COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

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

MONDAY, 23 FEBRUARY 2004

DUBBO

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Monday, 23 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 Tony Smith

Members in attendance: Mr Cobb, Ms Hall and Mr Mossfield

Terms of reference for the inquiry:

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

WITNESSES

Committee met at 9.04 a.m.

MILLAR, Mr John, General Manager, Returned and Services League Aged Care Association Ltd

MILLER, Mr Gregory Neil, District Manager Dubbo, United Protestant Association of New South Wales Ltd

CHAIR—Welcome. These hearings are being undertaken as part of our inquiry into long-term strategies for ageing in Australia. Today's hearing focuses on remote, rural and indigenous aspects of ageing. At this stage, we will be hearing from four witnesses—although I do have to talk to my colleagues, as there is the possibility of another witness appearing—about age and respite care services, with an obvious emphasis on rural health and specialists in ageing as well as on those involved with the training of aged care workers. We have allocated about 40 minutes to each witness. You will have the opportunity to make a five-minute statement, at the conclusion of which the committee will ask questions.

I must inform you that this hearing is a formal proceeding of the parliament. If you veer from the straight and narrow too much in whatever you say, you can be held to account. I simply tell you that by way of information. It is a formal proceeding of parliament and it is recorded by Hansard. We look forward very much to hearing from you and we thank you very much for appearing before us. Would one of you like to commence by giving a five-minute opening statement? At the conclusion of that statement, the other witness can do likewise.

Ms HALL—Are you also representing Aged and Community Services in this area?

Mr Millar—Yes. I am the regional chairman of Aged and Community Services.

Ms HALL—Are you putting its position forward also?

Mr Millar—Yes, certainly. Greg is the training coordinator of the same group. We are very much involved in Aged and Community Services.

Mr Miller—United Protestants Association of New South Wales Ltd has, throughout New South Wales, facilities offering aged care services and child-care services. The UPA Dubbo district is made up primarily of Bracken House. It is a 39-bed low-care facility and includes one respite bed. A second bed for respite care, which is managed by the Commonwealth Carer Respite Centre, is also available there. We also have a three-bedroom flat, which is made available to Commonwealth carers for emergency respite. Last Saturday, 21 February, we opened a new 12-bed dementia wing to cater for dementia clients or residents in a secure environment. With our current renovations as part of that development we will develop another bed within Bracken House, which will bring Bracken House up to a 53-bed low-care facility by April 2004.

Currently within Bracken House we are running 19 high-care beds through Ageing in Place. We have a waiting list of about 180 people, some of whom will go into the dementia wing. Currently we hold about $1.2 million in bonds which, from retentions, gives us an average income of $6,300 per month. With recent additions in staff to cover the new dementia wing, we

now have a total of 38 staff: 26 care staff in the Bracken House environment, six in community aged care packages, four in administration and two in maintenance and gardening. The maximum bond we receive is $75,000; we have capped that locally at $75,000. As quoted by ACS, the average bond throughout Australia is $98,775. So we are underneath the limit there.

In addition to Bracken House, UPA Dubbo has 14 Lillimur self-care units, which are available for people who are able to look after themselves. We have 25 community care packages that are funded, and we run up to an extra five unfunded ones. Because of local demand we could run a lot more, but we can successfully run another five unfunded ones. We also have the Lillimur Opportunity Shop, which is run entirely by volunteers. That gives us an income of about $75,000 a year, which goes solely to Bracken House. That shop is run purely for the benefit of the residents of Bracken House. We also have the Bracken House Auxiliary Committee and its fundraising activities throughout the year usually give us about $10,000 per year.

All of these services go to supporting UPA in Dubbo. Basically, without those other district services to support it Bracken House would not survive. So in the future we will be looking at continuing development in all services wherever possible to maintain our viability.

To give you some idea of where we are coming from, the cost of certification to bring Bracken House, which is now a 15-year-old building, up to the departmental standards now required, was $162,208 in the last 12 months. We will have another ongoing cost of $1,900 a year for the new fire reporting system. We no longer have direct access to the fire brigade here in Dubbo; we have to go through a reporting network that takes the phone calls and then passes them on to the fire brigade. Ongoing problems we are expecting relate to the new Building Code of Australia rules. They were changed some time ago—in June 1999—and it was anticipated that more changes would be made. We are still waiting for those. We anticipate those changes will come out shortly.

Once again, it will affect Bracken House if they bring out changes that require us to do more modifications. A recent new Commonwealth requirement is for fire certificates to be issued for every fire service we have, within Bracken House and every building we own. These fire certificates are a massive reporting requirement involving me, as the manager, signing off that every fire facility or piece of fire equipment has been certified by an expert. Once that is done, a certificate is issued. I collate the certificates and then send the report, with all those certificates, to the council, the fire department and the Commonwealth department. It is a massive amount of paperwork, which basically will put the responsibility for fire safety back onto me as the manager.

We are faced with increased costs all the time. ACS's advice to the industry is that there are increased costs experienced that are not recognised in the Commonwealth Own Purpose Outlays index. The calculations for that are made up of two parts: 75 per cent is wages, and the balance of the other costs makes up the remaining 25 per cent. The wages component is increased by the amount of the safety net adjustment provided to the lowest paid worker in Australia. There is no relationship to the increase in the wages for aged care. The adjustment is made on what the lowest paid worker in Australia gets. Under the COPO index, in June 2003 we received approximately a one per cent increase in funding. To compare wages rises: registered nurses have received approximately 18 per cent recently, and carers have received approximately four per cent—and we have received the one per cent.

I am sure you are all aware of insurance premiums for public liability and workers comp. There are increased costs for compliance with workers comp legislation and new regulations. The premium discount scheme, which we are part of, is aimed at reducing our premium, but the cost of meeting that reduction in premium far outweighs the savings. It is a great initiative—it makes the workplace safer—but it does not save us money. We have return-to-work plans where we are supposed to get injured workers back to work promptly. This sort of legislation is good for the workers but involves a tremendous amount of paperwork all round. We have compliance costs from government administration requirements—the fire certificates I mentioned—and the local councils are now required to supervise all of these requirements. There is the cost of refurbishing older buildings versus the cost of building new ones. As I said, Bracken House is a 15-year-old building. We have had to do serious renovations to make it comply with current legislation. We now have to change its status from a class 3 building to a 9C building, again at tremendous cost.

In relation to fees and costs associated with accreditation for residential aged care, the basic fee you pay with your application is in the vicinity of $6,900—that is an application fee to have our organisation accredited—and then there is the staff time, the paperwork and the ongoing costs incurred in meeting that accreditation standard. I do not disagree with the accreditation standard, but the cost of achieving it is horrendous. There is no increased funding to support that accreditation process.

The COPO index fails to recognise real staffing and operational costs and therefore fails to accurately index pricing on both of its parts. Aged care providers meet the cost of the high level of building standards that the government requires, and this is over and above the normal building certification standards. Aged care facilities have a higher standard of buildings than other organisations. We comply with both normal building standards and Department of Health and Ageing standards, with duplicate costs and administration costs. We meet the certification requirements of the department, we have to meet the requirements of the Building Code of Australia and then we have to meet local government codes.

Rural and remote areas are disadvantaged. We have lower property values so therefore lower bonds are available, but we also face increased costs for travel for training and building and equipment services. Last year Bracken House staff performed 1,300 hours of training—that is the cost of the staff hours plus the cost of the courses and, quite often, the travel. A lot of those courses were held in Sydney, so we had to send staff to Sydney for the courses.

People are also living longer. The average entry age into Bracken House about 12 months ago was 87. The oldest resident we have is 94. The average age of entry according to ACS is 83. Ours is 87. The problems we face in the future are viability of Bracken House. Without the support of the UPA Dubbo district, it would be a major concern. The answer is to replace the COPO index with a method that reflects the real cost of aged care. I believe ACS is looking for an injection of about $10 per bed day.

In relation to efficiency and productivity, since 1997 the aged care industry has had to restructure. There has been no increased funding to cover this and the costs since that time have been increasing faster than the incomes. As for quality care costs, we need a qualified and trained work force now. We must attend mandatory fire and manual handling training. Every staff member must attend those courses at least twice a year. We must produce quality buildings

to meet those certification requirements and to meet the needs that the incoming people expect society to provide them in their ageing years. These days, people expect a much higher standard of care, a higher standard of buildings and a higher standard of entertainment. We also have to produce quality equipment and quality infrastructure to match that. Thank you. That is all I have at the moment.

Mr Millar—My story is going to be very similar to Greg's. I am the General Manager of the Dubbo RSL Aged Care Association. We run three aged care facilities at Dubbo. We run a 62-bed hostel incorporating a 20-bed dementia specific ward and 42 beds of low-care accommodation. Within those 62 beds at the moment, we have 24 high-care residents which we are ageing in place. At Wellington, we run a 46-bed nursing home and in Tullamore we run a 21-bed nursing home. That particular nursing home was taken over by this association in October 2002 as it was about to close for many reasons. One of those reasons was obviously the viability, and there were some management issues there.

Wearing two hats at this particular time, both as regional chair of the ACS and as general manager, I was asked to go there to give some advice and to see what was happening. After many meetings—which also included the present chairman, our local member, John Cobb; the local state member, Tony McGrane; and the Department of Health and Ageing—this association decided to take on the management and running of Tullamore nursing home and we also picked up its liabilities, which amounted to close on $200,000.

The reason we did this—I say 'we'; obviously, I had many negotiations with my board—is that we could not see another 21 places providing aged care leaving this region. We decided to take it on. By taking it on we also realised that Tullamore was going to become an MPS. That was to happen in March or April this year and it should happen by March or April next year, hopefully. When that MPS was commissioned the government said that this association could transfer those 21 high-care beds back to Dubbo.

That leads me to the new proposed venture we are taking on, which is a 60-bed high-care facility here in Dubbo. We have been fortunate enough to have been awarded 10 high-care beds and 24 low-care beds to help fund that new facility. We will also, of course, transfer the 21 beds from Tullamore. Due to certification, we need to make some changes at our high-care facility in Wellington. We will have to transfer five beds from Wellington to Dubbo because of certification issues such as privacy and dignity, which require us to convert four-bed wards to one- and two-bed wards. We need to lose five beds down there to make that a viable proposition as far as certification goes. Greg has already mentioned the high cost of meeting Commonwealth standards for certification.

We also operate a very large self-care village here in Dubbo with 148 units: 143 of those are two-bedroom units and there are five one-bedroom units. Our total residential aged care residents amount to 129 and our self-care residents amount to 204 at this stage. Of course, the Dubbo RSL Aged Care Association supports the veteran community and the aged and frail of the Orana region. We are a stand-alone organisation. We do not have the support of the Dubbo RSL Memorial Club or the sub-branch; there is certainly a perception out there within the community that that happens. That is not the case. This association has been a stand-alone association since 1997 when I was appointed general manager. It was one of the first jobs I had to do. We are

certainly very strong kindred organisations, along with the Department of Veterans' Affairs and many other organisations that we classify as kindred organisations.

