COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

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

TUESDAY, 25 FEBRUARY 2003

LAKE MACQUARIE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Tuesday, 25 February 2003

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

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

Terms of reference for the inquiry:

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

WITNESSES

Committee met at 9.06 a.m.

CHAIR—Good morning and welcome. I declare open this public hearing of the House of Representatives Standing Committee on Ageing as part of our inquiry into long-term strategies for ageing. Today we will hear from Hunter Health; Lake Macquarie City Council; Professor Julie Byles, the director of Hunter ageing research, the Hunter Medical Institute and director of the Centre for Clinical Epidemiology and Biostatistics; Aged and Community Services Australia, Hunter region; and Mrs Laraine Dunn, who is a fitness leader.

It is clear that the ageing of Australia's population will have a profound impact on Australia in terms of social, economic and political activity. Areas such as the Hunter have extensive experience with a range of ageing issues due to the lifestyle attractions of the area for older people. I will now proceed to call the witnesses.

[9.07 a.m.]

WARD, Dr John Alan, Clinical Director, Aged Care and Rehabilitation Services, Hunter Health

CHAIR—I welcome the representative of Hunter Health to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of the parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Dr Ward, would you like to make an opening statement before I invite members to proceed with questions?

Dr Ward—I guess when you think about ageing, the research into ageing seems to say fairly clearly that there is a third age and a fourth age. Until about the mid-80s—this varies; for some people it is early, for some people it is later—people are fairly healthy. The vast majority of people are healthy and active. They have the capacity to improve both their functional state and their mental state. They have the capacity to be very vitally involved in society. So the most important issues for them are those issues that are going to contribute to what you might call healthy ageing.

From about the mid-80s on, this changes. People enter a fourth age in which the capacity to improve diminishes, in which there is an inexorable decline in organic function and mental function which starts to then involve a substantial proportion of the population. For an organisation like Hunter Health, this is the group for which they are most involved in providing services. If you ignore, for example, the paediatric and obstetric beds in our hospital, older people occupy the majority of our hospital bed days. They take up the majority of our services for GPs and for community health. Certainly the 80-plus group make up 75 per cent of people in residential aged care facilities. So we tend to focus on this group. This is where we tend to see acute, urgent problems. There are a couple I hope to discuss with you today, where things seem to be what you might call almost in a crisis situation, where we are crying out for some solutions. On the other hand, I think it is terribly important to remember that the vast bulk of people are in that third age group and are probably putting an effort into healthy ageing, so the whole population is going to do far more good, you would say.

CHAIR—Thank you very much, Dr Ward, and thank you for your submission, which covers a lot of the relevant areas. With healthy ageing, what sort of initiatives are you able to do as a local health service?

Dr Ward—The area that we are most involved in is physical activity. The reason for this is that we find that promoting health has to be a positive thing. If we promote it in a negative way, it basically fails. There is no point in running education programs to show people how not to fall. People are not interested. They do not see themselves at risk of any of these things. However, the promotion of physical activity is very popular among older people. It has an enormous number of health benefits in terms of reducing falls injuries, reducing depression, controlling blood pressure and controlling blood sugar. It has a social benefit. People like exercising in groups and meeting new people. So we have put our money into the promotion of exercise. We run a program here called Active Over 50, which Laraine Dunn will tell you about. She is one of our exercise consultants. She will tell you about it later.

That is only a small part of healthy ageing. When we saw what happened on the Central Coast, we wanted to do a similar thing. A couple of years ago we got together the four major local governments here, in Newcastle, Port Stephens and Maitland, and all the relevant state and Commonwealth bodies and we set up a healthy ageing project. DADHC has agreed to fund this for the first year. We are hoping fairly soon to start employing a project officer, who will look at the issues in our community, run focus groups around the area and see what makes life good for older people and what makes it not so good. I am sure in the end we will come down to things you have probably heard 100 times before—that older people need a valued social role. They need something that gives meaning to their life. Lifelong education is a huge component of this. Work in some capacity, either paid or voluntary, is important. There is accommodation and transport and those sorts of issues. They are not ones we can do much about as Hunter Health. But together, all the departments have a responsibility to work together and to own whatever solution comes up.

CHAIR—Are you having any success in reducing the incidence of falls?

Dr Ward—We are certain we are. It is very difficult to be clear. We are not doing any quantitative research on our own project. But this is being done elsewhere. I do not think you need to reinvent the wheel. The research evidence is clear. Of all the risk factors for falls injury, exercise—physical fitness, muscle strength and balance—is the one that you can do something most easily about. Most properly carried out intervention trials have shown that it is certainly very easy to improve muscle strength, balance and many of those risk factors. You can probably reduce falls by about 20 per cent. However, I think that is only one side of it. I think it is really falls injuries which I am trying to prevent rather than falls. We would rather people not fall. But it is terribly easy to stop older people falling; you just put them in a chair, put a blanket around them and turn the telly on. They will not fall, but you will not have done much for their quality of life.

But if people are out there being more vigorous and more active, they walk in the way that active people walk, not in a sedentary way with your centre of balance backwards. They may well fall, but if they fall, they fall forwards. The worst that will happen is that they will break their wrist; they will not break their hip. So what we are really trying to do is this: by making people more active, they may not necessarily fall less but they will injure themselves less, they will certainly lose their confidence less and you will not see this great change in their way of life that you see.

Ms HALL—I noticed, looking at your submission, that you talked about GPs and the problem associated with GPs in large aged care facilities. Would you like to expand on that a little.

Dr Ward—Firstly, I think in aged care generally the key nexus of aged care is the person, their carer and the GP. Everything we do has to be friendly to that nexus. If it is not friendly, we are wasting our time. In this major innovation project that we have in the greater Newcastle area, which is the integration of aged care and community health into one geographically based, one-stop shop, one entry point, one common assessment system for older people, that is one of the key principles—that it has to be GP friendly. The problem for older people is when they go into aged care facilities, particularly if the facilities are large. There are a couple here that are large. Of course, the largest of them all is what we used to call Allandale, which has 340 beds. The other problem is that some of them are remote from major centres. They are in areas where

there are not a lot of GPs. That was the big issue for us at Allandale. There are few GPs. The ratio of GPs to patients there is about 1:3,000, which compares to about 1:1,200, which is apparently the desirable ratio. So we have limited numbers of GPs who are prepared to come to aged care facilities.

