

Southlake Integrated Health Care Committee

Morisset Multipurpose Centre
PO Box 123
MORISSET NSW 2264

A Southlake Integrated Health Care Facility

*The case for better health care services for a
growing community in the City of Lake Macquarie*



September 2009

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Background

In 2007 a community meeting was convened by Greg Piper MP, the State member for Lake Macquarie. The meeting was in response to a petition signed by over nine thousand people and was attended by over three hundred people. The theme of the addresses and representations from the floor of the meeting was the lack of public health facilities in the southern region of the City of Lake Macquarie.

The meeting agreed to establish a community representative committee to investigate the needs and develop the case for better primary public health care facilities that included a local inpatient facility.

Over the next two years the Committee, known as the Southlake Integrated Health Care Committee (SIHCC), gathered evidence from the local community, doctors including *GP Access* (Hunter Division of General Practice), NSW Health and other reports and documents relevant to the issue. Visits to various health care facilities were also conducted over the period.

This report is the culmination of that work to date. However, as in all aspects of the health care the landscape is changing as the Commonwealth government seeks greater intervention in matters of health care delivery and funding.

Nevertheless the basic needs of the southlake community are not likely to change in the interim and this report details the case for better long term planning for the region.

John Quinlan
Chair
Southlake Integrated Health Care Committee (SIHCC)

Committee members

Greg Combet AM, MP Minister for Defence Personnel, Materiel and Science, Minister Assisting the Minister for Climate Change¹
Councillor Wendy Harrison
Robert Kemmis
Rosmairi Okeno
Carolyn Pettigrew, Secretary
Greg Piper MP²
Col Roach
Councillor Arnold Tammekand

¹ Annie Freer, Electorate Officer assisted the committee in various ways including with access to government reports.

² Peter Morris, Research Officer carried out extensive research for the committee.

Contents

Background	i
Executive Summary	1
Introduction	4
Southlake Profile	5
The Area	5
Regional growth	5
Population	6
Age Profile	7
Income Profile.....	8
Disability Profile.....	9
Local Growth Scenario	9
Local Health Services and Planning	11
Access to Hospitals and Outpatient Clinics	11
Local Medical Services	11
GP Super Clinic.....	12
Residential Aged Care	12
HNEH Future Planning	13
HNEH Model for Morisset	14
Community Health Forum.....	14
Major Reports	16
The Garling Report	16
NSW Auditor General - Out of Hospital Care Report.....	17
Australian Medical Association on Hospital Access.....	17
National Health and Hospitals Reform Commission Interim Report 2008	18
National Health and Hospitals Reform Commission Final Report 2009...	19
Models	20
NSW Health HealthOne Model	20
Lithgow Integrated Health Care Facility	20
United Kingdom Experience.....	21
A Model for a Local Hospital and Allied Health Services	22
The need for inpatient sub acute/intermediate beds	22
Hospitalisation but not in an acute bed hospital.....	22
Sub acute and rehabilitation care	22
Transition care	23
Transfers from Residential Aged Care.....	23
The Model Community Integrated Health Care facility.....	24
Public or Private	25
Location	26
The Future.....	26
Appendix 1 Local Case Histories	27
Case study 1 Dialysis	27
Case study 2 Dialysis	28
Case study 3 Double Knee Replacement	28
Appendix 2 Ambulance Transport Costs	30
Bibliography	31

Executive Summary

The southlake area of the City of Lake Macquarie has virtually no public health facilities. There are no public or private hospitals in the area.

This project started and continues with the overwhelming support of local communities. The SIHC Committee took into account the needs expressed by the local communities and the developing health care trends both nationally and internationally.

This report presents a compelling case for a fully integrated public/private health care facility in the Morisset area – a one stop shop for a broad range of health care needs and one that includes sub acute hospital beds.

The southlake area of the City of Lake Macquarie has virtually no public health facilities. There are no public or private hospitals in the area.

The recent awarding of GP Super Clinic funding to the private Waratah Health Services will improve medical services in Morisset. Nevertheless the Clinic falls short of the scope of the community based comprehensive primary health care centres and services as presented in the final report of the National Health and Hospitals Reform Commission.

Whilst the treatment of patients in the home purportedly demonstrates positive clinical outcomes the SIHC Committee supported by the NH&HRC Report contends that there is a strong case for sub acute hospital care to

- provide rehabilitation services not readily available in acute care hospitals
- provide appropriate transition care for older people to prevent unnecessary admission to nursing homes
- ease the demand for acute care hospital beds for people who are too ill to be cared for at home but who still need medical supervision.

There is strong evidence that these issues are being experienced and addressed overseas especially in the UK. The concept of an integrated health care facility incorporating a community hospital clearly has a place in the modern health care spectrum of services.

In broad terms the Southlake Integrated Healthcare Facility would provide the following:

Primary Health Care and Services

- GP clinics and out of hours service
- Non-complex imaging and diagnostics, scans (X-ray, CT, ultrasound, bone density) and scopes (endoscopy, biopsy)
- Specialist and out-patient clinics

- Basic treatments and nurse-care (wound dressing, inoculations etc)
- Minor procedures (minor fractures, cuts)
- Children's services
- Youth services
- Specialised services for Aboriginal and Torres Strait Islanders
- Mental health services
- Physiotherapy
- Speech therapy
- Dental services
- Ambulatory day care/ respite care to support carers looking after seriously ill or infirm people at home
- Community care services for those with ongoing health issues but for whom hospitalisation is not appropriate. This particularly relates to frail aged people and includes assessment programs, dementia monitoring, wound dressing and podiatry services
- Specific chronic disease programs, both educational and treatment, for conditions such as diabetes, asthma, arthritis, respiratory diseases/smoking cessation, drug and alcohol treatments, mental health programs, sexual health
- Pre natal and post natal services, recognizing that birthing will normally occur at a major hospital. In some circumstances new mothers may utilise transition beds for short periods
- Multi-disciplinary outreach teams ("hospital in the home" and palliative care)
- Pharmacy
- Voluntary support and carers facilities
- Community health care library
- Social services eg financial counselling

Sub acute hospital care

- Urgent Care Centre (as opposed to full accident and emergency)
- Day procedures / day surgery unit
- Treatment programs delivering chemotherapy, kidney dialysis
- Full diagnostics including radiological services
- Step-down, rehabilitation and GP beds for those recovering from a major acute event such as heart attack, stroke or major surgery such as joint replacement; either as an external patient or as a transition inpatient; using the services of physiotherapists and other consultants in a facility that includes a range of exercise equipment, treatment benches and hydrotherapy
- Palliative care
- Mental health unit (step-up and step down)
- Mortuary

This document represents an important contribution from the growing communities of the southlake area of the City of Lake Macquarie to the future planning of health care services. The data and arguments within the report articulate a compelling case for the establishment of a public integrated health facility in the southlake area.