What I am going to say about some of the problems were have is going to be a repeat of what the previous speaker, Greg, has already mentioned. In particular there are the BCA rules and the dual accountability involved in being accountable to the BCA guidelines—of which we are still patiently awaiting an update and have been since 1996—and the guidelines set by the Department of Health and Ageing. There is a dual accountability there and, as Greg mentioned, the costs of meeting the guidelines set by both departments certainly escalate.

In certain cases, as far as the nursing home is concerned, we also have to meet the guidelines of New South Wales private health. They have their own particular set of guidelines and their own particular way of enforcing those guidelines. We have to meet those, of course, because they are also the authority that issue New South Wales nursing home licences. So in that particular case you do answer to three masters, and at times it is very hard.

Another of the problems we see is, obviously, the recurrent funding, as Greg also mentioned. I know that at the moment the RCS—the residential classification scale—is in the process of being reviewed against the present formula of the COPO. Every aged care provider in Australia, bar none, would be hurting at the moment. There is no doubt about that. Our expenditure is certainly outstripping our income, and no-one can continue to remain open when their income is being outstripped by their expenditure. Our expenditure is outstripping our income for many reasons, one of which is the wages issue. Again, the wages are set by another governing body—the New South Wales Industrial Commission. They are not set by the federal government, who supply our subsidies and our recurrent funding, and never the twain shall meet, from what we see. That is certainly one of our problems.

Another issue I wish to mention is the shortage of qualified staff, particularly RNs. There seems to be not only a regional shortage or even a national shortage but a global shortage of RNs, particularly in aged care. That is because of the disparity in wages between the public sector and the private sector. My association has spent thousands of dollars advertising for RNs, and we cannot get them. I can understand why they do not wish to come. It has reached the stage where we have decided to recruit two RNs from South Africa. That process is now underway, and it will cost this association some $30,000 just to get them on the ground in Australia.

There are some problems with that, of course, where those particular staff do not qualify for Medicare services, so we need to supply them with private health insurance and several other things. That was the only way that we could see to get around the RN shortage without, dare I say it, dangling a carrot and breaking the guidelines about the wages that are set. We have done that. It has been approved by the Department of Immigration and Multicultural and Indigenous Affairs, and those two nurses should be in the air within the next two weeks. That is one of the things that this association has seen. Obviously we need RNs to be compliant and to keep our doors open. We also need PCAs and AINs for personal care duties. Their wages are at the bottom end of the scale, although not right at the very bottom, and you will find that some are reluctant to come and work in aged care, again because of the wage structure.

Accommodation bonds and accommodation charges are certainly a problem. In nursing homes, we now charge for accommodation. You can claim a maximum of $13.84 a day. It takes

a lot of payments of $13.84 from residents to fund a capital works program. I am sure the committee would be well aware of what a capital works program would cost to meet certification charges. We find that that certainly threatens our viability in the nursing home environment, where both our nursing homes are of a fair age—Bellhaven at Wellington is some 23 years of age and the one at Tullamore, which we still need to maintain to meet government compliance, was first commissioned in 1979. Although all our facilities are fully accredited at this present moment and have passed the certification test under the new instrument, we still need to do major works, particularly at Belhaven. We will be stepping out of Tullamore during the MPS process.

CHAIR—John, I might get you to wind up there. We do have some questions and we are using up our time. Is that all right?

Mr Millar—That is fine.

CHAIR—We have used up a bit of time, so I am going to confine myself to a couple of questions. Firstly, you have outlined the skilled staff problems. You mentioned that you have 180 people on your waiting list. I assume that they are not all yours and that they might also be on Greg's waiting list and various other ones?

Mr Millar—I would assume they are on every waiting list.

CHAIR—I would hope so anyway. Could you just make a quick comment about how long you think the waiting lists are in Dubbo? It is very much a growth industry in Dubbo—to what extent are beds needed?

Mr Millar—I believe that we will have no trouble filling the new 60 bed facility that we are about to undertake to build. As I said, I believe there is duplication between Greg's waiting list and my waiting list and also probably Lourdes Hospital and Ozanam Villa. By last count, there were some 240 that I am aware of. I have not done a comparison with the ACAT team since the last one I did for you, which was some months ago, and I think that was about 257. It is certainly around that number. There seems to be a bigger focus on the waiting list for dementia and Alzheimer's related diseases. That is where a lot of the care is going to be required.

CHAIR—Greg, you mentioned the index. Could you explain where you think the index does not work?

Mr Miller—John will be able to answer that a bit better than I can as he has probably had a bit more experience at it, but as I pointed out the wages make up 75 per cent of that index. They are basing their index on the safety net adjustment figure provided to the lowest paid worker. When they are looking at wages going up, they are only looking at the lowest paid worker in Australia. It does not bear any relationship to the wages in aged care.

Mr Millar—That is exactly right. The first component of the COPO index—the Commonwealth owned purpose outlays—relates to 75 per cent of the wages. The second component is 25 per cent for others. As Greg rightly said, the index for the wages component with the safety net adjustment only relates to the lowest paid workers in Australia. Even though aged care workers are not quite the lowest, it never gets to that lowest thing; there is that safety

net, so the COPO formula is never recognised for aged care workers—thus we never get that increase in recurrent funding. I think Greg spoke long enough about the other 25 per cent. The increases in general insurance, public liability and workers compensation far outstrip that 25 per cent.

CHAIR—That is what I wanted to hear. I do not know if you are aware that we are going to Tullamore this afternoon. John, do you want to make a quick comment about the problems faced by the small independent aged care facilities?

Mr Millar—I can only speak on Tullamore. As I said, Tullamore was about to close its doors when this association took over. The letter of closure from the department had been drafted and was ready to be issued when we decided that we would stick our hand up and go for it. There are many problems there for a small community. For example, Tullamore has a population of some 400 people. It has 21 beds plus a public hospital on the same site, and we employ 26 to 28 people out of the Tullamore region to staff the nursing home. Of people who are eligible to work—if you take the children and the elderly away—we employ probably 35 or 38 per cent of the population of Tullamore. To get skilled nurses out there in such a small community is a real problem. There is not one roster that does not have to be filled by making numerous phone calls or by the director of nursing doubling up. That is certainly a problem out there.

Another problem there is that we could probably fill the nursing home at all times, because when someone needs to be placed the ACAT team say, 'We can give you a bed at Tullamore.' The natural reaction from families is, 'Where's Tullamore?' particularly if they reside in Dubbo or Tamworth or wherever. That is a problem. Tullamore will always end up with some of the community using the facility, but it is not always filled. If the Tullamore facility is not always filled—it is only 21 beds—and if we are down one or two beds, our viability is again very much threatened. Again, the only reason that it is staying afloat is the economy of scale and that we, as a stand-alone medium operator, can support it by cross-subsidisation from our other facilities. But it is certainly a problem in small areas. I hope that answers the question.

Ms HALL—Thank you very much. It was very interesting listening to you. You identified a lot of the problems that we have heard about in other precis—you are right. I wonder if you could break up your waiting lists according to categories and give me an idea of whether dementia patients are waiting for high care or low care. I know you said that dementia was going to be a growing area, but is it mainly high-care or low-care beds that people are waiting for? Also, what is the shortfall with the community aged care packages?

Mr Millar—Regarding waiting lists, we could just look at Dubbo itself—particularly Greg, because he only looks at low care, and our hostel up there is also low care. When the ACAT team do the assessment, they need to assess them as low care to start with, because they cannot come in as a high-care resident in a low-care facility. That is another problem we see. After we get them in as low care, particularly when they have Alzheimer's or dementia related illnesses, they deteriorate and you have to reassess them via the ACAT team and the 2624s. They will probably end up as high care. Greg will talk to you about CACPs. I do not have any CACPs at the moment.

There is another problem with the high-care residents that are on waiting lists. Most nursing homes throughout the district have three- or four-bed wards—sometimes more—and there is a

gender problem. If you have a four-bed ward with a vacancy in it but it is all men, it is very hard to accept a woman, because of the privacy and dignity required under standards 3.6 and 3.8 of accreditation. So you may have to let them go and let that bed stay empty, because of that gender problem. This comes back to certification and bringing the home down to one- and two-bed wards. Again, that is where we have trouble with capital funding.

Ms HALL—You have told us a story of an industry, or a sector, that seems to be weighed down by and struggling to survive red tape. Have you got any solutions as to how it should be changed? What should happen to streamline it and get rid of some of the red tape? You might like to refer to the RCS whilst you are answering this question. Also, in relation to the RCS, you might like to talk about whether or not you are subject to the clawback—the reassessment—and how it affects your facilities when people are reclassified.

Mr Millar—I will talk about the clawback, because it has certainly happened to us. It seems to be a set routine. After you are accredited—the Aged Care Standards and Accreditation Agency comes through and gives you a tick when you pass your 44 outcomes out of 44—within two to three weeks the validation team will come through, looking at your RCS, and you will find yourself losing categories. To me that is very bizarre, because the Aged Care Standards and Accreditation Agency certainly goes through your care plans and your progress notes and gives you a tick to say that you are compliant. Then, lo and behold, through come the validation team. It might be the interpretation of one word—whether it is 'management' or 'supervision'. I can show you an instance where we called it 'supervision' and they called it 'management' and for that we lost three categories.

Ms HALL—Have you had those decisions reviewed and people put back up to the category they were in before?

Mr Millar—No. They were not. We were unsuccessful in our interpretation. But we may get another review team the next time that agrees with our first decision. It is the person on the day that makes the assessment.

Ms HALL—Do you think the review system has flaws in it?

Mr Miller—I definitely do, yes. My objection to the current review system is that the assessors come out to review our paperwork. They look at our paperwork only. They do not look at the end result—a happy, well-contented resident; they do not even see the resident. They look at our paperwork to see what we have done and, as John said, the interpretation of one word can determine our funding. It has nothing to do with the job we are doing out there on the floor to look after that resident. While they are just reviewing our paperwork and the wording, our skilled carers are also required to be skilled in their report writing. Just the misuse of one word can mean dollars. If they looked at our residents and reviewed our RCSs on the results with the residents, we might be getting a different result.

Ms HALL—And the red tape more generally?

Mr Millar—I suppose on a daily basis the aged care industry would use three or four acres of Brazilian rainforest in paper. It is ludicrous. Just to support what Greg said, I do not know of any other industry where you would make an assessment of a facility or a job that is done without

looking at the end product. For people not to look more at the residents and the facility is absolutely ludicrous, but instead they just look at the paperwork trail—at the audits that we have to perform, because there is an audit trail for what we do each week. If you are doing a paperwork check, in our eyes you are not looking at the care that aged care providers are providing, and that is frustrating.