Aged care facilities are difficult environments for GPs to work in. You have to get in there. The patient is not necessarily where you want them at the time you arrive. Often they may even have gone out for a visit or they have gone to the toilet and you have to find a nurse who knows what is going on. You have to find their record. It is not an easy environment. For GPs, usually when the patients come in, all their equipment is there. That is the environment they like to work in. So aged care facilities are not what you would call GP friendly.

A lot of people have tried to wrestle with this, including the Hunter Urban Division of General Practice. When Warabrook opened up, they discussed this with the Commonwealth Department of Health and Ageing and were going to do a project on it, which unfortunately did not come to anything. We approached it at Allandale by employing a full-time primary care nurse, who actually runs the practice. Then we employed with her a half-time general practitioner. We had to get him from Nigeria, but he is absolutely excellent. He is Nigerian and he came from Zimbabwe. Together they look after about 200 of the residents. She arrives at work at about 7.30 in the morning. She goes around all the 12 or 15 lodges. She knows exactly what is going on, who has had a problem during the night, who needs to be seen urgently, what the issues are for the day. She has his practice worked out by the time he arrives at 9 o'clock. In four hours they can get through 20 or 30 people with no trouble at all. She organises the enhanced primary care items, the case conferences, the care plan reviews. She is working in a proactive sense.

We have done primary care plans on everybody, so we are not just reacting to the situation. We are planning their care in the way that they would in a general practice. I believe that is the ideal way to provide good primary care in aged care facilities. It would be of great advantage if you could move on from that to involve the GPs in some sort of clinical governance issues around the management of Medicare as well. That is probably the next step for us. To their great credit, Commonwealth Health are now going to evaluate this for us.

Ms HALL—You mentioned Allandale. I notice, looking at your submission, that you talk about the guidelines for the allocation of beds and aged care places. You mention two things: the geographical issues and the targeting of the allocations based on over-70s as opposed to over-80s. Would you like to speak a little about those two issues?

Dr Ward—The Commonwealth's targets, which are based on the population over the age of 70, were a very good way of geographically dividing up the beds in 1985 or whenever it came in. It was an excellent way of equitably dividing up the beds around the country. What I would argue, and I think many others are arguing, is that it is not a good way of meeting demand over time. Three-quarters of the population over the age of 70 are actually between 70 and 80, whereas in aged care facilities it is exactly the opposite—three-quarters are above 80. That would not matter if the rates of growth of the two groups were the same, but the rate of growth of the 80-plus group has been probably twice as high as the rate of growth of the 70 to 80 group.

What has happened is that, because of the greater rate of growth over what they see as the targets, I think we have fallen behind in our residential aged care facilities. This has been offset

a little by a couple of things: the introduction of CACPs for low-care people has been a huge boon. The ageing in place in low-care facilities has allowed some let-out from the high care. CACPs have absorbed some of the demand for low care. Ageing in place has absorbed some of the demand from high care. But I think we have now hit a high-care crisis, quite frankly. I am speaking very parochially here. Although we are well behind the guidelines for low care, we are getting new low-care beds quite nicely in the next few years. So we are quite happy about low care. It is probably about the level for our demand. Even though at the moment we have 800 people in the Hunter waiting for low-care beds, many of them are not actually waiting. They are people who have taken out 2624s as insurance against some failure to remain at home. So if you went out today, you would not find 800 people wanting to go to low care. The fact that we are getting about 100 new low-care beds a year for the next two years is probably pretty spot-on for us.

Our problem is with high care. Over the last three months, we have watched the number of people sitting in hospitals gradually rise. It is now double what it was about three months ago. It is going to continue to rise. We are receiving only 60 new high-care beds in the next two years in the Hunter. So we believe we have hit a high-care crisis here.

Ms HALL—In your submission, you talk about dementia care. The last paragraph of your submission points out that you have national and New South Wales policies for dementia but the two do not seem to integrate. Would this be a common problem within aged care? Would you like to expand on what you have said in your submission about that issue of dementia and the two levels of government.

Dr Ward—You see it most clearly in two areas. One is transitional care and the other is dementia. The problem with dementia at the moment is that no-one is clear who has funding responsibility for it. No-one is clear whether it is a Commonwealth responsibility, a state responsibility or a Hunter Health responsibility. That seems to be the most urgent issue that needs to be cleared up. The other areas of health care we do not like are the divided responsibility and difficulties, but we can work with them. Funding issues are clear enough to work with them.

But with dementia, it has been absolutely unclear who has responsibility. So you find in some areas HACC has funded dementia nurses working in the community. In eastern Sydney, for example, there are something like 12 or 15 HACC funded dementia nurses in the community. That is where I came from. In the Hunter, we have one for a population of about twice the size. In the Illawarra, you have a Commonwealth funded dementia support unit assessing and managing the difficult behaviours out in the residential care facilities. There is nothing in other areas. It is totally inequitable.

The chronic neurodegenerative diseases, which really are just an example of other chronic diseases, are really endemic. We are going to have to face them in the next 10 years. Dementia is the major example of it. We will really struggle if we do not have an efficient system to assess people with dementia, which I believe occurs at the GP/dementia nurse level, the two working together in the basic assessment of ordinary dementia. Then you need one clinic in each area that can assess the more difficult dementias, such as the younger people, the more complex problems, the difficult behaviours and the difficult legal issues.

The next thing you need is a system that can assess and manage the people with difficult behaviours. Seventy per cent of people with dementia are fine. There is simple stuff that can be worked out at GP/dementia nurse level. It can be case managed at that level and they are fine. They are provided with carer support and kept out of aged care facilities as long as possible. But at any stage you have about 20 or 30 per cent of people with very difficult behaviours who are beyond that level of competence to assess and manage. It is very difficult to assess. It depends on background personality, the way people have lived their lives, their previous psychiatric disorders, their mental health disorders, their physical health and their social support system. It is complex. It is nothing that you can assess in half an hour or an hour. It is difficult stuff. It requires a high level of expertise.

In each area, you need a small group of nurses who can go out immediately and deal with these issues. When someone is out in the street exposing himself to the neighbours or who has just assaulted somebody, it cannot be something that comes through an intake meeting and gets handled next week. It has to be handled that day and you have to stay in there long enough until you deal with it. You need a system to deal with it. So we need this system of managing people who develop difficult behaviours at home or in aged care facilities.