Introduction

The primary function of an integrated health care facility is to keep people healthy and out of hospital. The challenges of delivering an integrated primary health service are many. Those challenges notwithstanding, some people do become ill and need the care only available in a hospital.

The broad discussion on health care reforms however, revolves around the cost of acute care hospital treatment and the need for greater health promotion and illness prevention to offset the need for hospitalisation and its attendant costs and risks.

The poor relation in these discussions, which is often overlooked, is the need for sub acute or intermediate beds especially for older patients.

This document outlines the case for a one-stop shop integrated health care facility that incorporates sub acute inpatient beds serving the growing southlake communities of the City of Lake Macquarie.

The SIHC Committee does not have access to data such as ambulatory sensitive conditions for the postcodes represented by the southlake area but we predict that such data would indicate the paucity of primary health care in our area particularly for public patients.

Nonetheless, the information gathered indicates a rapidly growing aged, low income population with health and medical needs that are not being adequately addressed.

The SIHC Committee is well aware of the constraints on State funded primary health care and hospital services, but the whole question of funding and responsibility for the health of the nation is shifting as the Commonwealth Government investigates new funding arrangements and perhaps new roles.

This document was prepared largely prior to the release of final report of the National Health and Hospitals Reform Commission. The SIHC Committee believes the final Report strengthens the case for the type of facility we have outlined.

Therefore this document represents an important contribution from the community to the future planning of health care services.

Southlake Profile

The Area

The southern lake area of the City of Lake Macquarie consists of a number of small urban clusters surrounded by semi rural properties. The district also includes substantial areas of bushland, with the Watagan Ranges forming a backdrop to the area. Hence, it is an attractive area which draws people seeking a less urbanised lifestyle.

The area is part of the Lower Hunter and is included in the Lower Hunter Regional Strategy 2008-2031. The strategy predicts that growth is likely to continue beyond 2031 in the broader region of the Lower Hunter.

Key industries in the area are mining, power generation, light manufacturing and service industries.

The largest concentration of population in the southlake area is along the Morisset Peninsula and Morisset itself. Other centres are Cooranbong, Dora Creek, Eraring, Wyee, Wangi Wangi and Rathmines. The area considered in this report includes all of postcodes 2264, 2265 and 2267, 5% of postcode 2283 near Wangi and 3% of postcode 2259 at Wyee.

Regional growth

The forecast for the Lower Hunter region and the Morisset/southlake area in particular is one of growth. The Lower Hunter Regional Strategy 2008 states:

The Regional Strategy is based upon a population growth scenario which forecasts a regional population of 675 000 persons by 2031. This equates to an additional 160 000 persons over the period 2006–31. This growth scenario responds to current levels of growth and recognises that this growth will continue as the Region broadens its economic role in the context of the NSW and national economy.³

The Lower Hunter Regional Strategy is the land use planning framework to guide the sustainable growth of the Lower Hunter over the next 25 years. Importantly the Strategy identifies Morisset as an emerging growth centre reiterated in the Regional Strategy Update⁴.

Key elements of the Strategy (2006) relevant to this paper are to:

³ NSW Department of Planning 2006, *Lower Hunter Regional Strategy 2008-2031*, p5

⁴ NSW Department of Planning 2009, *Regional Strategy Update Report*, p7

- *Provide for up to 115 000 new dwellings by 2031 ensuring the potential to accommodate both the changing housing demands of smaller households and reduced occupancy rates of the existing population as well as meeting the housing demands for an additional 160 000 people.*

- *Promote Newcastle as the regional city of the Lower Hunter, supported by a hierarchy of major regional centres at Charlestown, Cessnock, Maitland and Raymond Terrace, emerging major regional centres at **Morisset** and Glendale–Cardiff as well as specialised centres and lower order centres.*

- *Boost the economic and housing capacity of key centres by refocusing a higher proportion of new housing in these centres.⁵*

Population

Recent population figures place the population of the City of Lake Macquarie at 195,559 making it a larger local government area than Newcastle, Maitland or Gosford⁶. Lake Macquarie is the fourth largest local government area in NSW, eighth largest in Australia.

The following extract from the Lake Macquarie City Council Ageing Population Plan 2008-2017 outlines the city wide scenario.

The City of Lake Macquarie has an estimated population of 190,000. The City covers approximately 750km², of which 110km² is lake. The lake geographically divides the City and creates difficulties for organisations providing services to an ageing population. The eastern side of the lake consists of more densely populated older urban areas, whereas the western side comprises scattered communities, some of which are semi-rural and isolated. The northern area is a mix of densely populated older suburbs and small townships.

As indicated above, the area under consideration on the south western side of the lake covers a number of small but growing “villages” centred on Morisset. The total population at the 2006 Census was about 23 000 with age and income profiles as outlined below.

⁵ NSW Department of Planning 2006, *Lower Hunter Regional Strategy 2008-2031*, p10

⁶ Australian Bureau of Statistics June 2008.