Mr Miller—That is basically just the RCS. Look at the same process in accreditation: in accreditation they do look at the end result and they do speak to residents, but basically they are looking to see that we, on paper, can prove that we are doing what we say we do. They are still looking at the paperwork to give us the accreditation.

Ms HALL—Thank you. If there is extra time, I will ask questions later. I have a stack of questions to ask.

Mr MOSSFIELD—I think we are all getting the picture of the cost of administration and maintenance and the fact that the industry needs more funding. That is coming across fairly clearly. I would like to touch on a few points. Greg, you were saying that before they can get in people have to be assessed as low care—that is the category—and then they may move to high care after that?

Mr Miller—Yes. I am with a low-care facility. I can only take in a low-care resident. To take in a high-care resident is virtually not done.

Mr MOSSFIELD—What if the need arises for a high-care person to be placed in a nursing home? It might be that their partner, who had been looking after them, has passed away and so all of a sudden there is a need for a high-care person to be placed in an aged care facility. Where do they go?

Mr Miller—If I recognise them as being a high-care person, I will not take them in. However, the initial assessment is done by the ACAT, and that would be presented to me, along with the 2624 form, indicating that they require low-care residential accommodation. It is possible that we bring them in and they settle in for three weeks, and then we do the initial assessment on them. They could be assessed as being a high-care person at that stage. But if they were presented to me as requiring—from the ACAT assessment—high-care accommodation, I would not take them in.

Mr MOSSFIELD—But they could become a high-care person once they are in?

Mr Miller—Yes, they could.

Mr Millar—You could take them in under a respite situation in an emergency and look at the assessment after that time. That is one way. If it were imperative that someone needed that sort of care, you could take them in under a respite situation and do it that way. Of course, we always try—no matter what their condition is—if at all possible, to take them in to give them some sort of care, whether it be officially or unofficially.

Mr MOSSFIELD—What I am trying to establish is, when people come in as low care, what is the progression from that point on, as far as you are concerned, if they then become too ill for

your organisation to look after them? Is there a clear passage for them to go elsewhere in the area?

Mr Miller—If we entered in a low-care person and they remained low care for 12 months and they were reassessed in the next 12 months as needing high care and getting beyond the services we can provide—we cannot provide for complex nursing procedures and things like that; we can handle behaviour problems but we cannot handle residents requiring complex nursing, because we do not have the RNs on duty for 24 hours a day—we would have to start looking for a nursing home to place them in because they are beyond the level of care that we can provide. Once again, the question is: where do you put them in a nursing home if you have not got the nursing home bed available? Quite often they have been shipped to other areas, such as Tullamore and Yeoval—places away from their family—just to get them into a bed.

Going back to the respite question, we use respite extensively to gauge what incoming residents or potential incoming residents are like. If they have applied for respite, they come in and stay one, two or maybe three weeks, and that gives us some time to assess what their needs are and whether we can care for them. We have, on occasions, had someone come in who has obviously been high care, and right from the word go we have said, 'No, we cannot provide the level of service that they require. They are obviously nursing home material.' We do not want to take on someone for whom we cannot provide the appropriate level of care. We have to make that decision every now and then. Most of the time it works out well. We assess them and determine whether they are a low-care or maybe high-care potential, but we base it on behaviours and things like that, not on medical needs.

Mr MOSSFIELD—What role would public hospitals play in this process? Would they finish up with high-care patients that the nursing homes cannot cater for?

Mr Miller—No. I think you will find they have their own crisis up there on beds. We have quite often sent what we considered to be seriously ill residents up there for medical attention, and they have just boomeranged straight back. They go through emergency, are assessed as okay and are sent straight back.

Mr MOSSFIELD—You mentioned the need for an additional $10 per day per patient. Could you clarify that figure and where it fits into the scheme?

Mr Miller—That is the recommended figure that ACS are quoting now to enable the industry to survive.

CHAIR—Thank you both very much. For your information, the results of this report will be tabled in parliament around May or June, and after that time they will become public property. But anybody else who wants to make a submission can still do so.

[9.56 a.m.]

NORTH, Dr Robert Alan, Sub-Dean, Dubbo Clinical School

CHAIR—Welcome. I must inform you that this hearing is a formal proceeding of the parliament and is recorded by Hansard. What you say is evidence and, if it strays from the straight and narrow, you can be held to account for that. Would you like to make an opening statement before the committee asks you questions about ageing and health?

Dr North—I was a general surgeon in Dubbo from 1968 to 2001. My work was initially in all fields, including orthopaedics and gynaecology, but latterly I had a particular interest in breast surgery. I attended Lourdes geriatric hospital frequently for consultations. Since my retirement from clinical medicine, I have been appointed sub-dean of the new Dubbo Clinical School of Sydney University, and I am also a board member of the Macquarie Area Health Service.

I would like to comment on several aspects of aged care as I see it. Twenty to 30 years ago, geriatric patients were generally cared for and admitted from their communities to a hospital or nursing home by their GPs. Where appropriate, referral to specialists would occur. There was little in the way of community and nursing care on an organised basis. A great change in care in hospitals and the community has taken place in the last 10 years. In larger centres like Dubbo, GPs are rarely on the hospital staff, and geriatric patients are cared for by hospital and specialist practitioners who are not seeing the patient in the community. On return to the community, the patient is under the care of the GP and a much expanded community nursing staff. The continuity of care from hospital to community is therefore interrupted, and this sometimes results in poorer communication, especially on the medical side. The nursing side is much better coordinated.

I see the necessity for encouragement for GPs to return to hospital positions in the geriatric area, particularly as specialist geriatricians will never be in a sufficient supply to undertake total care. Perhaps a part-time career medical officer position for the GP would suffice. GPs are often reluctant to visit nursing homes regularly. They often attend late at night or in the early hours when key staff are not present. Sufficient reward must be available to encourage better attendance—or you could have something like a paid part-time position, as I mentioned before. There is a chronic problem of shared federal and state control of aged care, with differing awards in nursing homes, dementia units and geriatric units. There must be ongoing planning to one day have health care in Australia under the one federal umbrella. I see this as particularly important in aged care, but in all facets of medicine I believe it is an urgent need. Finally, the provision of geriatric outpatient clinics run by qualified specialists in the medical and nursing professions would help to support the community carers in keeping patients out of hospital.

I will just say a few words now about training. The current medical curriculum in Australia includes a short period of specific geriatric training. This is at present being carried out in Dubbo and Orange and is enthusiastically provided by medical, nursing and allied health staff. I have a comment on nursing training. There is a reluctance of trained nurses to practise in the geriatric area. A suggestion has been made that enrolled nurses and assistants in nursing should be encouraged to upgrade to a higher level of nursing, and these facilities are already available.

Local young people in Dubbo are attending the nursing graduate course at Charles Sturt University, and they may be more inclined to work in local areas, including in geriatrics. Training in this field should be available here so that they remain in the community. I believe it is important to avoid expensive and impersonal agency nursing staff, and this is largely being avoided in Dubbo at present. Notice should also be taken of the desire of the nursing profession to have permanent rather than casual appointments.

I have some comments about postgraduate medical training. With increasing government control of medical practice, indemnity problems and the necessity to reduce excessive hours of work, medical practitioners in aged care hospitals and other facilities will be less likely to be visiting medical officers—which I think is desirable—and more likely to be hospital-employed doctors who have little community contact. Specialisation in medicine takes nine to 10 years at least. With the increasing feminisation of medicine, safe hours policies and the desire for a better lifestyle, more hospital care will be undertaken by career medical officers rather than specialists. The latter will oversee the career medical officers, probably by visiting from larger centres or supervising surrounding large areas. As I mentioned before, nursing homes may find it more beneficial to have a paid part-time appointment of a CMO or a local GP, rather than to depend on casual visits.

I also have some comments about allied health training. At present, physiotherapists, speech therapists and occupational therapists at Lourdes Hospital in Dubbo are privately contracted and not employed by the institution. I wonder if this is the best method for employment. There are rural enticements for people training in these allied health professions, as there are in medicine and nursing. Training these people in a rural facility may encourage them to work in the regions. Albury has physiotherapy and there is pharmacy, I think, in Orange and Wagga. I believe that these rural training positions are very desirable.

Finally, the Macquarie Area Health Service multipurpose centres have been set up, which have reduced the number of acute beds, which were not filled, and increased the number of aged care beds in towns such as Baradine, Warren and Trangie. This has enabled old people to stay in their communities, while providing aged care in these towns. The loss of hospital and residential facilities in a town spells the doom of the town. It may be economically unsatisfactory to maintain these situations, but this depends on the political philosophy of the government of the time. Once again, the function of these aged care facilities is spread between federal and state governments, and I am sure this is an inefficiency. That is all I have to say at this stage.

CHAIR—Thank you very much, Doctor. Bob, you mentioned GPs being reluctant to visit nursing homes. By ‘sufficient reward’, I suppose you just mean money or other recompense. Is it partly just that the home has to work in with doctors to enable visits to happen at better times, or do you mean that doctors are simply so busy that the only times they can visit nursing homes are way out of hours?

Dr North—I think probably it is a combination of things. I think that visiting the nursing home, which is usually not urgent, is put at the bottom of the pile and tends to get done early in the morning or late in the evening. It is an interruption to the day to drive to the nursing home and see the people. If a GP has a particular interest in that area, I think they are more likely to have set hours of visiting, which is beneficial. I am not sure about the monetary reward for GPs

visiting nursing homes. I think probably it might not be considered adequate, but I really would not like to comment on that.

CHAIR—I think you mentioned earlier that they might be better off having part-time affiliations. Do you think we have enough doctors and staff for that to work in an area like this?

Dr North—I think we probably have, and it would probably be more appropriate if a doctor who was interested in this field of medicine were appointed, rather than asking a whole lot of them, some of whom might not be particularly interested in that topic.

CHAIR—That leads me to my other question. You will have to excuse my ignorance. How important is it for a doctor to have specialist geriatric training when dealing with the aged?

Dr North—As I said in my submission, specialist geriatricians are very sparsely scattered in the west, and that is not likely to improve. I think the years taken to become a specialist are hindering people from doing specialty work, because it takes such a long time. I think the specialist geriatrician is going to be seen as an overall adviser and mentor to the career medical officers and GPs working in the field, and this is what is happening in Dubbo at present.

CHAIR—So the specialist will be more of a manager than hands on?

Dr North—I think so, yes—and dealing with specific, difficult situations.