With the rather more difficult ones, many of them can be handled at home or in dementia specific aged care facilities, either low care or high care. But for a small number—for the Hunter, we estimate it is about 20 to 30 low care and about 20 to 30 high care—their behaviour is so difficult that they cannot be managed in an ordinary aged care facility. Many of these we manage at Allandale at the moment. We have traditionally used Allandale over the years. We have Boronia, at James Fletcher, but that is a short-term thing. Allandale has been our let-out point. But you cannot run these places on the RCS subsidy system. It is simply impossible. Many of these people need one-to-one nursing for days at a time. There must be some system of supplementing the staffing of these facilities. You probably need one low-care facility and one high-care facility in each area that is prepared to take on these more difficult people.

Finally, in addition, you need a fairly small—for us, probably six to eight bed places—place that can handle the violent people. At the moment we have them in Ibis at Morisset. Something like that would be enough for the whole of northern New South Wales. There needs to be one facility in northern New South Wales and one facility in southern New South Wales able to handle a very small number of people who are actually dangerously violent.

Ms HALL—Thanks, John. I also note that you talk about the national solution to the provision of community support. You talk about the extended aged care at home packages and the need for some sort of consistency and moving from a pilot. Would you like to add to that?

Dr Ward—For us, this would be the only immediate solution to our high-care crisis. If the Commonwealth came in today and said, 'Here is another 100 new high-care bed licences,' I think they would probably sit on the table. No-one would even pick them up at the moment. We have unused high-care licences in the Hunter. There are plenty of them. We do not have any aged care providers rushing in to pick them up and build high-care facilities. We would like more licences. Are you going to Coffs Harbour?

Ms HALL—Yes.

Dr Ward—They have done a brilliant multiple development there, getting all the different players to come together, such as council, developers and aged care providers, to work in partnership. I am sure that is the approach that we have to take here of building high care along with other aspects of retirement village communities, where there are all sorts of services and facilities available. I am sure that is the long-term answer. But that is not going to help us out of the high-care crisis we are in at the moment. The only way we see ourselves getting out of it is through transitional care and EACH packages. We would desperately like EACH packages immediately. If we could use our unused licences to provide those EACH packages, we would be very happy.

Mr MOSSFIELD—I have two questions. One concerns the waiting time for assessment by the aged care assessment team.

Dr Ward—It depends whether you are urgent or non-urgent. For the urgent, it is virtually nothing. It is a day or two, or today if it is immediately urgent. For non-urgent, it averages for our urban ACAT about 15 to 20 days. For our rural ACAT, it is about 16 days.

Mr MOSSFIELD—So you think that is within a reasonable period?

Dr Ward—We think we can do better in our new integration, in which we will be decentralising our ACAT staff into what we call our CARE networks, which is our Community Aged Rehabilitation Extended networks. Instead of having a centrally based ACAT team, we will have aged care assessment done within a multidisciplinary aged care service. We think that will be a lot better. We will know a lot of these people already, so it will not be a fresh assessment. We see it as being a more efficient system.

Mr MOSSFIELD—The point has been made, of course, that people do not ask for an assessment until it is really urgent. They battle on for as long as they can. Therefore, I suppose, any sort of wait at all creates problems for them.

Dr Ward—We try to assess that, obviously. If there is something that needs to be done urgently, it is done urgently. Probably the area of biggest need is this assessment of difficult behaviour in dementia.

Mr MOSSFIELD—Another issue that has caused the committee some concern has been raised before and you have raised it in your submission. It relates to the fact that there are insufficient services for young people with disabilities. They are being forced into HACC. That is a major problem. Irrespective of the fact that they are taking beds or facilities for older people, the fact is that they are not getting the service they should get. What is being done to address that issue, as far as you know?

Dr Ward—This is the other classic example. Ms Hall mentioned the relationship between the Commonwealth and the state. We desperately need a joint solution to the problem of personal care out in the community and residential care for younger disabled people. You can understand how it has happened. There is a community wish to manage these people outside institutional care, and that is wonderful. Of course, they need huge amounts of personal care. Once they get into the system, they are there for decades. However, older people who get personal care certainly will not need as much and may only be in the system for a year or so and then move

off and someone else comes on. These people are there for decades, so they gradually eat up the HACC services.

This has been an issue here, but DADHC has responded to it recently very well by releasing slightly more than half a million dollars for personal care for older people in this latest budget. That makes a big difference here. It is earmarked for older people.

Ms CORCORAN—You talked before about having lots of unused high-care licences sitting on the table. Can you tell me why they are unused?

Dr Ward—Well, we do not have lots. We have many more unused low-care licences. I think at the moment it is somewhere between about 100 and 150 high-care licences that are unused here. They are unused for various reasons. Some have been fairly recently allocated so there has not been the opportunity to use them. That would be a small number.

Ms CORCORAN—Because the facilities are still being built?

Dr Ward—Or the land is still being prepared and so on. I know there is quite a large private facility here in west Newcastle that falls into that category. Some have been due to closures, such as the closures at St Catherine of Sienna. There will be licences freed up from the sale of Allandale to the Little Company of Mary and the change in the configuration there from all high care to a mixture of high care and low care. So it is for all those reasons.

Ms ELLIS—You made a reference to waiting lists in the sense that some people take out a 2624 as a bit of an insurance policy. Do you have any views on how we could better monitor the real waiting as against the just-in-case-I-want-it waiting? Is there any way that that can be done better?

Dr Ward—ACATs will have some idea of who is really waiting out there. As a geriatrician, I recommend that people should hang on at home. However, I always tell them, 'If you hang on too long, by the time you make your decision, you're going to wind up being suitable only for high care and you are not going to enjoy that.' However, low care is really a very pleasant way to live. I try if possible at the right time to suggest to people that it may be a good time to move into low care. You may live out the rest of your low care in a pleasant environment with your own room et cetera, coming and going as you like. It is a pleasant way to live. Unfortunately, I have seen as a geriatrician that many of the people who were in high care 20 years ago are now in low care. So low care is slightly less attractive now than it was 15 years ago. We almost need something else now at that lower end of the market. I do not know whether you are familiar with the concept of Abbeyfield supportive houses, but I think we desperately need something like that.

Ms ELLIS—Very much so.

Dr Ward—I think we desperately need something like that. We see an awful lot of older people out there whose only visitor each day is Meals on Wheels, or their home care that comes a couple of times a week. For the rest of the 24 hours, all they have is the television. They are worrying about the gutter and the stove that is falling apart and whether somebody is going to break in. It is not a great life for them. I think if we were a really compassionate society, we would be thinking about other alternatives for these people.