Age Profile

2006 CENSUS DATA										
POPULATION										
POSTCODE SUBURBS	POSTCODE AREAS AND PROPORTIONS INCLUDED					AREA		AUSTRALIA		PERCENT DIFFERENCE
	2264 peninsular morisset	2265 cooranbong mandalong martinsville	2267 wangi	2283 toronto rathmines arcadia vale	2259 wyee wyong area	TOTAL	PERCENT	NUMBER	PERCENT	
PROPORTION	100%	100%	100%	5%	3%					
AGE IN YEARS										
0 TO 4	683	259	148	62	109	1261	5.5	1260405	6.4	-0.9
5 TO 14	1632	660	314	155	252	3013	13.1	2676807	13.5	-0.4
15 TO 24	1428	772	327	138	172	2837	12.3	2704276	13.6	-1.3
25 TO 54	4462	1777	1006	410	591	8247	35.8	8376751	42.2	-6.4
55 TO 64	1652	532	480	161	170	2996	13.0	2192675	11.0	2.0
65 AND OVER	2789	973	497	210	238	4687	20.3	2644374	13.3	7.0
TOTAL	12626	4973	2772	1137	1532	23040	100.0	19855288	100.0	0.0
MEDIAN AGE (weighted average)	43	40	45	42	37	42		37		

The median age in the catchment area is 5 years above the national average. It is significant that the proportion of people under 15 years is about the national average, whilst the main variations are in the adult and seniors categories.

The population between 15 and 54 years of age is 7.7% below the national average, while those 55 and older is 9.0% above.

This has significant implications when considering future health service needs.

Data from the Lower Hunter Regional Strategy and the Lake Macquarie Ageing Population Plan confirm that the average age of people in the defined catchment area will increase at a rate faster than the national average. Hence, in the future there will be a greater proportion of people aged over 55 requiring health services.

The ageing phenomenon is measured numerically and structurally.

Structurally there will be a decrease in the proportion of the population that is young and an increase in the proportion that is aged. Currently, 17% of Lake Macquarie's population is aged 65 years and over. It is estimated that by 2022, 25% of Lake Macquarie's population will be aged 65 years and over. Furthermore, by 2022, the 85 years and over age group will double from the current 1.7%, to 3.3% of the population.

Structurally, Lake Macquarie is ranked at the 53rd oldest LGA in NSW. By 2022, it will be ranked at 44th position. The average increase in the population aged 65 years and over for Lake Macquarie is 0.50% annually.⁷

⁷ Lake Macquarie City Council 2008, *Lake Macquarie Ageing Population Plan 2008-2017*, p7

Income Profile

2006 CENSUS								
INCOME - POPULATION 15 AND OVER								
POSTCODE SUBURBS	POSTCODE AREAS AND PROPORTIONS INCLUDED		WEIGHTED AVERAGE			AREA AUSTRALIA TOTAL	PERCENT DIFFERENCE	
	2264 peninsular morisset	2265 cooranbong mandalong martinsville	2267 wangi	2283 toronto rathmines arcadia vale	2259 wyee wyong area			
PROPORTION	100%	100%	100%	5%	3%			
Pop'n 15 & over	10311	4054	2310	919	1172	18766		
INCOME \$/WEEK								
Median Individual	369	360	395	383	394	373	466	-20.1
Median Household	749	889	826	875	879	803	1027	-21.8
Median Family	987	1070	1056	1061	1057	1021	1171	-12.8

The 2006 Census data provides a disturbing picture of the income profile of the area. Both the median individual income and the median household income are more than 20% below the national average.

The detailed reasons for this low income profile have not been thoroughly researched, but undoubtedly include the higher than average age profile and consequently lower incomes from pensions and other retiree income sources.

Generally, income for people aged 65 years and over is lower than for people under 65 years. In 2004, research found that 9.9% of Australians were living below the poverty line and that some groups were more affected than others. For example, 39% of people aged 65 years and over were living below the poverty line. In 2004 the poverty line was \$249 per week for a single person, based on 50% median income. In 2007, the single aged pension is \$268.85 per week..... in 2006, in Lake Macquarie, 40.87% of people aged 65 years and over had a weekly income up to \$249.00, and 58.67% had a weekly income up to \$399.00.⁸

This indicates that a substantial proportion of the southlake population exists near or below the poverty line. Consequently they have a greater need for public health facilities in their community because of the absence of public transport to regional hospitals.

The demographics of the southlake area (age, income, education level etc) also support the contention that:

The people in most need are often the least well equipped to navigate their way around the incredibly complex health system.⁹

⁸ ibid p9

⁹ National Health and Hospitals Reform Commission 2009 *A Healthier Future for all Australians- Final Report 2009*, p101

Disability Profile

The Lake Macquarie Ageing Population Plan indicates that the incidence of disability increases with age:

- *51% of people aged 60 years and over reported that they had a disability and 19% of this age group reported a profound or severe core-activity limitation;*
- *Of all people aged 60 years and over, only 14% reported needing assistance because of disability or old age to manage everyday activities.*

However.

- *84% of people aged 85 years and over, reported a need for assistance to manage everyday activities;*
- *83% of people with a disability live in private dwellings;*
- *The activities of older people with a disability most commonly reported needing assistance with were home maintenance (47%), health care (39%), transport (36%), housework (36%) and mobility (28%).*

This shows that an ageing population will create increased demand on health care and support services to assist people to stay in their own homes¹⁰ and be serviced by an integrated health care facility.

Local Growth Scenario

In the southlake area the above data points to a rapidly increasing population, an already older than average population that will continue to age faster than the national average, and a low income profile.

The Lower Hunter Regional Strategy predicts that the area will:

- Experience a population increase of 166 000
- Generate 66 000 new jobs
- Require 115 000 new houses

Population and housing growth in the southlake area is evident from the major housing estate developments that have already been approved or are forecast. These include Morisset Town area, North Cooranbong, Trinity Point, Scarborough Gardens and Koopahtoo Local Aboriginal Land Council land along Fishery Point Road and at Wyee. Development of these sites will accommodate at least 6 850 new dwellings and a population increase of 18 860, which is an 82% increase in the current population.

¹⁰ Lake Macquarie City Council 2008, *Lake Macquarie Ageing Population Plan 2008-2017*, p10

There will also be a range of other developments in the area. Hence, the present population may easily grow from the present 23 000 to 50 000 in 15 to 20 years time, producing a 117% increase over current levels.

Retail developments currently proceeding support these predictions. Coles has recently opened major supermarkets at Morisset and Bonnells Bay, with a third approved for Cooranbong. Woolworths has commenced construction of a major supermarket and specialty shops complex at Morisset. These large retailers know where population growth is expected and their current investments reinforce the prediction that Morisset and the wider southlake area is on a rapid growth curve.