Ms HALL—Thank you very much for your good submission. I am particularly interested in some of the comments you made about when patients present at hospitals and when they move to the community. Do you think there needs to be a plan developed that links the treatment that is received when a person is in a hospital to what happens to them when they go home? Do you think there is a need for a more person-focused approach to the care of an older person so that a smooth transition from one phase to the next can be ensured? In that way, everybody who has contact with that person is involved in the planning process, right from the start. That will ensure that the information flows to the appropriate people.

Dr North—I think this is terribly important. In the past, there was a lot of lack of communication when, for instance, patients from Dubbo Base Hospital were transferred to Lourdes Hospital and then Gilgandra. Quite often, transport might suddenly become available and the patient would be shifted before the necessary letters or communications were written. I think this is improving a lot now, but there is still a difficulty in getting that transition. By planning ahead—and this is happening with the nursing staff at the base hospital—and knowing the patient is going to go to this facility, this communication can be effected better, particularly on weekdays. It is on weekends, often, that the communication falls down. A lot of work is being done to facilitate what you say, and I think it is terribly important, because in step 1, step 2, step 3 it is very easy to lose track of what is happening. There needs to be a common denominator going through this to ensure that there is a continuity of care.

Ms HALL—And that links in to the provision of the HACC programs, Meals on Wheels and all the ongoing support services that people need.

Dr North—Which all have to be coordinated. There has been a suggestion of the possibility of a transition place—I do not know where it would be; perhaps at the base hospital or perhaps at Lourdes Hospital—for patients who are seen to need nursing home care. When there is no bed available, patients could go to this transition place to await the necessary placements. I think it is very important to try to place aged people in the community from which they came. We have often had to place people in towns remote from where they had lived, and I think that is a dreadful thing to do to an old person.

Ms HALL—I want to go back to the issue of training. This committee received evidence in Sydney from Kichu Nair, who is situated in the Hunter. He told the committee that one factor he believes is missing is the appropriate training of people working within hospitals to recognise issues with older people—say, if a person presents showing certain symptoms which are actually caused by something else. So he saw the need—and this links into what you are saying—for greater training generally in relation to geriatric issues and the need for that to be transferred to a greater knowledge within the GP work force.

Dr North—Certainly we rely on a specialist geriatrician to give most of this training. If there were a resident geriatrician here, that person would then be able to be associated with an official trainee registrar. That applies to all medical specialties. If there is a specialist in a particular field, then a training registrar can be appointed. This immediately raises the level of potential training of students and nurses because these skilled people are there. By having a part-time geriatrician, I am not sure if Lourdes Hospital, for instance, could employ a training registrar. I would have to find that out because I do not know. It is getting these key positions. You need the top person there to be able to appropriately train registrars who can then be recognised in their specialty, and this time can be taken as appropriate training.

Ms HALL—Could you tell us about the geriatrician work force in this area?

Dr North—There is no full-time geriatrician in this area. Geriatricians visit from Prince Alfred Hospital, but there is really hardly anyone who comes at this stage as a supervising geriatrician.

Ms HALL—How often does a geriatrician visit?

Dr North—A geriatrician in palliative care comes every fortnight and that is about it at the moment.

Ms HALL—Really? So there is quite a work force shortage there and an unmet need within the community?

Dr North—There is very little geriatric supervision. I think Dr Palmer used to be a resident geriatrician here and he comes up a little bit, but I do not think he is officially on the staff.

Ms HALL—Thank you. There are other questions I could ask but I do not want to hog the questioning.

Mr MOSSFIELD—Thank you for your presentation. I am just reading your note relating to the Dubbo Clinical School, which you are associated with. I see that there is a scheme in operation where some 45 to 50 students spend half a year in the area.

Dr North—The federal government's policy on the rural clinical schools is that 25 per cent of all medical students in Australia will spend 50 per cent of their clinical training in rural areas. That training in third year or fourth year, depending on the clinical school, includes a term in geriatrics. If they are in the city, they do geriatrics as well of course, but we are giving some of the students their geriatric training here and indeed that is happening this morning.

Mr MOSSFIELD—Is the scheme progressing well?

Dr North—Yes. It is a popular scheme, and students have applied for almost a full endorsement of the course here this year.

Mr MOSSFIELD—There is also mention that much applied research can be done in rural areas. Is that progressing at all?

Dr North—The clinical school here has just appointed a research officer who is going to start work in March. That is with federal funding help. I do not know the topics of research, but our planning is that we hope to pursue the research topics from the clinical school into Aboriginal health and aged care and rehabilitation and diabetes.

Mr MOSSFIELD—We might move on to Aboriginal health. We have been to Alice Springs and Darwin and seen some issues there relating to that section of the community. What is the position in Dubbo relating to aged care for Aboriginal people?

Dr North—I think it is fairly fragmented and it would be included in the general aged care. I cannot tell you the details at all, but I think Aboriginal health care at present is rather fragmented. We have been trying to get a module together for students to study Aboriginal health care, but it is in such a fragmented situation that at the present we are in a bit of disarray trying to organise it.

Mr MOSSFIELD—Are there any Aboriginal people involved in health care at any level—nursing, for instance?

Dr North—Yes, there are: there is an Aboriginal medical centre in Dubbo, which is not terribly well attended, and we have Aboriginal representatives in aged care in the area health service. They are certainly involved.

Ms HALL—The issue I would like to take up with you now is the issue of the state and the Commonwealth and the fact that you believe there needs to be more streamlining. I think you made a really bold recommendation that the Commonwealth take over the responsibility for health and aged care—something I would not necessarily disagree with. Given that that probably will not happen, have you got a fall-back position or something we could look at recommending that would avoid what I see a lot of: blame or cost shifting between the two sectors? There is a problem and the state blames the Commonwealth or the Commonwealth blames the state and in the long run it is the people, that both represent, that miss out.

Dr North—I think a subsequent speaker this morning will probably be able to enlarge on that with much more authority than I can. It just seems to me that, if there were one agency or one instrumentality controlling health or, specifically, aged care, it might be more efficiently organised. There seems to be antipathy sometimes in nursing homes. At Lourdes Hospital, for instance, part of it is run as a state government health service with acute geriatrics, and at the other end of corridor is a nursing home wing which is financed by the federal government under different awards. It seems to me that that is an extraordinary situation. But I really cannot comment on the financial side of it, because that is not my area of expertise. It just seems to be commonsense for it to be under one instrumentality, and that possibly goes for health care as well. We used to have problems at the base hospital with writing prescriptions for patients. On one hand we would be asked by the federal system to give the patient a week's supply of drugs when they left hospital, which was financed by the hospital pharmacy and hence the state government, but then the hospital would ask us to write an outside prescription for the patient to go to the chemist so the hospital would not have to provide them with any drugs. Who is right?

Ms HALL—Is there much discussion between the Commonwealth and the state in this area about aged care? Do you think that there is communication or no communication?

Dr North—I think there is probably quite a lot of communication about what is happening with health care in this region. I think our local members, both federal and state, are quite aware of this, but whether the actual departments are, I do not know. On the area health board we are certainly aware of it.

CHAIR—Aged care is probably one area where there is less confusion between state and federal than most. If you are talking about the hospital system as against straight aged care: yes, there is a real mix and it would seem that hospitals want people to be in aged care because that is not state, and for anybody with a chronic condition the aged care people want them to be in hospital. We always get into terrible strife as to who pays for what. It is a mixed situation. Thank you very much indeed for coming. If there is anything further you would like to add to your submission, please do not hesitate to do so.

Dr North—Thank you.

CHAIR—Would someone like to move that we table this submission?

Ms HALL—I move that your submission be tabled and received by the committee.

CHAIR—We will now stop for a smoko.

Proceedings suspended from 10.19 a.m. to 10.43 a.m.

KENNEDY, Mr Michael Anthony, Non-Executive Director, Catholic Health Care Services Ltd

CHAIR—Welcome to today's public hearing. I remind you that this is a formal proceeding of the parliament and is recorded by Hansard, so you can be held to account for what you say. Would you like to make an opening statement before the committee asks you questions?

Mr Kennedy—Catholic Health Care Services is the owner and operator of Lourdes Hospital—an aged care facility in Dubbo—and aged care and hospital facilities right throughout the state, especially in the central west. I have prepared a submission—for which I am very thankful to Joanna Marr, the manager of aged care services at Lourdes—which highlights a number of issues, in particular with aged care facilities.

I may take questions from the committee on this, but I want to address how my involvement with aged care has come about. For eight years I was on the board of the advisory committee of Lourdes, which was appointed by the diocese of Bathurst. The diocese owned and operated Lourdes, which was a hospital and aged care facility, as well as extension services for the Macquarie Area Health Service. It is what is called a third schedule hospital, which is funded by NSW State Health. During the period in which I was a board member, the aged care facility became a Commonwealth aged care facility.

It became apparent to the diocese and the board, which was composed of citizens of Dubbo, that we were unable to cope with all the complexities. In 1997 the bishop appointed Catholic Health Care Services to manage the hospital and nursing home. Catholic Health Care Services was established in 1994 by the bishops of New South Wales as a lay organisation to take over where the diocese and the religious orders were struggling to operate health care facilities. One of the first dioceses to take advantage of the skills and facilities of Catholic Health Care Services was the diocese of Bathurst.

After 1997, I was appointed chairman of the Lourdes advisory committee. At that stage we were still responsible for the operation of the hospital and had engaged Catholic Health Care Services as the manager. In the year 2000 I was appointed, being the only country representative, as a non-executive director of Catholic Health Care Services. In 2003, Catholic Health Care Services negotiated with the diocese to lease the hospital and take over the licences and operation of the hospital and aged care facility.

In 2002-03, Catholic Health Care Services, together with the advisory committee of Lourdes, negotiated with State Health a seed capital grant to rebuild the aged nursing facility, which was a quite old and non-purpose-built 33-bed facility. We were going to fail the accreditation in 2008, so it was absolutely critical that we rebuilt the nursing home. It took some time to negotiate that transfer of licences and the capital grant. Using that capital grant, together with the borrowing capacity of Catholic Health Care Services, we are at present building a 62-bed purpose-built aged care facility on the northern edge of the hospital campus, between the hospital and Charles Sturt University. It will be a state-of-the-art facility, costing in the vicinity of $10 million. Of the 62 beds, 32 beds will be high-care beds and 16 of those beds will be dementia-specific beds. There will be a further 32 low-care beds, of which 16 will also be dementia-specific beds.

This leads to some comments made in the paper. We have found that dementia is an increasing issue in aged care. A number of patients presently in our care have high-level dementia, and our facility provides care for a number of patients with part or full dementia—hence the building of the facility. In all our aged care facilities that we have built in New South Wales in the last five years we have built specific facilities for dementia care. The issue now arising from that is that our staff are being challenged to cater for the behaviour of the demented patients. In our paper we address some of the issues. Dr North, who appeared prior to me, discussed some of the training issues that are required for general practitioners and our staff.