Ms ELLIS—So do you think we need to get a bit more real about what low care now is?

Dr Ward—I think so.

Ms ELLIS—Do you think we need to change the terminology?

Dr Ward—We certainly have to be vastly more realistic about what high care is.

Ms ELLIS—Exactly.

Dr Ward—Which is not a home. High care involves psychogeriatric facilities that should have very skilled nursing and skilled medical care. These are very important health facilities now.

Ms ELLIS—Do you have a view about how people make the decision, at what point and under what influences? Do you have any views about how people decide between taking out a CACPs package and low care?

Dr Ward—Almost everybody says to you, 'I want to remain at home,' because it is a terribly difficult decision to make, particularly for women. It is a very difficult decision to give up your home with the memories and those sorts of things. For many people, the CACPs package is clearly their first entry into the system and the very best thing they could do. But I think if you are giving them some advice, I always say to them, 'If you were my mother, this is what I would say to you. Stay at home while it is fun, you are enjoying it, it is okay and your enjoyment outweighs your anxiety about all these negative factors. But at some point, when things start to swing the other way, think about low care because that is the best way to keep yourself out of a nursing home.'

Ms ELLIS—What are the waiting pressures for CACPs packages in this region?

Dr Ward—It varies hugely from area to area.

Ms ELLIS—Generally, then.

Dr Ward—It varies from nothing to 12 months.

Ms ELLIS—So it would be fair to assume, then, that given perfect outcomes, quick and easy access to CACPs packages would definitely assist in the process you were just referring to about how people proceed from their home, maintaining themselves in it, on into the lower care, if that is where they end up going?

Dr Ward—Well, I think it has been a bit distorted, certainly here and in every area, because of the shortage of personal care for older people through the normal channels, most of which have been home care. So people have tended to use CACPs in desperation, really. With the increased availability of personal care for older people, we will now see CACPs being used very much more appropriately. We will see what the real need for them is. I agree that what you say is right. The big gap is going to be in support services for post acute care, which do not meet the HACC guidelines and do not meet CACP guidelines.

Ms ELLIS—I want to ask you a different question altogether. It is about planning. We have the formula that is applied across the country that you have referred to—the 70 age cut-off formula for places. I do not necessarily disagree with the view you have put about the 70 rule-off. They are aimed at local health regions.

Ms HALL—They are area health services.

Ms ELLIS—Area health services regions.

Dr Ward—Yes.

Ms ELLIS—Is that approximately how they are applied?

Dr Ward—I think that is approximately right. It certainly is here.

Ms ELLIS—Roughly, that is the guide that is used?

Dr Ward—Roughly, yes.

Ms ELLIS—Do you have any comments about how we could better plan where there are areas of absolute dire need as against areas of pretty urgent need as against areas of lesser need? How well do you think we actually plan, in the true sense of the meaning of the word 'plan', for where we respond and how we respond to the needs of the community in aged care? Is that formula enough, or do we need to be more clever about how we do it?

Dr Ward—If we could correct the formula and go to an age adjusted system, which I gather would be fairly easy to do, the other issues are really local issues and we could solve them locally. We have a second monthly meeting which we call the Commonwealth-state steering committee on aged care. Commonwealth Health attends, as do DADHC, Hunter Health and the aged care providers. We discuss these issues at those meetings. We started this about a year ago. We have now stopped shouting at each other. We were shouting over a particular project. Jill probably knows what project I am talking about. We have now stopped shouting at each other and we are starting to work together. I am sure it is the way to do it—for people to see that we all have common problems, we are all in this together. We can then start to discuss the various issues. They will be overcome. We also get the aged care providers to present at these meetings and tell us what their plans are. So it is like a partnership arrangement. They can then see where the areas are. Of course, most of them are charities and churches, so they have a real interest in the issue. If there is a gap, they will say, 'Maybe we could meet that.'

Ms HALL—One of the things that Annette was getting at was the fact that over the years areas like the Hunter have had the number of places that they have skewed by the fact that we have got that big facility at Allandale. It is in an area that is quite isolated from the rest of the area. You have other areas such as Lake Macquarie and Newcastle that have actually got a chronic shortage of places. She was wondering if there was a way to break that down—area health, maybe local government areas or something like that.

Dr Ward—But that was a political problem. While Allandale remained in government hands, there was little we could do about it. Now that we have sold it to Little Company of Mary, we

can start to do the sensible things that should have been done a long time ago. We will move those beds. Those beds will be moved to the greater Newcastle area. So they are not going to be lost beds. In fact, by some quirky mathematics, we have gained beds by the move. Those beds will be high-care beds all moved to the greater Newcastle area.

Ms HALL—I suppose what I am trying to get at here, and what I think Annette was trying to get at here, was this: leaving aside the issue of Allandale being a state facility, under the current system there is the potential where you may have a facility that is in an area such as Allandale is in that could skew it for a whole region. Is there a better way that would bypass the fact that you may have this big facility in this area that would take in those other areas of need?

Ms ELLIS—It is a bad analogy but the only one I could think of. I have spoken to my colleagues about this. In child care, the other end of the spectrum, there are attempts by some private operators or others to say, 'We'll put a child-care centre here' when there are areas of demand as against just areas. The thing I am getting at in drawing that analogy is: given our scientific ability to project and given our understanding of the ageing process that those projections involve as well, is there a better way of working out where areas of demand are and will be? I think the formula needs to be readdressed seriously for a range of reasons. Putting that aside or putting it just on the side, is there a better way of working out literally where those areas of demand are for home care, for low or high-level care, without getting too scientific about it or too precise but doing it better than we are doing it now?

Dr Ward—Yes. I think this is our job. For example, we have an area dementia plan in which we have worked out all the projections of the population by local government areas. We have broken it down. We know that we have three growth areas here, for example—Westlakes, Port Stephens and Maitland. They are going to be the three areas where the aged population is going to grow more rapidly than the other areas. So we have to take that into account and make sure that our services are grown much more in those areas than they are, say, in the areas where growth is going to be less. So we do that for everything. We did it for CACPs, respite day care and community services.