Local Health Services and Planning

Access to Hospitals and Outpatient Clinics

Access to hospitals for southlake residents is poor, with no history of adequate provision by NSW Health.

The nearest hospitals¹¹ are:

- Wyong 31 km
- Gosford 57 km
- John Hunter 51 km
- Toronto Polyclinic 21 km

For the majority of residents, ambulances only take patients to Wyong Hospital unless prior arrangements have been made or the case is a major emergency¹². Wyong Hospital, despite recent major upgrades, is still overstretched and waiting times in Emergency are extensive.

Critically, there is no direct or reasonable public transport link from Morisset to any of these hospitals. This means that neither patients nor family members are able to attend unless private transport is available.

Travel times to hospitals providing dialysis services are onerous. The cost of transporting patients these distances is also considerable and expends a significant portion of the local ambulance service's resources. (see Appendix 1)

Attendance at diagnostic scanning services also requires travel to other centres not readily accessible by public transport.

Local Medical Services

Southlake is serviced by general practices at Dora Creek, Cooranbong, Morisset, Wangi Wangi, Wyee, Bonnells Bay and Rathmines. The doctor to population ratio is approximately 1:1850, substantially beyond the 1:1200 that is regarded as acceptable and the 1:900 in some parts of the Sydney metropolitan area.¹³ If the greater Westlake area is considered, the ratio of patients to GP's is twice the accepted standard¹⁴.

Some practices have closed their books to new patients.

¹¹ Distance from Bonnells Bay Post Office

¹² Residents in the northern part of the area may be taken to John Hunter.

¹³ GP ACCESS 2008 presentation to SIHC Committee

¹⁴ Hunter New England Health 2008, *The Way Forward for Morisset: A Discussion Paper on Proposed Models of Integrated Primary Care for Morisset*.

Services provided by private practitioners in the area include physiotherapy, massage therapy, podiatry, imaging and pathology, optometry. None of these are available as public health services.

Notably however, the nearest MRI Imaging facilities are at John Hunter and Maitland Hospitals. Because of inadequate public transport within the region, some patients opt to travel to Sydney by train to access these services.

Hunter New England Health provides a very limited home nursing service to the area as an outreach from the Toronto Polyclinic. This is equivalent to 2 days per week. It is the only public health service provided in the southlake area.

There are a number of community based organisations providing counselling, support and transport services in the area but their services are limited.

GP Super Clinic

The Commonwealth Government recently awarded a \$2.5m contract to Waratah Medical Service to assist in development of a GP Super Clinic in Morisset. This will partly fund a major expansion of the existing practice and will be a welcome addition to medical services in the area. When complete in mid 2010 it will encompass:

- expanded GP services, including extended hours
- visiting specialists,
- imaging services (including X-ray, CT, bone density and ultrasound scans, but not MRI)
- pathology services
- a rehabilitation facility

All services will be bulk billed, a significant issue for a low income population.

Waratah Medical Services has received expressions of interest from specialists to work at the new clinic. In addition, arrangements are already in place to recruit additional of GPs for the needs of the practice.

Waratah Medical Service has offered accommodation to the Hunter New England Health Service for allied health professionals but at the time of writing this offer had not been taken up.

Residential Aged Care

Morisset has a relatively high number of retirement villages and further developments are planned.

However, given the age profile of the area the number of residential aged care beds does not meet national recommended ratios (44 places per 1,000 people aged 70 or over).¹⁵

Residential beds in Morisset area	Current (2008) number of beds	Commonwealth recommended bed numbers by 2016
High care residential beds	220	264
Low care residential beds	96	264

HNEH Future Planning

The only currently available NSW Government health services plan for the region is the Hunter New England Health (HNEH) *Health Care Services Plan November 2006*. The growth of the southlake area is ignored by this plan and no plan exists to provide health services to an already significant population that is both expanding rapidly and ageing faster than the national average.

The population data on which the plan was based predates the Lower Hunter Regional Strategy and is clearly incorrect.

The southlake area was not mentioned in the sections dealing with Clinical Directions and Community Services. There was no recognition of the current lack of services, the socio-economic disadvantage of the area or projected population growth. These issues were canvassed but HNEH failed to recognise their significance in the southlake area.

This historic planning failure must be rectified in the next generation of such plans.

Proposed actions in the regional strategic plan with respect of Community Services would appear to be very supportive of expanded services in the southlake area if the reality of the future demand was acknowledged. For example the summary in the strategic plan includes the following:

expand community services in areas expected to have significant population growth particularly in those aged 65 years and over.....

expand community health services in areas where access to health services is limited, the community is isolated, and/or the community is socio-economically disadvantaged.....

¹⁵ Hunter New England Health 2008, *The Way Forward for Morisset: A Discussion Paper on Proposed Models of Integrated Primary Care for Morisset.*, p6

*expand community based programs addressing chronic conditions and for people with mental health problems....*¹⁶

Each of these triggers for expanding community services exists in the southlake area.

HNEH Model for Morisset

Early in 2008 HNEH conducted a review of health services, service utilisation and demand for health services in the Morisset and surrounding areas¹⁷. This review quotes from *A New Direction for Hunter New England – Health Service Strategic Plan Towards 2010*, which appears to be an update of the previous regional plan.

The review document contains the statement, "*the population of Morisset, Wyee and Cooranbong is expected to double between 2001 and 2031,*" an acknowledgement that the southlake area is on a high growth curve. Nevertheless, the probable growth of the area continues to be significantly understated.

The population is likely to increase by 117% during the 15 to 20 year period from 2006. The continuing underestimation of population growth and therefore of demand for public medical services is of major concern.

In the review HNEH proposes a HealthOne model of primary health care for Morisset. In a positive sense this model meets some of the needs of the community but it does not address the need for sub acute hospital accommodation.

Community Health Forum

In September 2008 HNEH facilitated a Community Forum at Morisset to identify community expectations about future health services for the area.

The health issues identified were a mixture of acute and sub acute care requirements. It was also recognised that many of the required health services could be met by services provided in the community as either community based or visiting services to a centre or as services provided directly to people's homes.