In our Norton unit, which will become the aged care facility upon completion, our manager of aged care is conducting training for, particularly, the young staff in caring for these patients who have behavioural issues. Caring for people with dementia is a very difficult task. Unfortunately, there is to our knowledge no accredited training in this area, so we have had to develop our own training. One of the things that is interesting is that we are training young assistants in nursing who are working at the aged care facility and studying at Charles Sturt University, which is one of the great benefits of having the local university facility. They are working full time and studying part time. The only problem is that, when they become graduates, as registered nurses they will then go into the hospital system for their required training and it will be difficult under the current salaries and award conditions, as addressed in the paper, to attract them back to the nursing home.

Lourdes is a very diversified facility and has a number of streams of care in place at the moment. One of the things that we are particularly known for is looking after difficult and critically infirm people who are aged or under the aged classification. We have six long-term residents in the nursing home at the moment who are not classified as aged. They are provided for with the current aged support from the Commonwealth and require a high level of nursing care—7½ hours a day, and it is quite critical care. Lourdes have looked after these people as we tend to be the carer of last resort.

One of the other areas we are very much involved with is respite care. We are the Commonwealth aged care respite centre, but we also provide respite care for people who live at home with their carers to give the carers a break. There are two types of respite care. One type is where a carer comes into the home. The other is giving the carer a break at home by moving the patient to Lourdes for a short time—usually two or three weeks. We find there are usually some behavioural difficulties and some clinical care required during that period.

Moving away from the nursing home for a minute, there are two programs that we have run very successfully at Lourdes. One short-term one run over the last two or three years, aimed at aged care, is the Home Club, which provides care from nine to five, five days a week, for up to 15 dementia patients who live at home in Dubbo and are usually cared for there by carers who work part time. The carers would work during the period that their elderly or demented resident is at this Home Club. We have a person on staff who specialises in dementia care, and we have other staff who provide facilities for these people, keeping them entertained and giving them activities during the day. That is a local initiative that we started when we had the area available following the vacation of another service in the town. It is funded by both HACC and Lourdes.

The other facility is a day care centre in the David Palmer centre, where up to 50 clients a day are physically picked up in buses—we have two buses—from their home and taken to the

facility during the day. It mainly provides diversional therapy, and they do activities such as basket weaving, playing cards and so on. This is a service that is very much valued in the community. We are having difficulty in funding this service. It is being funded from the hospital budget to date. There is no specific funding being made available for this, and it is actually coming via the state health system at this point in time. It looked as though we might not be able to maintain this facility, and we had vast protests from the community when we closed it one day because we had a bus break down. So it is obviously a highly valued community facility. I will leave it at that.

CHAIR—Thank you. By and large, do you think you are drawing your residents from smaller towns further out or are they primarily from Dubbo?

Mr Kennedy—A little bit of both. We have instances of people who live in Dubbo whose families are out in the western towns and, therefore, they come to join them in Dubbo. And of course we have a large number of locals as well. So I would say it is both, but I have not got the breakdown of it. We certainly would draw from Narromine, Gilgandra, Trangie—those sorts of areas.

CHAIR—Do you think that the children of aged people are tending to try to bring them to a place like Dubbo now rather than put them in a local facility simply because of the medical situation? Do you think there is more of a push from people further out to now come to Dubbo not just because it is a bigger, more cosmopolitan place than home but simply because the medical facilities are so much better?

Mr Kennedy—I think that is right. There are a couple of issues. Obviously families of the more elderly have moved to Dubbo. There is no doubt that Dubbo is an attractive spot for them. Therefore they bring their family to Dubbo to be closer to them. In my role as an accountant, I talk regularly to aged clients about moving to Dubbo, Tamworth or Wagga, where the medical facilities are better.

CHAIR—Can you give us any idea of what your waiting list would be? How big is the demand beyond what Dubbo can handle now?

Mr Kennedy—No, I cannot give you those offhand. I know we always have a strong waiting list. I can get them for you.

CHAIR—Okay. Is there anything you would like to bring to this committee's attention that you believe makes aged care of any style different in Dubbo, or a smaller place than Dubbo, to aged care in Sydney, Melbourne or Brisbane?

Mr Kennedy—The issue that I want to address—and thank you for giving me the opportunity—is that Catholic Health Care Services is having a lot of success, not only in Dubbo but also in places like Forbes and Bathurst—and we are talking about smaller facilities in places such as Condobolin, Grenfell or West Wyalong—where we are working in partnership with the local shire councils. In Forbes we are working with Jemalong Retirement Village, where there is a local committee—which is exactly what happened in Dubbo, except it was through the church; Lourdes was run by a local group of citizens.

We are trying to bring to those smaller centres our skill in aged care. We have built up a number of staff and people who are skilled in aged care and who are located not just in the regions but in the city areas. We are trying to bring management skills. We have strong financial, HR and IT skills that we are bringing across the region that may not be based in the region, although we are trying to develop a regional concept. We have staff employed, right throughout the region, that service more than one facility.

The other thing that Catholic Health Care Services brought to Lourdes is the ability to raise capital. It is a growing organisation that is now attracting the interest of the larger banks and even some of the retirement superannuation industries that are interested in investing in the industry, if they can get the right model. We think we can bring together those packages and then work with the local community. Because we are a not-for-profit organisation, we are not aiming to go in there and reap the rewards; we are aiming to work with the local community to give them the best facilities.

CHAIR—So what have you done in Jemalong and Forbes? I know they are looking at one I put them on to in Broken Hill the other day. It seems that any home with under 50 beds or so that is independent is running into trouble. Could you itemise some of the issues? Obviously you can use your size to give greater throughput benefits.

Mr Kennedy—How we came to get involved with Jemalong is that in about 1997 the Sisters of Mercy were in dire straits with the Mater Aged Care Service at Forbes. They called upon us and we came in as a management contractor there. With Commonwealth help, with some seed capital and with some finance from the diocese of Canberra we rebuilt a 32-bed facility at the Mater, which is now trading successfully. The only issue we are starting to run into, which my predecessor Dr North addressed, is that we are having some staffing difficulties with nursing staff. Other than that—management wise and financial wise—it is on a very sound footing.

On that basis, the Shire of Forbes—I think the council president had attended some of the functions at the Mater when we opened it—invited Catholic Health Care Services to assist them in the management of their nursing home, which was running into the same issues. We are now in there managing Jemalong for that board. The board is still in place, and we are aiming to do exactly the same thing as we did with Mater—that is, to rebuild with purpose-built facilities. One of the great benefits of purpose-built facilities is that you can get economies of scale. You can get economies of operation, and you can deliver the services on a more economical basis.

CHAIR—I would imagine the scope for what you are doing is unlimited in country western New South Wales, as there are so many small facilities.

Mr Kennedy—We have a region now in the central west with six or seven facilities and several approaches. We are also working on the north coast and looking at the central coast and at Port Macquarie. So you are right: there is a huge demand developing.

Ms HALL—Reading the background information we have and listening to your submission, this question arises for me: how closely do you work with the state at Lourdes and what is the linkage like between the two? Basically, you are operating out of the same facility. I am interested in issues like the availability of allied health workers in the area and, if there is a

shortfall, how that affects the services to older people in the area. Maybe that is flicking over a little more to the state side of things, but I am sure you can give me an answer to that question.

Mr Kennedy—Your question has two parts. The answer to the first part is that we have a complex relationship with the state. A third schedule hospital is actually a public hospital. It is funded by the state through the local Macquarie Area Health Service. I have not been chairman now for 12 months, but part of my life was continually trying to negotiate the budget for the hospital facility. As a third schedule hospital, you have to provide the services according to the budget. With the current health care budget being under huge pressure, we always tried to operate within budget—in fact, we normally came in just slightly under budget—but we were then always affected by the cash flow issues of the local area health service. That budget was a comprehensive budget that funded a whole range of services, from the mainly rehabilitation beds in the hospital ward through to all the area health extension services. Some of the things this included have been mentioned: speech therapy, physiotherapy, aged care assessment teams—a whole series of facilities mainly directed at the aged but often directed at young people who had had accidents. We had a brain injury ward. So it was a very diverse range of services being funded by one budget, occasionally supplemented by a Commonwealth program directed at some specific service.

As to your second question about the allied health services, Lourdes is very fortunate in that most of the allied area health services are run out of that vicinity, and so that helps in providing care to the aged. But, as was mentioned by of the previous speaker, those workers are contracted. They are not on staff in the aged care facility; they are actually contracted from the hospital facility. There is a continual shortage of and difficulty in attracting those staff. Allied health is a growing area of demand. I have family members who have trained in allied health, and they have no difficulty in getting jobs in hospital facilities, or facilities attached to hospitals, in both the capital cities and the regions. There is a just a shortage. It is being addressed by training in the regional universities, but it will take some time.

Ms HALL—This is a broader question about psychogeriatric aged care services. Is there a shortage in the area? Are there any specifically designated psychogeriatric beds within the area?

Mr Kennedy—To my knowledge, there are not. A previous speaker mentioned Dr Palmer, who was the long-term aged care physician at Lourdes. We lost a lot when we lost Dr Palmer about four years ago, and we have not been able to replace him. He was full-time on staff. We have just appointed a doctor from overseas who has a specialty in rehabilitation, but I believe that he is not a geriatrician. We have two local doctors—Dr Sahukar and his wife—who visit the hospital, who have provided the aged care on site for some time now. Dr Sahukar is considering retirement; his wife, who is much younger, is staying on. We are very grateful for their continued service. It is an area that we would like to be able to have access to.

Ms HALL—So, there are no psychogeriatric beds and you care for the more difficult people. What happens if somebody does need to be placed in a psychogeriatric facility?

Mr Kennedy—You are getting beyond my expertise. I cannot really answer that. We would give them as much care as we could until there was some—but I really cannot answer.

Ms HALL—Would they have to leave the region, basically?

Mr Kennedy—If it were very difficult, I think so, but I would have to get some answers from the clinical staff on that.

Ms HALL—If you could get that reported to the committee, that would be very good.

Mr Kennedy—Yes.

Ms HALL—Do you offer community aged care packages?

Mr Kennedy—Not at Lourdes.

Ms HALL—What about Catholic Care of the Aged?

Mr Kennedy—Absolutely. We have community aged care packages running out of most of the other facilities, and it is something that we would like to introduce at Lourdes, but I think there are other facility providers in Dubbo at the moment.

Ms HALL—Other facilities who are providing it?

Mr Kennedy—Yes.

Ms HALL—With Catholic Care of the Aged and the packages that you are offering in this area, is there a shortfall?