Ms ELLIS—Do you see that local government has a role in agreeing with you on those three areas and then actually having an active liaison with the industry in terms of land provision and zoning and so on? Can you actually see a proactive, into the future arrangement rather than a speculative one? In other words, someone could not toddle into town and say, 'I'm going to buy that block of land; I'm going to appear to put up an aged facility; I'm going to apply for the licences' without that occurring. So there is a better way of doing it. Would you agree that that is a good initiative to consider?

Dr Ward—Absolutely. I think there is a much bigger role for local government in all of this. At a place like Coffs Harbour, where the local government has taken a really proactive role, you can see what the benefits are.

Ms ELLIS—I know we are running short of time. I will ask just one more question. It is completely different. In your submission there is quite a bit of discussion about young people with disability and their 'incursion', for want of a better term, into the HACC funding and so on. I want to ask a more general question. In the era we are now in, we now have people with disability ageing, which is another question again. As a gerontologist, do you have a view about how well we do in fact, or are we doing it well enough in dealing with the person with the

disability going into the ageing category? That could be at 40 or 50 or 30, depending upon their condition. But it is an issue that I think we need to begin to contend with more than we have. Are we doing it well enough?

Dr Ward—I think we do it fairly well for physical disabilities because they are the ones that we easily understand. The person who carries a physical disability through into older age has usually been a client of the rehab system. Because we work very closely with rehab here—we are all one entity here in the Hunter, which is the ideal way—that is not a problem for us. With respect to people who develop a physical disability at a younger age, such as motor neurone disease or Huntington's disease, we are fairly skilled at that anyway because we have just inherited that by default over the years. The difficult one for us has been intellectual disability. Here we have approached that by having regular meetings with DADHC. Every three months we meet, about 12 or 13 of us, to develop shared expertise. We teach them about geriatric medicine and psychogeriatrics. They teach us about intellectual disability. We now do all our assessments jointly. We manage all these people jointly now, and that has been a big advance for us.

Ms ELLIS—That would also involve their future needs for accommodation?

Dr Ward—Yes.

Ms ELLIS—Living accommodation and so on?

Dr Ward—We are just starting to come to grips with those issues. They are much bigger issues. All we really have at the moment is an aged care industry. For younger people with a disability, there is a certain amount of accommodation. We really have not got this intermediate accommodation.

Ms ELLIS—Let us look at the intellectual disability group. For people with an intellectual disability who may not be at home but may be at a facility, such as a group house or something else, should we put a bit of work into allowing them to having an ageing in place process in front of them?

Dr Ward—Absolutely, yes.

Ms ELLIS—Do you know of anywhere where that is already done in this region?

Dr Ward—No, I do not. It is done by default a little. They like to hang on to their people, if they can. But then at a certain point they say it is too difficult. You could say, 'Well, if we could move in the services, it would clearly be better to have these people living in a small house than move them into a larger facility.'

Ms ELLIS—So that comes back to your comments about how we can better do the HACC and the division—

Dr Ward—Between Commonwealth and state, yes.

Ms ELLIS—Okay. Thanks very much.

CHAIR—Thank you very much, Dr Ward, for your submission and for your evidence this morning. Many of the issues that you have raised are obviously issues which the committee is very interested in. I thank you for your thoughtful presentation.

Dr Ward—Thank you for hearing me.

[9.48 a.m.]

BOGAERTS, Ms Jill, Community Planner, Ageing and Disability, Lake Macquarie City Council

CHAIR—I welcome the representative of the Lake Macquarie City Council to today's public hearing. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Would you like to make an opening statement before I invite members to proceed with questions?

Ms Bogaerts—When I considered this, I tried to look at the population over the next 40 years. I have tried to consider myself in this, being one of the baby boomers as such, and some of the issues that we have now and where we are likely to progress over the next few years. Some of our current issues are things like support services, housing, transport and financial security, including income security. They are issues that I think at the moment we need to take into consideration.

CHAIR—Thank you for that. I would like to ask you a little about the employment of mature age workers. The evidence we have had before the committee suggests that across the whole of Australia the growth in the labour force is going to slow down quite dramatically over the next 20 years and eventually it will be very low in 40 years. What sort of things can councils do, do you think, in order to encourage mature age employment and improve the attitudes of businesses towards mature age employees?

Ms Bogaerts—Council employs an economic development officer here who has been taking some interest in mature age workers. In this local area, we are about to have a fairly large industry close down, Pasminco, which will be closed down over a three-year period. There will be several hundred workers, most of them over 40, who will be unemployed. Pasminco is actually looking at running some sort of retraining program for these workers similar to what happened with BHP. I know our economic development officer has been involved in negotiations with the company with regard to how council can fit into that situation as well and what we can do.

CHAIR—In your city council area, what percentage of people would be over 65 here?

Ms Bogaerts—I have the figures for the over-55s in front of me. Roughly 25.57 per cent is over 55. So it would be about the 20 per cent mark, I think, which is over 60.

CHAIR—So that is quite high. Are you seeing any evidence that businesses are targeting the over-65 market?

Ms Bogaerts—Businesses generally are not. We have some housing developments that are targeting the 55s and over. In this area we have some mobile home or manufactured housing estates which target specifically the 55s and over. Some difficulties arise where you have large groupings of people in mobile home parks. For instance, we have about three per cent of our population aged over 55 living in a caravan or manufactured home estate. One of the issues that

comes up is that those estates do not have similar things in place with regard to support and facilities for older people if they went into SEPP5 aged accommodation, like a self-care unit, retirement village type arrangement. It is difficult for council to actually try to keep control over what happens with the development of those sorts of estates.

CHAIR—What do you think needs to be done to support healthy ageing in your area?

Ms Bogaerts—At the moment, we are trying to be a little proactive in encouraging all of the groups together to increase our participation rates in activity. One of the things that council has been looking at now is recreation plans. We have been looking at trying to provide facilities which actually are suitable for more active lifestyles for older people. In our community facilities, such as our multipurpose centres that are being built, we are looking at trying to encourage a range of community groups, like U3A, computer clubs and so on into those facilities. There is a computer club in the Westlakes area, which is one of our lower population areas, which has 400 members aged over 55. That is quite spectacular membership. Actually, for Seniors Week we are working with Newcastle City Council at the moment. We are looking at a program which concentrates on healthy ageing. We have about 20 activities, including everything from tai chi, learning to surf, seniors aerobics, guided tours and walking for pleasure. That is the sort of range of activities, plus some computer activities and the U3A activities in our program. So we are trying to encourage participation rates.