¹⁶ Hunter New England Health 2007, *A New Direction for Hunter New England Health Service Strategic Plan Towards 2010*, p101

¹⁷ Hunter New England Health 2008, *The Way Forward for Morisset: A Discussion Paper on Proposed Models of Integrated Primary Care for Morisset*, p6

There were 31 health issues identified as needing services in the community. The top 10 by order of priority were:

- ageing/frailty/geriatric health
- heart attack and stroke
- mental health issues
- diabetes
- respiratory disease
- dental health
- women's health
- trauma/accidents
- obesity
- lifestyle

The second function of the forum was to identify gaps in current services. There were 26 service gaps identified. These were predominantly non-inpatient services which could be provided from a primary care centre, and included a range of community health services and visiting services linked to general practitioners, as well as to other specialist services. The top 10 by order of priority were:

- visiting specialists
- geriatric/aged services/day surgery/ scans (including imaging) and scopes
- more GPs
- accident/trauma/emergency centre
- after hours care
- mental health – crisis care, follow up, emergency beds
- palliative care, (especially outreach)
- dental services
- better ambulance services (response times)
- transport to health services

Major Reports

The provision and cost of health care is a major issue facing both State and Commonwealth Governments.

There are many models available to suggest how the needs of a growing and aging population may be met.

The following summarises the most relevant points of these in developing the case for better health care services in the southlake area including inpatient services.

The Garling Report

The Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (The Garling Report) investigated provision of acute care and recommended how it can be improved within a constrained budget.

The report emphasises services provided in hospitals, with a general emphasis on providing fewer services in smaller hospitals. While the report is specifically about allocating services to *existing* hospitals, a favourable mention is also made of multi-purpose services (MPSs) which “provide integrated acute health, nursing home, hostel, community health and aged care services under one organizational structure.”¹⁸ Some current district hospitals appear to operate in this manner.

- Criteria for provision of health services in hospitals are:
- current population,
- staffing in the face of workforce shortages,
- concentrating demand for specialised services,
- safety & quality in healthcare,
- efficiency and working within severe funding constraints.¹⁹

Planning of services based on a sound understanding of need is the first of four stages under NSW Health's Total Asset Management Plan.²⁰

The Garling Report supports provision of services based on population, yet its own population data for the Morisset area is outdated. The report argues that limited funding and staffing means that more services should be centralised within *existing* hospitals, but no arguments are presented against sustainable provision of suitable services at new centres.

SIHCC is aware of the constraints on the NSW health budget, but does not see the Garling Report as an impediment to the equitable provision of services.

¹⁸ Garling, P 2008 *Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals*, p 926

¹⁹ *ibid* p 929

²⁰ *ibid* p 929

NSW Auditor General - Out of Hospital Care Report

A report delivered by the Auditor General, *Delivering Health Care Out of Hospitals* sets out to examine how to reduce burgeoning health care costs associated with hospitals. The Government's response to the report was *Caring Together: The Health Action Plan for NSW*.

This report acknowledged out of hospital health care programs already in existence do have good clinical outcomes and can reduce the time patients spend in hospital. However, the Auditor General stated:

*NSW Health needs to demonstrate that expanding its **out of hospital initiatives** is one of the practical alternatives to help meet growing demand. It needs to identify the number of patients who can potentially be treated out of hospital, and plan for securing the necessary resources and implementing significant changes.²¹*

NSW Health responded positively to the recommendations in the Garling Report; inter alia:

Increasingly NSW Health is investing in opportunities to provide care and treatment for patients using alternative modalities to hospitals. Attention is moving from the historical focus on acute hospital bed availability to a broader focus on treatment availability in a variety of settings.

Nevertheless, aside from prevention and early intervention the emphasis of the NSW Government response was out of hospital programs to reduce demand on acute care hospital beds.

The two relevant programs nominated were the *Severe Chronic Disease Management Program* and the *Hospital in the Home Program*.²² The issue of sub acute beds was not addressed.

Australian Medical Association on Hospital Access

The Australian Medical Association (AMA) released a statement citing research that claimed emergency department (ED) overcrowding in public hospitals was due to a shortage of beds. The research showed that an annual **20 to 30% percent excess mortality rate** was because of access block.

Further research also indicated that certain assertions such as telephone advice services, additional GP services close to acute care

²¹ NSW Auditor General 2008, *Delivering Health Care Out of Hospitals*, p3

²² NSW Dept of Health 2009, *Caring Together: The Health Action Plan for NSW*, p 12

hospitals, even bulk billing did not significantly reduce emergency department workload.

The fundamental issue cited in the research was the number of inpatient beds.

Whilst increases in the number of acute hospital beds in public hospitals was part of the solution improved management of medical patients with complex conditions in the community could also be part of the solution.²³

National Health and Hospitals Reform Commission Interim Report 2008

In 2008 the Australian Commonwealth government commissioned a report on the long term reform of the Australian health care system.

The interim report, released in December 2008, detailed a number of reform policy directions. The Commission sought input from a wide spectrum of health care practitioners as well as the community. As a public document, the report is most valuable as it records perspectives on the health care system which have not been filtered by State health bureaucrats.

Significant in this report is the recognition of the importance of sub acute care.

Sub acute services are sometimes known as the "invisible services" or "missing link".²⁴

Sub acute care provides the 'glue' that connects acute care provided in hospitals with community care provided in people's homes. It includes services such as rehabilitation, geriatric evaluation and management, new programs such as Transition Care and other 'step-up' or 'step-down' programs. These services work hand-in-glove with other services such as respite care, community nursing, and home and community care services. Sub-acute services will often involve multidisciplinary teams, with strong input from a range of specialist allied health staff.²⁵

The report also noted the importance of connectivity between primary health care services especially for people with chronic and complex conditions.²⁶

²³ Australian Medical Association 2009, *Access blocking taking its toll on lives*.

²⁴ National Health and Hospitals Reform Commission 2008, *A Healthier Future for all Australians – Interim Report*, p 147

²⁵ *ibid* p 11

²⁶ *ibid* p 95

National Health and Hospitals Reform Commission Final Report 2009

The final report of the National Health and Hospitals Reform Commission presents a wide range of recommendations regarding the full spectrum of health care provision.

The proposed primary health care centres and services will greatly assist people to access the services they need without stressful and unnecessary visits to emergency departments in hospitals.

