they can do and what they cannot do. You would get a really good return for some funding at a national level to offset the funding that we see, every time we turn on the television, for unhealthy choices.

Ms HALL—That is a good suggestion.

Mr DeBono—The value of having trained Aboriginal health workers to access communities was touched on earlier, I suppose. A short period of time ago—just a number of years—there were about four trained health workers in the whole far west. Now that number is around the 45 to 50 mark. That has been a huge improvement in terms of gaining access to those parts of the community that you would not normally see. But beyond the Aboriginal health worker training program, if the governments could support training of ENs and RNs so that you could have people right through every tier of the health system that would certainly encourage a lot more participation. It would create a lot more interest in people's own health in terms of a primary health care model.

Ms HALL—That is good. Thanks.

CHAIR—In terms of the MPS, I believe we have to do something like that with Menindee. We are able to show that areas with smaller populations and no Aboriginal population at all and that are nowhere near as isolated are getting them now. So do not give up. We are not.

Mr Doyle—I think that one thing people tend to forget about Menindee is that it is one of the few towns that is actually growing in the far west.

CHAIR—Thank you all very much. Is there any other comment any one of you wants to make relevant to Aboriginal or aged issues in general, especially those that are not necessarily about health care, for example questions about people's lives: what makes it worth living when you are 70 or 80? Is there anything in particular you want to make a comment about that you may not have already heard today and that may be different? A lot of issues are different for Aboriginals, I realise, but what is different particularly in this area of the world? Are there any comments any of you want to make before we finish?

Mr DeBono—I do not know what was said previously about the day care activities, but certainly in places like Balranald and Wentworth they are very popular with the older people. There are transport services arranged for activities. They might go to the show, the pictures, shopping or on a picnic. They seem to be one way of getting the people together and really enjoying their time. It is just organised day care.

Mrs Bell—I have a comment about looking at any feature of aged care and the particular relevance to our types of areas. Everything is looked at on a numbers basis and, particularly in Menindee's case, we are not able to produce the numbers that fit into the criteria, and I think the needs of our people are often neglected simply because of a numbers game. I would like to see more emphasis on the fact that there are those smaller, very isolated communities that do need the same services as offered in other places, but it is not being considered.

CHAIR—Thank you very much. It was all very valuable. I will make a general comment about what will happen to the inquiry at the conclusion of the community forum. I thank the four of you very much and I thank all of the witnesses who have appeared today.

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

That this subcommittee 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 11.41 a.m.