Mr Kennedy—In community aged care packages?

Ms HALL—Yes.

Mr Kennedy—I am not aware of that.

Ms HALL—Maybe you could get a little bit of information for us on the community aged care packages.

CHAIR—We do have a lady here who deals with that. We might have time to bring her on.

Ms HALL—Good, because we were talking earlier. Mr Kennedy, I would like any information you can give me in that area. Also, is there a big demand for respite and is there a shortfall in that area?

Mr Kennedy—We think that respite is a very important area. Firstly, it enables people to stay in the home and be near their loved ones; and, secondly, it encourages and supports people in caring for people who otherwise would have to compete for a bed in the aged care facilities. So at Lourdes we would do everything we could to encourage people, by our administering the respite care centre and by these respite care beds. It is something that our staff are very keen to have in the facility.

Ms HALL—Earlier this morning we heard about the red tape: how the red tape is influencing and the impact it is having on the aged care sector. Is it an issue within Lourdes—the RCS and the other requirements that are placed upon you for accountability, accreditation, workers compensation and all those other issues rolled into one?

Mr Kennedy—Our staff believe it is a major issue. You have probably touched upon what our organisation is challenged to provide to assist organisations such as the one the chair was asking about at Jemalong. We normally have to come in and assist them with their RCS classification, with their workers compensation premium and with risk management strategies. We often have to assist them with their basic financial management systems and their clinical care systems, to help them with their accreditation process. The small facilities without a large organisation to support them struggle with red tape. We understand why it is there and the importance of it. Our staff would like to get rid of the RCS classification, but I do not know if anyone has come up with a workable solution, because even in our paper we keep touching on the need. There are different types of patients who need more care or less care, so you have to differentiate between these patients. Otherwise you have the same issue that we had with the hospital and the state, where we had one bucket of money and had to try to ration it amongst our services.

Ms HALL—Have you been affected by the clawback? Have there been reviews where people have been classified down and therefore the funding level has been reduced?

Mr Kennedy—Not to my knowledge.

Ms HALL—Could you get more information on that and send that through to us too?

Mr Kennedy—Yes. To be honest, I think we often come out with a better result when we have those visits.

CHAIR—We actually do not have your submission.

Mr Kennedy—I am sorry; it was emailed on Friday.

CHAIR—We worked that out between us, but just be aware we have not seen it yet. If you could give us your copy at the end, we will move that it be accepted.

Mr MOSSFIELD—We are interested in the concept that you have been putting forward today relating to the whole of health care, not fragmented health care as it certainly is at the moment. Are you aware of any other organisations that are operating under a similar arrangement?

Mr Kennedy—In the regions I am not aware of any others, but certainly there are some in the city areas. These include Uniting Health Care and some of the other Catholic organisations, such as Sisters of Mercy, who are just at the moment transitioning their North Shore facilities to Catholic Health Care Services, and Little Sisters of Mary. There are some other organisations in the city regions that are trying to run larger programs, but in the regions I am not aware of any.

Mr MOSSFIELD—What recommendations do you think that this committee could make to assist organisations such as yours and others to move in the direction that Lourdes has moved in?

Mr Kennedy—That is a good question. The consolidation of the industry is a moot point in the areas in which I meet. Some say it will happen by natural effects; some say that it will not happen because various organisations will cling on and try as long as possible to retain their independence. The biggest issue here is independence and history of operation. I think economics will eventually spell it out. I do not know whether some system of accreditation of organisations or encouragement of organisations will work. I think, literally, that the role of government is to back winners—to back people who are doing it successfully—in the allocation of beds and in assistance with funding. The whole accreditation process is somewhat aimed at that anyhow.

Mr MOSSFIELD—I have another question on funding. Of the residents that you cater for in the aged care sector, how many would be paying accommodation bonds and how many would be concessional payments? Do you have any idea of the break-up there?

Mr Kennedy—The only facility that we are charging bonds on at the moment is in low-level care. We run an operation at Boddington in the Blue Mountains, which is the old Red Cross hospital, and it has been completed in the last five years. We have about 40 bonded residents in low-level care and about 20 concessional residents there.

Mr MOSSFIELD—Is your organisation doing any research into age related illnesses?

Mr Kennedy—We do not do any ourselves. We have occasionally assisted or contracted people, but we do not do any.

Mr MOSSFIELD—You are a public hospital, so I suppose there is potential for other public hospitals to take up the same system that are you operating under—or would there need to be a support mechanism like a religious background?

Mr Kennedy—I want to clarify this point: the public hospital is somewhat unique to Lourdes. I think there are only two or three third schedule hospitals left in New South Wales. I do not think we should confuse this. Most aged care facilities will be stand-alone. Occasionally, I think you will find that in regional towns we are now seeing multipurpose facilities—

CHAIR—Yes, it looks like a multipurpose.

Mr Kennedy—where they are built together. But most of our facilities are separate and stand-alone from the hospital.

CHAIR—Thank you very much. I have to be honest: what you have said has been very enlightening in the whole facet of aged health care as well as aged care itself. We thank you very much for that.

Mr Kennedy—I apologise for the paper—

CHAIR—You could give it to us right now. The committee has determined to induct this as a matter of record. Thank you very much.

Mr Kennedy—Thank you to the committee for the opportunity; it was wonderful.

[11.17 a.m.]

PATEMAN, Ms Janice Elizabeth, Manager, Ozanam Villa, Society of St Vincent de Paul

CHAIR—Welcome. It is my duty to tell you that this is a formal hearing of parliament. Hansard will be recording it, so you are accountable for what you say. Thank you very much for coming. Would you care to make a short statement about where you are going, anything on aged care in general, what people expect of their life in their senior years or anything to do with that before the committee asks you questions?

Ms Pateman—Ozanam Villa here in Dubbo is owned by the society of St Vincent de Paul. It is a 49-bed facility, with 48 permanent beds and one respite bed. It is a low-care facility. We house a variety of residents, including dementia patients, mental health clients and young residents—when I say young, I mean aged in their 50s and 60s. We have some issues that have been affecting us of recent times, especially with regard to dementia residents and mental health residents, with crisis situations where we have not had access to support groups or support facilities for short periods of time. Another issue goes to funding our categories, especially category 8. Even though we do not have people in category 8 at the villa now, I know there are people out in the community that do need housing and support but are technically able to look after themselves. Under the ethos of the society of St Vincent de Paul we need to give these people a home, but we have not got any sort of financial support to do that. I have one lady in a crisis situation right now who does need housing but, unfortunately, without dollars to back up our end of the bargain we cannot give her that.

We have discussed at the local ACS branch, as well as amongst ourselves as managers of the facilities here in Dubbo and our society's facilities, the funding—and it is a hard one to put an increase on. I know we are talking about, say, an average of $10 a day per bed, but with the mix of our clients at present, with our categories—we have many high-care residents in a low-care facility—that does support it. However, that number fluctuates very rapidly as, with ageing and especially the winter months, we lose quite a few. In terms of the society in general, to stay in aged care we have just done a revamp with respect to the society and our 23 facilities, and aged care has been taken away from other areas of the society's care needs. We are restructuring right now to keep us in aged care.

CHAIR—Thank you very much. You mention what to me is obviously a critical issue in country and, especially, rural and remote areas, and that is that people's assets do not always allow them to take advantage, as we would hope, of hostel or low-care situations where bonds are involved. Do you believe it is mostly directly related to the value of the house?

Ms Pateman—Yes, I think so. Of our 49 residents, we have maybe eight to 10 who have paid an entry bond. Most of those people have sold their family home to pay that entry bond because they have not had a carer et cetera in it. But in taking that family home away from them, their children have felt that they have lost something. It is really a vicious circle for these people.

CHAIR—They do not seem to be aware that the bulk of that money is returned?

Ms Pateman—No. It is very difficult to get that across to families. They look at the dollar factor—just that dollar sign. You sit down and you explain. In addition to the booklet that the department put out this year or late last year—which I do congratulate them on; I think that is a great booklet—we have worked on a bit of an explanation to try and explain how the bonds are derived and that sort of stuff and what goes back to them. We have based it on a bit of a breakdown over a couple of years.

CHAIR—Once you sit down with them and go through it, does their attitude change at all?

Ms Pateman—Some. Some still find it hard to comprehend. It is telling them: okay, after so many years we are going to stop taking that retention figure out and there will be a lump sum to go back. With our facility we get a lot more of the disadvantaged type of person, with homes that are less valued—the West Dubbo type homes, where you are only looking at a minimum value on that home—and, deep down, I suppose some children feel that that has been their inheritance and they are going to lose it, so it is still an issue of concern there.

CHAIR—Yes, it is certainly about that. By and large, how many of your beds end up in high-care use?

Ms Pateman—At present out of 49 beds I have 14 high-care residents.

CHAIR—Does every one of your beds have the facility to cater for high-care residents?

Ms Pateman—No, not really. Our facility is 25 years old, so some of our rooms are built to the specifications of that era—they are smaller rooms. It is difficult to get aids in there. We cannot get high-low beds in and out of the rooms—we only have ensembles. There is a big difficulty there. We have some larger rooms that we can access, and we have actually converted one room into what we call a high-dependency palliative care room as well as a respite room, and we can chop and change that room. I know you can shift residents around, but once are you in a nice big room you do not want to give that up for a little room because Joe Blow next door needs a higher level of care.

Ms HALL—Do you think there is too much red tape at the moment? Would you like to comment on the RCS and all the other requirements—I noticed that you rolled your eyes as I said RCS—that you are faced with as an aged care provider?

Ms Pateman—I suppose the RCS is long-winded, with all the questions et cetera, but how do you condense those areas? Luckily, for my sake, I have just handed that area over to my care manager, so she does all that to give me a bit more time to manage properly. The biggest thing that we face is getting through to our staff, because in aged care you will find that 90 per cent of the staff are unskilled—there are more middle-aged women who are in their 50s and even older. I have even got staff in their early 60s who have not had good schooling and cannot understand why we have to do all this. They came into the industry when you did not do much and you did not have to document. All of a sudden they have been swamped with the paperwork, and they find that very difficult and hard to handle. I had a couple of illiterate employees and we have taught them to read and write in the last five or six years that I have been at Ozanam. You can see it across the board. We do one-on-one training. Our training calendar for the next six months

is just atrocious in what we are putting across to our staff to help them in their documentation skills and their understanding of the RCS and then in marrying that up to care plans et cetera.

Ms HALL—That brings me to the question of clawback, the reviews and the reclassification downwards, and the fact that those reviews are done purely on paperwork as opposed to being person centred. Do you see that as an issue? Has it affected you?