The Report further reiterates the case for better sub acute services as outlined above. It recommends:

...a substantial investment in, and expansion of, sub-acute services including a major capital boost to build the missing facilities required to provide sub-acute care. We recognise that much sub acute care can be provided on an ambulatory (or non-inpatient basis) and can be provided outside acute hospitals. We need extra capital investment for these ambulatory services, but we also need significant investment in more sub-acute 'beds' in inpatient facilities. And, of course, we need to ensure that we have an appropriately trained workforce available to deliver this expansion in sub-acute services.²⁷

Highly relevant to the situation in the southlake area are the recommendations to strengthen primary health care services in the community and the funding of these services. Key recommendations are:

bringing together and integrating multidisciplinary primary health care services, with the Commonwealth Government having responsibility for the policy and government funding of primary health care services that are currently funded or managed by state, territory and local governments; (SHICC emphasis)

*improving access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community, through the establishment of Comprehensive Primary Health Care Centres and Services, which would be available for extended hours.*²⁸

Of special note in the recommendations of the Report is the need for services for:

- People with mental illness and better connection across the spectrum of care (recommendation 74)
- Youth (recommendation 71)
- Palliative care support (recommendation 54 and 56)
- Public dental care (recommendation 88.1)

²⁷ National Health and Hospitals Reform Commission 2009 *A Healthier Future for all Australians* - Final Report 2009, p106.

²⁸ *ibid* p9.

Models

NSW Health HealthOne Model

HNEH has proposed a HealthOne style facility to satisfy community medical needs. However, availability of funding is uncertain and not planned.

HealthOne is a NSW Health department program that is currently funding development of 15 primary health care centres around the state. In many of the areas where these facilities are being established there is already a hospital in the same town or nearby.

This is the crux of the issue for southlake; there is no nearby hospital providing the range of sub acute services that is required by a substantial, rapidly ageing and fast growing population.

The GP Super Clinic model with the addition of home and community care services is very similar to the HealthOne model.

Whilst the Morisset GP Super Clinic will be a welcome addition to service levels in the southlake area, it will not address a number of critical needs that are driven by difficulty of access to acute hospitals and the lack of public transport services to those hospitals.

Lithgow Integrated Health Care Facility

Through a site visit, SIHCC was impressed by the Lithgow Integrated Health Care Facility²⁹ that was opened in 1996 as a replacement for a much older hospital. This is probably the most recent facility built in a NSW rural/regional area that serves a population of about 20 000.

The model proposed by SIHCC for a public Integrated Health Care Facility at Morisset is based on the Lithgow facility.

SIHCC has been advised that the major impediment to building a new facility is attracting staff, but this was not the experience at Lithgow.

Prior to the 1996 development, Lithgow which at 20 000 has about the same population as southlake, had an old hospital and the town's GPs were aged between 50 and 70 years of age

The new facility immediately attracted quality specialists to consult and perform procedures in the day surgery unit and this in turn attracted an influx of younger GPs. Consequently, the average age of the 25 GPs in Lithgow is now 40 years and they provide 24/7 coverage for the emergency department and other medical needs of the facility. It has been a huge success and provides a solid model for the southlake area.

²⁹ See <http://www.wsahs.nsw.gov.au/lithgow/index.htm>

The predicted GP age profile at Waratah Health Care and the expanded Tristar Morisset Medical Clinic (a private medical practice in Morisset) are evidence that the situation in southlake is changing rapidly as younger GP's are moving into area.

United Kingdom Experience

The situation in the UK is not dissimilar to Australia despite the nationalised hospital system. With the threat of closure of some of the 330 community hospitals in England and Wales the role of the community hospital as the bridge between primary and acute care has received a lot of attention.³⁰ Although some UK community hospitals provide emergency services, as does Lithgow Hospital, most are described as providing the range of services envisaged for a community hospital in Morisset.³¹

These hospitals make a real contribution to the health and well being of local people. The hospitals enable acute hospitals to focus on patients who require specialist secondary care and ease the pressure on their beds, clinics and emergency services.³²

UK community hospitals generally do not have resident medical staff and the bulk of the inpatient services cover chronic disease and rehabilitation that cannot be provided in the home. There is a wide range of models. Nevertheless community hospitals integrating a range of health care services are a significant component of the future hospital plan for the NHS.³³

Whilst the driver in the UK of retaining community hospitals is the consolidation of diagnostic and allied health and social services into one facility, the core rationale for community hospitals is to treat local patients at the local level in the local community.³⁴

The model of health care delivery being developed for Northern Ireland mirrors the model proposed by the National Health and Hospitals Reform Commission. This is a radical new approach not only to the structure of services but also to the way in which new facilities are designed³⁵.

³⁰ after Prof Geoff Meads, University of Warwick, in *Community Hospitals, Specialist Support services and Intermediate Services*, Norfolk Health overview and Scrutiny Committee.

³¹ Care Services Improvement Partnership 2008, *Reviews of Community Hospital/Intermediate Care Provision*, p 6

³² Community Hospitals Association www.communityhospitals.org.uk

³³ *Reviews of Community Hospital/Intermediate Care Provision*. UK Department of Health, p8

³⁴ Community Hospitals Association 2003 response to the NHS document *Keeping the NHS Local: A New Direction of Travel*.

³⁵ Cole, J. (2009) *Strategic Planning for Health Care Facilities, Northern Ireland* in Case Studies, Investing in Hospitals for the Future. European Health Properties Network p16

A Model for a Local Hospital and Allied Health Services

In many respects some of the components of the model for better health care facilities in the southlake area already exist or are planned. However, at present there is not the overall vision or planning to bring these components together to serve future needs.

The need for inpatient sub acute/intermediate beds

The NHHRC final report recommendation 39 is that:

the investment in sub acute services infrastructure be one of the top priorities of the Health and Hospitals Infrastructure Fund.³⁶

SIHCC contends that there is a strong case for such infrastructure in the southlake area.

Hospitalisation but not in an acute bed hospital

Educating the community about the changing way the health system operates is seen as an important part of reducing the pressure on emergency departments (EDs). The assumption is that most people attending an ED don't need hospital treatment but see EDs as the best available choice given the difficulty of accessing GPs and diagnostic imaging or pathology on the same day.³⁷

However, the NHHRC noted statistics showing that many people categorised as non urgent or semi urgent presenting at EDs in major hospitals were in fact admitted. These people were too ill to be sent home and/or had already been seen by a GP who could not treat them in a local clinic. The need for local primary care with on site diagnostic and pathology services – a one stop shop – plus sub acute beds if required would reduce the load on EDs.