CHAIR—In terms of the ageing of our population, what sort of things do you think can be done to have it viewed as a positive? What I mean is whether there is any way that you are seeing community attitudes changing towards ageing and valuing the role that older Australians play in the community.

Ms Bogaerts—I guess I have noticed this time with organising Seniors Week that the media is starting to become much more interested in what we are doing and the fact that we are putting on a healthy ageing type program with some of the items that we listed on the program. So the media is starting to pick up on it locally. I guess business is doing so generally. Some businesses offer discounts to seniors, but it is not really an acknowledgment of contribution as such. It is more that it is good business to encourage this group into the shopping centre or whatever.

Ms HALL—Firstly, I know that you have expressed some strong feelings to me in the past about the formula for deciding where aged care places are located. Would you like to share that with the committee?

Ms Bogaerts—From the point of view of listening to carers and older people who need to be placed in an aged care facility, having the bulk of our high-care beds in the Cessnock local government area for the Hunter region is very difficult for families.

Actually, for people who want to visit family members in that facility it is extremely difficult. There are no direct transport links right through. For someone who wants to visit, they really need to either have a car of their own or a family member who can drive them or they need to go through at least three or four changes of transport in order to get there. It can take basically the best part of a day to get there and back for an hour's visit. Talking with the other HACC funded groups in the area and carers groups, we would like to see the placement of some of those high-care beds back into the areas of higher population such as Newcastle and Lake Macquarie in any review done of aged care places.

Ms HALL—Thank you. Looking at planning issues and how they relate to the allocation of aged care places, do you think that the system would be better if local government input was included? Do you think that some of the problems that arise when places are allocated could be bypassed if there were a better understanding of the planning and environmental issues in particular local government areas?

Ms Bogaerts—My personal view is that I think local government should be involved. But I think it would take some encouragement from state and Commonwealth governments for local government to actually take on a bigger role than they are at the moment.

Ms HALL—Could you expand on that a little, please.

Ms Bogaerts—Local government tends to consider that its main functions are the three Rs—roads, rates and rubbish. Any sort of community type service tends to fit into the background. We have a huge number of older people coming through. It is not until those people start to make an impact that our local representatives will really consider the sorts of things that they might need to get involved in, and the demand needs to come from our older people in order to get local government involved in it.

Ms HALL—From a planning process, looking at going through the DA stage here, there is often a blockage. Would you like to comment on that.

Ms Bogaerts—Some of the issues come up with the SEPP5 developments. We see quite a number of SEPP5 developments. We see some small infill developments. From time to time, we have developments which are anywhere between 100 and 250 beds or units. What we have been finding is that a lot of developers are actually looking at trying to locate those facilities out in the more rural areas, where the services are not as good as they could be. It is not just support services. It also creates problems in getting other services into the village as well, such as adequate environmental services to the site. So there are a number of issues. A lot of that relates to the cost, I guess, of getting the services on site. I am not sure that I have covered what you wanted.

Ms HALL—That is all right. You mentioned transport. It is in the last part of your submission. In that paragraph you talk about the need for equity in transport fees and the need for the availability of public transport and maybe a different mix. Would you like to expand on that a little and share some of your ideas there?

Ms Bogaerts—At the moment, our community transport project usually charges people about $6 to transport them, say, from their home to shopping or a medical appointment or whatever. If a person who was using government transport could go directly from their home, they would pay a much smaller amount of money to transport themselves. We need to look at trying to bring some equity back into the cost of transport. In Lake Macquarie we have public transport down the eastern side. We have public buses down the eastern side of the lake and across the northern tip of the lake. Down the western side of the lake we have a private bus service and we have a rail service. But there are not proper linkages in place for people to make connections when they are trying to get from place to place.

The other thing we also need to consider is that the public buses in this area are not currently accessible. In lots of cases, for access onto those buses from bus stops, we do not have proper

facilities in place. We need some assistance to get those sorts of facilities in place so that people can actually get onto those vehicles as well.

Ms HALL—Finally, would you like to comment on respite care.

Ms Bogaerts—With regard to respite care, we have had consultation with the HACC service providers in this area just last week. Respite care was one of the priority issues that came up. People want flexible respite options. They want to be able to decide how and when the respite is offered. In some cases, some people are limited by an organisation in the number of hours of respite care they can have. They might be using two or three providers in order to get the amount of respite they need. In some cases, the respite they might need, say, for somebody with slight dementia, is evening respite to help them get over that evening period. Those things are not available at this stage in this area. But respite generally is an issue. Home based and centre based respite in particular were mentioned.

Ms ELLIS—I want to take the respite question a bit further. Can you give the committee an outline. For a person who is caring for a family member or a partner at home with dementia, it is a pretty tough lifestyle. What does that person go through? What would they have to do to gain access to respite? Can you walk us through what they would need to be doing to gain that in this region?

Ms Bogaerts—They would need to make contact with either an agency which offered the service, or they may be able to enter the service through the carer respite service, which has been funded in this area and which seems to be working quite well. There would be an assessment done of the client. At the moment, we are trying to cut down our multiple assessments. I am going to sidetrack slightly. We have a pilot project operating in the Eastlakes area at the moment where anyone who is coming through the HACC services, for things like respite care, transport and food services, actually gets assessed in one place and they can get their package of services through one assessment rather than multiple assessments. That project is about to be expanded to take in the whole of Lake Macquarie and Newcastle, so that will cut down some of the difficulties for carers who are trying to enter the system. But it will depend on respite availability, whether they want centre based, what hours they want and whether they want actual respite in an aged care facility. So there are a number of other things that would need to be considered.

Ms ELLIS—So how do they find out who the agencies are? Are they told they have got a certain amount of money they can spend? How does that work?

Ms Bogaerts—In some cases, they are told that there is a certain amount of money they can spend. In other cases, they are not told.

Ms ELLIS—What is the difference there? I am really trying to get a handle on what that process is.

Ms Bogaerts—Some of it is the policy decision by the individual agencies. They are trying to make their dollars spread around a maximum number of clients and trying to achieve certain outcomes for their clients.

Ms ELLIS—We were talking about how they know who the agencies are and if they are given a bucket of money, how they know how much that is. Does the person caring for someone with dementia have to keep track of how much they are spending and how they are spending it, or are they just automatically entitled to a service?

Ms Bogaerts—No. The agency keeps track of how much is being spent.

Ms ELLIS—And how do they find the agency?