Ms Pateman—That has affected us on numerous occasions. It would be close to two years—about 18 months—since we had our last review. That was when our care manager started. We went down a couple of categories and then we gained a couple of categories, so that balanced out, but there have been times when we have dropped considerably, and again they are looking at the paperwork. The holistic care given to a resident is not always there on a bit of paper. With the number of times the families come into my office for support, financial help and advice, I do not get time to run back down and document that every five minutes. Some of that is missed out—I know that—but there are only so many hours in a day that we can do that.

Ms HALL—So you would say that the paper focus of assessment is something that has the potential to disadvantage your residents?

Ms Pateman—Yes, definitely.

Ms HALL—I noticed, when you gave your presentation, that you have quite a mix of people in your facility. It sounds to me like you probably have a greater proportion of younger residents than most facilities. Would you like to detail for us the tensions that the special needs of those residents create within the facility, and how it impacts overall on the facility?

Ms Pateman—At present we have two residents who are suffering from schizophrenia—we have had up to five at one time. That is an issue with behaviours and the older residents accepting these people. We now have only two, who are under 60 years of age, but I have had residents in their late 40s and early 50s with mental illnesses, alcoholism problems and so forth. I do not know whether it is an across-the-board situation, but I find that we, as a church group, get approached a lot by ACAT to take in these types of residents. Originally, before my days, that is something that was not entered into by Vinnies, but I come from a different era and I bring these people in and try, and I have had a success rate. Consequently, ACAT are now calling on us quite often—even last week. A gentleman aged 52 needs to be taken from where he is. He is not living in a suitable situation and he is a dry alcoholic. Unfortunately, I cannot accept him because I have another person who is associated with him. What do we do with this gentleman out there when I have a lady at my place? Do you bring one in and upset the other or do you say, 'I'm sorry.' It is a no-win situation.

Ms HALL—It sounds very difficult. Regarding psychogeriatric beds and the ability to place people with psychogeriatric problems, it sounds to me like you would probably be one of the organisations that ACAT would turn to.

Ms Pateman—It has done.

Ms HALL—If people cannot be placed, what options do they have?

Ms Pateman—We had a situation here only a couple of weeks ago with one of our dementia residents, who needed urgent assistance. His doctor is from overseas and, to me, does not understand the aged care population and aged care needs. All that the resident needed was an adjustment of medication. He was violent. The ladies that live in the same area as him were terrified—locking themselves in their room. Two of my staff were physically assaulted by this gentleman. I got called in at 10.30 at night to come down and see what I could do. My instructions, even before I got there, were, 'Ring the ambulance; ring the police.' The police wanted that gentleman to be scheduled. He was taken to base hospital and returned to us within two hours. The next day we had a repeat performance. Finally I was able to get mental health involved early in the next week. We did not have access to a local psychiatrist or psychogeriatrician, and there were other issues as well. In the end the mental health worker pulled some strings—I do not know how; she was blessed for that day—and got us an appointment the next day. Subsequently, medications were changed and he is back to his old self. He is a lovely gentleman now. But the fear felt by those other residents around him at that time, and the staff, was hard going for about a week.

Ms HALL—That sounds quite an enormous issue.

Ms Pateman—It is a big issue. As you said, I am getting these sorts of calls from ACAT for these people quite regularly.

Ms HALL—My final question relates to the relationship between ACAT and the aged care sector generally. How effectively is ACAT working in the area? Is it underresourced? I am interested in the overall working of the system with ACAT, which, as we know, is funded federally, and how it relates to the facilities and the needs of the people in the area.

Ms Pateman—With the local ACAT, I cannot fault them for support. We have a great working relationship. The difficulty is with their time, I suppose. Quite often I make a phone call and I need some assistance, and our local area girl is out doing a visitation et cetera and it may be a day or so before she gets back to us. The central west is spread over a lot of area. I have just accepted a person who has been in Narromine Base Hospital, so I have been communicating with two different ACAT reps and then sometimes I find that the message is not getting across to the local one.

I do not know what their funding situation is, but from my contacts I would say that there are not many up there to do the job that is asked of them. There just seems to be the one for here and the one for Nyngan—going out that way. As I said, I just find sometimes it is difficult to get hold of them. I have often had eight o'clock meetings at work with the ACAT representative on her way to work so that she can get her day scheduled around what our needs are. Usually we do not have a problem with working with them; it is just a matter of accessing them.

Ms HALL—What about the waiting time for people needing to be assessed for aged care services?

Ms Pateman—It varies, but normally the local lady is quite good and you can say that within the week she would be back to us.

Ms HALL—That is excellent.

Ms Pateman—As I said, I cannot fault our relationship.

Ms HALL—Thank you.

Mr MOSSFIELD—I would like to touch on, if I can, the demand for the services you are providing. You indicated that you are under pressure to take emergency accommodation from time to time. Do you have a regular waiting list besides what you have to do with the emergency side of things?

Ms Pateman—Yes, there are 79 names on our waiting list, all up. They have all been accessed by ACAT. They may have their names down at other facilities, though some of them do not because they only want to come to the Catholic one or the Vinnies one. Some of them are not ready. I have offered a couple of those people rooms lately and it has been a case of, 'No, I am not ready yet.' They cannot understand that when a room comes up they need to accept it. It may be another 12 months or a couple of years before a room comes up. I have some potential residents on my list that have had their names down for four or five years but, again, their needs are totally different. We work on a needs basis, as everywhere else does. At Vinnies we look at the big picture with respect to financial needs, family needs and supporting the family as well as the residents' needs.

Mr MOSSFIELD—Is it accepted that all nursing homes provide palliative care for their residents or are there occasions when they might have to go into hospital or something like that?

Ms Pateman—We provide palliative care at Ozanam subject to their nursing needs. If we cannot manage right to the end, it may mean they have to go to a hospice. Over the last 12 months I have had three clients go right through to the final stages of palliative care, but then I have had a couple who we have not been able to cope with. It just depends on their nursing needs. Again, the relationship we have with the palliative care team at Lourdes is such that I cannot fault them. If it were not for them we could not do this. We only have a registered nurse 25 hours a week. We cannot afford to increase her hours to full-time. She can only work so many days a week, she is not there seven days a week, and getting registered nurses out here is very difficult.

Mr MOSSFIELD—We have already been advised of that shortage of skilled staff. Finally, have you got any recommendations for the committee regarding funding you would like to put forward that might assist your industry in improving services?

Ms Pateman—How big is the bag! We are talking about roughly $10 a day per bed. It depends on each facility and what categories they have. A little while ago we actually had a category 1 in our facility and we managed with that lady. In a way, the money she brought in subsidised some of the lower categories. But, in general, I have no answers to that one.

CHAIR—Do you have any Aboriginal or Indigenous residents?

Ms Pateman—Not at present. We have had.

CHAIR—We have recently been in Alice Springs and Darwin and what has to be taken into account because of the cultural differences was brought to our attention quite forcibly. Up there

it is very much full-blooded Aboriginals that they are dealing with and here that would be a real rarity. But do you, when you have Aboriginal or Indigenous residents in your care, have to treat them any differently to anyone else?

Ms Pateman—In some ways, yes.

CHAIR—Could you expand a little bit?

Ms Pateman—In protecting them a little bit, because there is a lot of discrimination with the oldies. It is not the staff; it is coming from the older residents. That goes back to their childhoods and what they came across. The last lady I had of Aboriginal descent also had dementia and it was quite difficult to manage her. She was a beautiful person—the staff loved her. But I had one gentleman who was very bigoted and he really made it hard for her. You could not get through to him that she was entitled to a room as much as he was. It was hard.

CHAIR—So it was more that sort of thing than having to take into account their different needs?

Ms Pateman—We managed there. We had the support of the local Vinnies community, which does a lot of work out there in the community with the Aboriginal population in Dubbo. We called on them and they provided a lot of moral and verbal support—taking the lady here and there and just coming in to visit with her. She did not have family—her family were estranged. She had a sister-in-law who was really good for us, but she had her own personal issues that stopped her helping us a lot.

CHAIR—Thank you for your time and information. If there is anything you wish to present to us we can take that on board.

[11.40 a.m.]

CHEAH, Ms Vicki Debra, Manager, Community Aged Care Program, Baptist Community Services, New South Wales and Australian Capital Territory

CHAIR—Thank you for being with us. You represent, I think, some 40-odd community aged care packages for Dubbo, Wellington and Narromine.

Ms Cheah—Yes.

CHAIR—I have to inform you that this is a formal hearing of parliament. Hansard does record it, and you are accountable for what you say. Perhaps you would like to make a statement and then take some questions, especially about community aged care packages.

Ms Cheah—I would be happy to answer questions. I manage the community aged care program covering the local government areas of Dubbo, Narromine and Wellington, and I have been in this position for over six years now. Baptist Community Services is a large, not-for-profit organisation. The overall statement I would like to make, just like many of the other people who have spoken here today, is that there is an awful lot of need out there in the aged care community.

One of the things I have been hearing that I feel very strongly about is that there does need to be an understanding, overall, that aged care is very different from other types of care in the community. There needs to be an understanding that sometimes when the elderly community face issues of whether or not to choose a residential facility or community aged care they need some more education to know how to do this and perhaps some more assistance in understanding what care is out there. Many aged people find it difficult to get help in our health system, especially in the Dubbo area, because Dubbo Base Hospital have an acute focus. Sometimes aged clients who come in have chronic problems and they need a longer term focus, as opposed to the acute issues that Dubbo Base Hospital will focus on because of their own funding guidelines that they have to meet. From time to time I have come across instances of the aged community not being able to adequately communicate their needs and being inappropriately referred home or inappropriately referred to a service because their circumstances have not been appropriately diagnosed, due to it being a chronic illness, as opposed to an acute situation. Have I explained that?

CHAIR—Can you just expand on that a little? Can you tell us why you believe it happens?

Ms Cheah—Without divulging confidential examples, I have an example of a lady with dementia for whom we have been caring a long time. I think this happened about six months ago—I am sorry; I am being a bit vague because of my lack of preparation. We were providing care. She was presenting as being unwell—something was not quite right. We just knew, because of our regular contact with this lady, that she was not well. We arranged to take her to the local GP—again, finding a local GP who understands age related issues, especially when the patient has dementia, can be really difficult—and gave our interpretation of what was wrong. They referred her to the Dubbo Base Hospital, which, on the very same day she was taken there,

wanted to send her home. It took a lot of effort on the part of my coworker to convince them that there was something really wrong with this lady. She was eventually admitted, only because of our strong advocacy on her behalf, and was later diagnosed as having a pulmonary embolism—a clot in the lung—so she ended up staying in hospital, needing appropriate treatment, for more than a week.