Sub acute and rehabilitation care

Moving people from hospital to community care or avoiding acute hospital care altogether has been shown to have very positive outcomes. What is often missing is the recognition of the need for sub acute care services covering a wide range of patient needs.

Respite care and community nursing and home and community support services are all vital elements in "connecting care" for patients and their families. But they differ from sub acute

³⁶, National Health and Hospitals Reform Commission 2009, *A Healthier Future for all Australians – Final Report*, Canberra p 22.

³⁷ National Health and Hospitals Reform Commission 2008, *A Healthier Future for all Australians – Interim Report*, Canberra p 159.

services ... that use a different mix and intensity of specialist and allied health staff.³⁸

Health professionals reporting to the NHHRC noted that sub acute hospital beds were a very important part of integrated health care. In particular, this was seen as very important by rehabilitation specialists.

For example one quarter of people hospitalised after a stroke need inpatient rehabilitation.³⁹

Transition care

The Commonwealth Government provides funding for a Transition Care Program. However, this in reality translates to holding beds in acute hospitals while beds are found for patients in nursing homes. The NHHRC noted that:

A shortage of these services means that older people run the risk of being prematurely admitted to a residential aged care service.

That is, some older people are not given sufficient opportunity to participate in rehabilitation, improve their functioning and so return to living at home.⁴⁰

The NHHRC notes further that demand for nursing home beds may in fact signal gaps in sub acute services.

Transfers from Residential Aged Care

The Morisset area has a relatively high number of aged residential and care facility places.

It is common for people who become ill in aged care residences to be sent to hospital for care. Many of these people could be supported in the residences with improved primary care services under existing programs. However, given the concentration of residential facilities in the area, SIHCC contends that those who need hospitalisation for non emergency treatment would be better served by an integrated health care facility or sub acute hospital which would allow easy access for family and friends rather than being moved considerable distances to a major hospital.

Communication between local health practitioners is also likely to be more successful, resulting in better ongoing care for the patient.⁴¹

³⁸ ibid p 148

³⁹ ibid p 153

⁴⁰ ibid p 169

⁴¹ ibid p 131

The Model Community Integrated Health Care facility

The model proposed by the SIHC Committee for an integrated health care facility that also provides public sub acute beds will:

- be consistent with current Health department thinking on service delivery
- alleviate access issues in major hospitals by releasing acute beds otherwise occupied by sub acute patients
- alleviate waiting times in the emergency departments of the major hospitals
- provide a local point for service delivery, offsetting the lack of public transport to currently available hospitals
- reduce the costs of service delivery to both the community and to the NSW Health through a reduction in both patient transport costs and in acute facility operating costs
- allow patients to recover in their local environment assisted by family and friends

The concept of the model is to provide health care in a community environment, whilst utilising major hospitals for acute procedures.

Care would be provided both in the local facility and at home, as is appropriate for each patient. This is consistent with the “out of hospital” and “multipurpose centre services” concepts currently being developed by the NSW Health Department.

In broad terms the Southlake Integrated Healthcare Facility would provide the following:

Primary Health Care and Services

- GP clinics and out of hours service
- Non-complex imaging and diagnostics, scans (X-ray, CT, ultrasound, bone density) and scopes (endoscopy, biopsy)
- Specialist and out-patient clinics
- Basic treatments and nurse-care (wound dressing, inoculations etc)
- Minor procedures (minor fractures, cuts)
- Children’s services
- Youth services
- Specialised services for Aboriginal and Torres Strait Islanders
- Mental health services
- Physiotherapy
- Speech therapy
- Dental services
- Ambulatory day care/ respite care to support carers looking after seriously ill or infirm people at home
- Community care services for those with ongoing health issues but for whom hospitalisation is not appropriate. This particularly relates to frail aged people and includes

assessment programs, dementia monitoring, wound dressing and podiatry services

- Specific chronic disease programs, both educational and treatment, for conditions such as diabetes, asthma, arthritis, respiratory diseases/smoking cessation, drug and alcohol treatments, mental health programs, sexual health
- Pre natal and post natal services, recognizing that birthing will normally occur at a major hospital. In some circumstances new mothers may utilise transition beds for short periods
- Multi-disciplinary outreach teams (“hospital in the home” and palliative care)
- Pharmacy
- Voluntary support and carers facilities
- Community health care library
- Allied social services e.g. financial counselling

Sub acute hospital care

- Urgent Care Centre (as opposed to full accident and emergency)
- Day procedures / day surgery unit
- Treatment programs delivering chemotherapy, kidney dialysis
- Full diagnostics including radiological services
- Step-down, rehabilitation and GP beds for those recovering from a major acute event such as heart attack, stroke or major surgery such as joint replacement; either as an external patient or as a transition inpatient; using the services of physiotherapists and other consultants in a facility that includes a range of exercise equipment, treatment benches and hydrotherapy
- Palliative care
- Mental health unit (step-up and step down)
- Mortuary

Public or Private

Given the age and income profile for the southlake area, the SIHC Committee undertook the task of developing the case for the provision of public health care services and facilities.

This is not to say, however, that all the facilities envisaged could not be provided by a public/private partnership. Whilst the local community is wary of such models, successful partnerships of a different kind are being established with the same modus operandi as the Lithgow Hospital.

The SIHC Committee believes there are various options to be explored.

Location

The SIHC Committee believes that ideally all the services envisaged should be provided on one site and integrated into a public transport hub.

However, the committee has deliberately eschewed the identification of a precise location for the proposed integrated health care facility for a number of reasons. Whilst various parcels of publicly owned land have been identified, including the site of the Morisset Hospital (currently providing psychiatric and developmental disability services), restricting the development of the hospital to publicly owned land effectively rules out any public/private partnerships. This decision was formed through the committee's discussions with private health care facility developers.