Ms Bogaerts—That can be extremely difficult. We get quite a number of calls here to put people in touch with agencies. If it seems when people come to you and you provide some general information that they are going to have multiple needs, we usually refer to the aged care assessment team or Community Options or to the carer respite centre. It just depends on the situation that is presented when people ring in. If it is somebody who just needs a bit of a break because they need to go shopping, they are usually referred on to the smaller services. They tend to pick up the smaller need for respite. We have a HACC support project in this area which has done a fair bit of publicity in regard to local service provision. We have a fairly active carers action group as well. It holds monthly meetings and tries to encourage people to come along and has some little articles in local newspapers from time to time.

Ms ELLIS—You talk about housing for aged and disabled residents. You say there should also be increased access to home maintenance and modification services and so on. Can you tell us what the situation is in relation to, say, home modification and maintenance services for older people in their homes at the moment?

Ms Bogaerts—We have just had an increase in the amount of money available for home maintenance in this area. That has been taken up pretty quickly. That was the first maintenance money as such to come into this area. What I hear when people ring and ask, 'How do I find out about villages, retirement villages? What can I do?', is that usually when they are talking about looking, maintenance is one of the first things they mention. We have fairly high home ownership rates in this area, a lot of detached houses and quite large properties for people to look after. The fact that people have difficulty looking after their home tends to be the catalyst for making people think, 'I need to go to a retirement village.' They need to get some other sort of support. They need to reduce their expenditure. But maintenance of houses also eats into people's budgets. Their assets tend to be tied up in their property rather than having a disposable income which they can use to bring someone in of their own accord to help them with maintenance.

In our area, our home modification service has just taken on Newcastle as well. They do approximately two bathroom renovations a week. That would be a total fit-out of bathrooms. They have an extensive record of carrying out quite a considerable number of jobs per month. They subsidise their services. The subsidy they offer is roughly 50 per cent of the employees of the service, the labour fee, and about a 40 per cent subsidy for any contractor's fees. The client pays for the actual fittings and so on, the materials.

Ms ELLIS—The reason for the questions, if I can sum up, is this: the emphasis on assisting people to stay in their homes for as long as they can is a very strong and positive thing but will not be of any use at all if services like respite, home maintenance, home help and all those other things are not fully resourced to promote that. You are nodding. You obviously agree with that.

Ms Bogaerts—Yes, I do.

Ms ELLIS—Would you agree with the assumption that there is a gap at the moment between the two? How well do you think the community, through funding, is allowing people to see that process through to the best end that we can?

Ms Bogaerts—There is a gap in home modification services. Part of the gap actually relates to assessment for the modifications to take place. That delays service provision. I do not see just home modification as the answer. I think we need to look at other things.

Ms ELLIS—Everything. They were just illustrations.

Ms Bogaerts—Yes. Certainly there is a gap. We need additional resources if we are going to continue down the path of people owning their own homes and living in their own homes with a range of services.

Mr MOSSFIELD—You raise in your submission the question of income security. I think that is very appropriate and very important. I congratulate you on highlighting that issue, particularly as we are looking at the issue of the Australian population ageing over the next 40 years. What prompted your submission in that regard? Are there any concerns you have that you would like to expand on?

Ms Bogaerts—As I said earlier, I was looking at the 40-year period and thinking about myself. I would fall into that period. The superannuation guarantee came in 10 or 12 years ago. A lot of people would be in a similar position where they would not have had superannuation in place until that came into being. I am concerned that, unless there is a proper system in place whereby a base income is maintained for people, people will drop below the poverty line and they will not be able to maintain a standard of living that would appear to be reasonable for someone in a country like Australia.

Mr MOSSFIELD—There have been comments made by different people about the age pension and even extending the qualifying age for that up to 70. Do you have any comments on that?

Ms Bogaerts—It is something that probably does need to happen, when you look at the population numbers for Australia. But the current older population sees it as their right. There does need to be a change in thinking about entitlement to a pension or a benefit as well. It is going to take a bit of time and community education to get around that process.

Mr MOSSFIELD—Isn't there a little concern amongst the female population that they are now extending the age entitlement for the age pension to the same level as for men? Would that be creating any problems for, say, widows and people like that—or maybe their entitlement to some other form of benefits?

Ms Bogaerts—I have heard a few comments along that line, but I would not say that I have heard a significant number of comments along that line

Mr MOSSFIELD—I will turn to a completely different issue. Yesterday we spoke to some people who expressed concern about being forced out of manufacturing homes by the proprietors of those establishments so that other developments can take place. That, of course, would create enormous difficulties as far as housing is concerned for those people. Is there anything you think a council could do to protect the tenure of people living in manufactured homes and that sort of accommodation who mainly would be our elderly people anyhow?

Ms Bogaerts—I am not so sure about council but certainly state government should look at introducing some regulations in regard to that area, yes. As for council, I am unsure what role council could play.

Ms CORCORAN—I wanted to extend the questioning down the path the chair was taking. You have not talked about it in your submission, so I do not mind if you do not have an answer off the top of your head. We have been talking about mechanisms and strategies to cope with older people. I actually want to turn it around and say that from my observations many older people have a lot to offer back. Is there a role for councils or other bodies in being positive about that and promoting that 'resource'—I cannot think of a better word—to community groups, schools or whatever?

Ms Bogaerts—Certainly council has a role to play. We do so in recognition of the contribution by volunteers in the area. We have regular appreciation type events where volunteers are recognised, older volunteers in particular. A lot of our volunteers in this area are older people. But we also are trying to, as I said earlier, involve our older people in planning. We are getting out and consulting more with our older people as well to try to get the input into local decision making at this level.

CHAIR—I thank you very much for your submission and for your evidence. We will take a short break.

Proceedings suspended from 10.18 a.m. to 10.36 a.m.

BYLES, Professor Julie Ellen, Director, Centre for Epidemiology and Biostatistics, The University of Newcastle

CHAIR—Welcome to today's public hearing. I remind you that evidence that you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Professor Byles has made a submission to the inquiry, submission No. 103. Copies are available from the committee secretariat. Professor Byles, would you like to make an opening statement before I invite members of the committee to ask questions?