This lady had our support and our knowledge and, as I say, the coworker is a registered nurse, yet she had a lot of difficulty getting through to the people in the acute setting that this lady had a problem, because of the lady's dementia and lack of ability to communicate with them. My concern is this: if this lady, who had our support, had so much difficulty, what about all those other people out there who do not have a regular service provider knowing their circumstances and who front up to the hospital for some assistance and get returned home?

Ms HALL—I might start where I finished with the previous witness: ACAT and its ability to act quickly and provide the assessments that are needed and then the ability from there for people to link in to the services that they require.

Ms Cheah—On a local human level, the team here in the local area are very good. But I do know from my contacts with the organisation at large that there are other ACAT teams in other areas that have a higher level of qualified staff on their team. For example, there are some places where they will have a geriatrician as part of your aged care assessment team. There is not one available in all of Dubbo, so they certainly cannot have one as part of their team. So there is a lack of expertise on the team for this type of service.

I would have to concur that from my experience in the last six years getting an assessment done when one is needed to be done quickly—for example, if I receive a referral from the community and we have the ability to deliver the service and we need the assessment to be done quickly, the team have been very good in getting that assessment done within a matter of a short period of time—sort of within a week or so, maybe two weeks, depending on the region that we are talking about. So they respond fairly quickly and that is very good.

One of the issues I am finding more and more, though, as a community aged care package provider is that there is a high level of need out there in the community for assistance and so more and more the aged care assessment team are pushing—because of the level of need—are pushing higher level need people as referrals on to us. So, instead of us referring a referral for somebody who just needs a minimal amount of service that is more appropriately aimed at a community aged care package, we are receiving referrals for people who really need a very high level of assistance in the home and the expectation is that we will meet that need.

Ms HALL—So what recommendation should this committee make to deal with that?

Ms Cheah—I guess there are a few recommendations. One of them from my perspective is that there is a new program called EACH, which is Extended Aged Care in the Home. I know that they have just begun within the last funding round to roll that out into some of the other areas. There has been a pilot for several years in New South Wales to actually assess this program. I believe that there is a need for that to actually come out into the more rural areas. They will face problems managing these sorts of programs, given the difficulty gaining registered nurses. So it is not going to be an easy process. But I do believe that there is a place

for these programs in the rural areas just as there is a place for nursing homes and hostels. I believe that is one of the answers that will help. For example, there would be many times that I could have a person come on and, if I have the increased funding, we could actually support them for a longer period of time before they need residential care.

Ms HALL—The issue of allied health workers' assessment of people who actually need to have home modifications and then actually moving on to the home modifications: what is that like in this area?

Ms Cheah—As you have heard from many of the other speakers, getting allied health workers out into this area is quite difficult. I did hear about some of the initiatives they have taken to sort of attract people here and it does help. But aside from actually attracting them, once they actually attract an allied health worker out here, if they are new as in just finished their training, which is often the case, they actually lack experience as well. I have been finding in the last six years that by the time they get somebody out here like, for example, an occupational therapist who goes out into the home to assess a person's need for rails, for modifications to the bathroom and things—by the time they gain that actual working experience in the community, working with the elderly in the community, they decide to move on because obviously they have gained what they have come here for, the experience.

More and more I am finding it frustrating to have young inexperienced people trying to deliver care to the elderly while not always recognising certain things. For example, an OT going to a client's home for assessment purposes might ask, 'How do you manage the stairs?' and the client might reply, 'Oh, I manage the stairs fine.' That worker does not realise that they should say to the client, 'Please demonstrate to me how you manage the stairs'—because the elderly person will tell you that they are managing fine most of the time.

Ms HALL—In your presentation a moment ago you talked about health workers and their need to be trained in issues relating to caring for older people. We have received this advice in evidence from those in other areas—not only from people involved in providing aged care services but also from clinicians. What recommendation would you make in relation to the training that people receive in that area and how it should be delivered? Also, is ongoing support needed in that area?

Ms Cheah—As far as I am concerned, two areas of training need to be developed. One is that I believe quite strongly we need to be educating the members of our community about their potential needs when they become elderly. A lot of elderly people in our community do not understand the issues that they will be faced with because they have never been taught about them: they may not be able to walk as well; they may need to consider their home environment.

I believe that the federal government should bring in guidelines regarding standards for the building of homes. For example, when a home with stairs is built, a ramp should also be put in. Then, way down the track, the elderly person, who by then might not be very financially able, would not have to modify their home, because such things are built into it already.

I believe also that education of health care providers is vital. Our population is ageing and the need for aged care will only increase. I believe that more education in age related issues needs to be given not just to health care workers but also to people like registered nurses. There needs to

be an understanding that this is an industry that will only grow. People should be educated to learn that it is beneficial to work in this industry and it is good to care for the elderly. They should be taught that a lot of benefits come from working in this industry.

Mr MOSSFIELD—You have certainly come up with some good ideas off the top of your head, considering that you were not prepared. You have raised the point about having homes originally built with the appropriate facilities for people as they age. Realistically people are not thinking that far ahead, I am afraid.

Ms Cheah—No, I know they are not. But I believe that we can bring about change if we start to educate our community that it is something they need to be doing. Maybe we cannot change the present but we can change the future.

Mr MOSSFIELD—That is true; however, older people who are currently living in older houses will have to adjust. I also related to your comment about identifying illnesses in older people—and I have done it myself. You simply say, 'Oh, that's old age,' and you do not consider that it could be something more specific. So your idea of an education program is very important. I wonder—this could apply anywhere, of course—what use is made of community organisations, such as aged pensioner associations. In the area I come from, there are many groups, such as the Lions Club, catering for retired people. You seem to be saying that we could use these people—both those who are themselves ageing and those who are associated with ageing people—and organisations for the purposes of education. I think that is very important and the committee will probably take it on.

Ms Cheah—Yes, I agree with you.

Mr MOSSFIELD—I thank you for what you have put to us; I can relate to a lot that has been said. I will leave it at that.

CHAIR—You must deal with people from the able-bodied stage through to the high-care stage—almost.

Ms Cheah—Yes.

CHAIR—The families of those who reach an elderly age always think, 'I shouldn't put Mum or Dad in a home; they must remain at home.' But it seems to me that people when they actually do get into a home quite often are happier after they get used to it because they have company. Do you find that? Do you ever follow people through until they are in the home and then talk to them? Do you find sometimes that, notwithstanding your care, they are actually less lonely and quite often happier?

Ms Cheah—Sometimes it depends on the individual, but I agree with what you have said. Part of what we do is that, when we recognise that people are getting in the upper limits of our care provision, we encourage them to consider their residential care needs. Because I believe in education, I try to educate them that they need to be forward thinking in that. So I try and encourage them into respite, in whatever facility is appropriate, or I try sometimes to encourage them into all three over a period of time so they can experience the respite in all three if they are not fixed on a particular facility. Very often, they are very reluctant and I think some of that is to

do with education. Because of elderly people's past experience with residential facilities—for example, when they were younger, they may have visited somebody they knew in there and they find it—

CHAIR—It is a bit unsettling.

Ms Cheah—It is unsettling, and certainly residential facilities have come a long way in recent years. They are more friendly. They are more aesthetically appealing because they are newer facilities. Once they get in there, quite often they are very, very happy.

CHAIR—Would you be game to make an assessment about what stage people are generally better off in homes?

Ms Cheah—I am finding in my experience that usually it is when they get to the nursing home level. I am not disputing the fact that there is a very definite need for hostel level care, especially for dementia specific patients. Sometimes they need hostel type care for dementia patients because they need the care. They cannot be in the home but they are still able to mobilise, communicate and do a lot of things. So there is a need for hostel type care, low-level care, for dementia people.

There are some people who are particularly social and they need that environment as well, but quite often I find that clients will come on to my type of service and remain with the support because they are getting socialisation. As well as care, they get the socialisation that is vital. They are getting contact with people and that helps to improve their quality of life. Sometimes, once they have come onto our program and they have developed those relationships, we can actually encourage other relationships that were existing in the community to re-establish. Just because they have got that encouragement, that helps them get back into that and they improve quite often with our support in the community. Many times they will stay with our program until they reach the higher level of care. But there are some clients who, with my encouragement, recognise that they are not coping as well, they are feeling lonely and they want more assistance, and they will go into low-level care earlier but sometimes they will go on to high-level care. So I think there is a place for both.

CHAIR—From where you are, do you see respite as one of the biggest shortages?

Ms Cheah—It is a shortage but, to be honest with you, one of the things I see a shortage of is actually care in the community. I have got people on my waiting lists. If I could support them in the community more—and respite is a valid shortage—

CHAIR—If you had more places.

Ms Cheah—If I had more places, I could support the people in the community more. I know that every provider has their own need too—'If we had more places'—and I agree with all of that. I agree that there is a need for higher level places and a need for lower level places, but there is also a need for more help in the community because that is your stopgap: if you support them in the community. That lady I spoke of earlier who has dementia has been on my program for something like five years. Prior to us starting, she was making several admissions to the hospital because of her dementia related issues. She was readmitting to the hospital, so she was

draining money from the health system because she was not managing at home. Because she has received the appropriate level of care in the home—it is not ideal, it is not fantastic, but it is enough to maintain her in her home—she has been in the home, as I say, for in excess of five years managing okay without needing absolutely residential care.

Ms HALL—Could you give us some idea of the level of unmet demand that exists in the community? How difficult is it to provide community aged care packages in outlying areas? Is that area underserviced more than the inner areas or the Dubbos and the centres of population?

Ms Cheah—Obviously it is more difficult to deliver services into outlying areas. As a provider, I cannot service a person appropriately in the Mumbil area twice a day seven days a week as I can in Dubbo—and I do sometimes do that in Dubbo. I have clients in the Mumbil area but, when their level of need gets to where support is needed twice a day every day, providing a staff member out there on that basis would send me bankrupt because I have to pay for their time and effort in getting out there, and the kilometres. Yes, people in outlying areas are underserviced. But I find that, quite often when they get to a higher level of need, they need not just service but also medical health support. Quite often they need to come into the community or into a community facility so that they can be provided with appropriate support. Although we do need to try and support people where they live, we also need to recognise that it is unrealistic for somebody living way out to expect to be provided with appropriate acute-level health care all the time, no matter what. There has to be the element of practicality in all of this.

Ms HALL—Do you have unmet need generally?

Ms Cheah—I have just returned from having five weeks annual leave and on my books at present I have three clients in excess of the 43 I am funded for. My coworker has just begged me to take on another three clients out there who apparently really need a lot of acute help right now. She has told me that there are another five at a lower level of need who specifically want us to give them assistance right now.

CHAIR—Thank you very much for making an unscheduled stop and for coming to give evidence; it has been very good for us.

Ms Cheah—Thank you very much.

CHAIR—I thank everybody who has appeared.

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

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

Committee adjourned at 12.02 p.m.