Co-locating has advantages for health care delivery but, as the private developers pointed out, there are also benefits from the perspective of infrastructure costs. Co-locating health care services with a commercial retail development and or other community facilities also brings advantages, eg reaching the threshold of demand for child care centres, maximising use of land and thus reducing costs for car parking, creating a hub for retail/commerce and transport which would service both the general community and health facility employees.

This type of model is strongly supported by health care planners overseas⁴².

The Future

The present delivery of health care is fragmented by historic and constitutional funding arrangements between the Commonwealth and State governments. One of the primary recommendations of the National Health and Hospitals Reform Commission was to address this issue:

to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding (recommendation 16).

The issue of funding is beyond the scope of this document but what we would look forward to is:-

- An agreed service model reflecting projected changes in demography, epidemiology, practice, technology, service development, and consumer expectations.
- A strategic capital development plan fully reflecting this model:
and
- The right type of facilities of the right design in the right place.

⁴² Cole, J. (2009) *Strategic Planning for Health Care Facilities, Northern Ireland* in Case Studies, Investing in Hospitals for the Future. European Health Properties Network p16

Appendix 1 Local Case Histories

The following are three typical stories from people who have experienced difficulties accessing health care and the concomitant issues involved in travel to existing facilities.

Some people who approached the committee with their stories did not want their circumstances recorded in case they had their "benefits" taken away.

Case study 1 Dialysis

Background

The patient arrived in Australia from the UK in the mid 1960's and finally settled into retirement at Bonnells Bay in the mid 1990's after living primarily in Melbourne.

Case History

The patient's health was good until about 3 years ago when she was diagnosed with kidney failure and heart problems. The patient who is 88 years old and who is quite frail has been admitted to Gosford Hospital about 12 times for specialist treatment over the past 3 years. Her carer husband is 90 years old.

The patient is obliged to travel by ambulance on Tuesday, Thursday and Saturday to the dialysis unit at Lake Haven Community Health Centre run by Gosford Hospital.

This facility has 11 Dialysis Stations and handles about 22 to 24 treatments per day. It operates 6 days per week and is staffed by 4 nurses.

Typical Dialysis Day

The patient must be ready for ambulance pick up by 7:30 am (normal pick up is around 8:30am.)

- Travel to Lake Haven 30 minutes.
- Dialysis preparation 15 minutes.
- Dialysis Procedure 4 hours.
- Patient's return ambulance booked for 1:30 pm (ambulance pick up can be delayed by 3 to 4 hours.)
- Patient is exhausted on return home.
- Patient spends following day recuperating.

Benefits of Local Dialysis

- Improvement in patient quality of life.
- Estimated reduction in ambulance costs of **\$17,166** per annum.

Case study 2 Dialysis

Background

The patient lives on the Morisset Peninsula and is aged in the mid thirties.

Case History

Patient has major health problems, is disabled and suffered complete kidney failure in early 2008 necessitating dialysis 3 days per week. The dialysis treatment is carried out at John Hunter Hospital. As is the case with other dialysis patients the ambulance transportation cost is considerable.

Typical Dialysis Day

The patient is picked up by ambulance at about 1:30pm. Because of the disability the patient cannot walk to the ambulance necessitating the use of an ambulance stretcher at home and at the hospital.

- Ambulance travel to John Hunter Hospital 1 hour.
- Dialysis preparation 30 minutes.
- Dialysis treatment 4 hours.
- Return ambulance travel from John Hunter Hospital 1 hour.
- (ambulance return pick up can be delayed for several hours and the patient often does not return home until after 10pm)

Benefit of Local Dialysis

- Improvement in patient quality of life.
- Estimated reduction in ambulance costs of **\$37,602** per annum.

Case study 3 Double Knee Replacement

Background

Patient has lived in Bonnells Bay for about 20 years and is aged in her middle 70s.

Case History

Patient has been active and in good health for most of her life but has suffered increasing problems with both knees over the past 10 years. Her specialist finally decided on a double knee replacement and without private health cover the patient spent 12 months on the Gosford Hospital waiting list. Finally this major operation was carried out in January 2009.

The patient, who lives alone, was discharged from Gosford Hospital despite having virtually no support network in place at all. Home care was provided by neighbours who assisted by driving the patient to weekly physiotherapy sessions at Wyong Hospital for several weeks (62 km return). The HNEH Safety Care Program was put in place after this time to handle transport and other duties.

Benefit of Local Rehabilitation

- A transitional bed at a local medical facility would have made the initial stages of the patient's rehabilitation much less challenging with onsite physiotherapy service and no road trips to Wyong Hospital.

Appendix 2 Ambulance Transport Costs

The following indicates the saving in ambulance costs for the above three case studies.

Comparative Costs Ambulance Transport						
Morisset Peninsula to Lake Haven - John Hunter - Wansey Dialysis Unit						
Case study patient	Lake Haven		John Hunter		Wansey Dialysis Unit*	
Ambulance call out fee	\$290 x 2	\$ 580.00	\$290.00 x 2	\$ 580.00	\$290 x 2	\$ 580.00
Cost per kilometre	\$2.62 x 52	\$ 136.24	\$2.62 x102	\$ 267.24	\$2.62 x 72	\$ 188.64
Cost per trip		\$ 716.24		\$ 847.24		\$ 768.64
X number of visits per week		\$ 2,148.72		\$ 2,541.72		\$ 2,305.92
Annual cost		\$111,733.44		\$ 132,169.44		\$ 119,907.84
Comparative Costs Ambulance Transport						
Morisset Peninsula to Morisset						
Case study patient	Morisset		Morisset		Morisset	
Ambulance call out fee	\$290 x 2	\$ 580.00	\$290 x 2	\$ 580.00	\$290 x 2	\$ 580.00
Cost per kilometre	\$2.62 x 10	\$ 26.20	\$2.62 x 10	\$ 26.20	\$2.62 x 10	\$ 26.20
Cost per trip		\$ 606.20		\$ 606.20		\$ 606.20
X number of visits per week		\$ 1,818.60		\$ 1,818.60		\$ 1,818.60
Annual cost		\$ 94,567.20		\$ 94,567.20		\$ 94,567.20
Annual Saving		\$ 17,166.24		\$ 37,602.24		\$ 17,166.24
Combined annual saving	\$291,876					

*Patient did not wish to divulge details for case study

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