Prof. Byles—Thank you. As I stated in my submission, I think the issues regarding population ageing are not restricted to those people who are old now or will be old in 40 years time; they are actually issues for the whole population. I think there are particular issues for women that need to be considered. That does not diminish the issues for men, but I think that gender is an important issue in relation to ageing and population ageing. I think also that we have to consider ourselves within a global context. It is not just our population that is ageing. In fact, our population is ageing at a different rate and in a different time frame than some of our near neighbours and some of our distant neighbours. We need to think about the implications for that as a country, an economy and as part of the global population.

CHAIR—Thank you very much. Thank you also for your submission. From the point of view of a federal parliamentary committee, what sort of things can be done to promote healthy ageing?

Prof. Byles—Healthy ageing is an incredibly broad term. Part of it is about health promotion and illness prevention. There is quite a lot that can be done there. Another part of healthy ageing is about being socially and economically healthy. So it is quite broad. There are a number of things that can be done. First of all, in terms of health promotion, we have quite a lot of health promotion efforts that are focusing on younger people. Some of these have been incredibly successful. In fact, things like quitting smoking campaigns and the prevention of the uptake of smoking have been partly responsible for reduced deaths from cardiovascular disease.

But we need to start to think about some of the conditions that cause a lot of morbidity in older age and what we can do to prevent them. Sometimes we know what we can do to prevent them but we need to get on to doing it. Sometimes we do not know. Arthritis, for instance is a condition that is extremely common in older ages. It is very debilitating and yet we know very little about how to prevent arthritis. We do know that reducing weight is helpful. We do know that maintaining healthy exercise is helpful. Beyond that, we do not know a great deal about reducing arthritis. Yet if we could, the gains in terms of healthy life expectancy would be huge. That is an example in relation to preventing illness.

Another aspect of healthy ageing is about maintaining active participation in communities, in working life, perhaps, or in social life. There is evidence to suggest that people who remain either in the work force or in the voluntary work force or somehow participate in society remain healthier into their old age. There are a number of government policies that could be considered to try to promote this participation. Obviously there are policies in relation to the work force. Earlier the committee talked about increasing the eligibility age for the pension. That may be

okay, but the problem at the moment is that we do not know what factors enable people to stay in the work force. It is not going to be as simple as asking, 'Am I eligible for the pension yet?' I think we need to understand much more about how working life can become an evolving life. At the moment, working life evolves so that people progress and are promoted, but we need ways in which people can redefine their working lives in another way when they are getting older so that they can maintain a role but it might be quite a different role than the trajectory they have been on through their younger years.

Similarly, with regard to whether people give up paid work, what things encourage them or allow them to engage in volunteer work? Quite a lot of our infrastructure in our society is informal through volunteering. A lot of this volunteering is provided by older people. A lot of the aged care that older people get is actually provided by other older people. What facilitates this and what impedes this? One of the issues that at least anecdotally appears to be impeding volunteering at the moment is the issue of insurance and public liability. That is something that needs to be looked at in great detail and rather urgently.

CHAIR—Thank you very much. You have mentioned one of the studies in the Netherlands and areas where, if we do better, we can improve healthy life expectancy. Some recent figures I have seen relate to life expectancy in Australia ranking about No. 6 in terms of incidence of smoking. We are the third lowest. Also, in terms of healthy life expectancy, or what is sometimes called disability adjusted life expectancy, we are No. 2 behind Japan. Is that in accord with your impression of where Australia is now? Obviously we can do much better. But how does Australia stack up internationally?

Prof. Byles—Yes, I think it is true that it does stack up quite well internationally. Some of that is because some countries have very poor healthy life expectancy rather than that we are doing so well. But I think it is on our side. As I said in the submission, I think that Australia actually is in quite an enviable position internationally. We have some advance warning of our demographic change. It comes at a time when we are quite economically well established. We have quite a lot of infrastructure. Yes, we are doing quite well in terms of health and healthy ageing. I think that means we are very well placed to be quite optimistic about the next 40 years and not at all pessimistic.

Ms HALL—Thank you for the in-depth submission that you presented to the committee. I was particularly interested in the issue you raised about equity within generations of older people and ways of ensuring that a wide range of needs are met. Would you like to expand on that a little for the committee?

Prof. Byles—Inequality in socioeconomic status has been recognised to have an impact on health. One of the things we forget about, especially in terms of mortality, is that these inequalities that are established very early in our lives can actually make a difference to what our lives are like when we are older, partly because we accumulate physical disadvantage and we accumulate some psychological disadvantage because of this inequality. But people accumulate economic disadvantage because of it as well. So if we are thinking about capital that people can draw on for aged care or if we are thinking about whether somebody has somewhere to live and how adequate that housing is—is it adequate for people to stay in their homes and be supported by community services—all of these factors are very much embedded in people's socioeconomic status and the accumulation of that status throughout their life.

In a system like Australia's, physical inequity can diminish as people get older, partly because everybody ages and there are some things that are not preventable. But one of the things that we have observed with the Australian longitudinal study on women's health is that the mental health inequity is maintained as people get older. This is quite an important cause of morbidity in older age.

I guess a principle that I would like to have a fair degree of prominence is that we need to think about equity in all of the policies that might be developed. It is not just how this affects the average person but how it affects the people particularly at the lower end of the socioeconomic scale.

Ms HALL—That brings me to the next section of your submission, which is a section on women. It also looks at young women and policies aimed at increasing fertility. There are statements you made earlier in your submission about the way we look at an ageing population and demographic changes. Would you like to talk a little more about that?

Prof. Byles—I will deal with the second part first. I feel that an ageing population is almost evidence of success for a country or a community—that we have long life expectancy, that children survive childbirth and infancy and go on to become adults and those adults survive adulthood and go on to become what we might call older people. So it is a success. I think that the declining fertility rates are commensurate with changes in women's status. I do not think any of these things are necessarily bad things, but it does mean that we have to re-evaluate how we see older people in our community and be prepared to provide care for those people and meet their needs and be prepared as a community to finance that. I am sure that will mean some adjustments to how public wealth and private wealth are distributed.

I am not an expert on ecology, but I think there are some issues about ecological sustainability. We cannot just keep driving the population so that we keep it at a pyramidal shape. It does have to become rectangular and we have to learn to deal with that. It is a global phenomenon. It is a natural phenomenon and a predictable phenomenon. With respect to young women—this is not my work but the work of my colleagues—the Australian longitudinal study on women's health was very interested in young women's aspirations and whether they are changing, whether they are evolving. It was surprising to them that young women actually have the same aspirations as middle-aged women. They do want to have children, but they are delaying childbirth until they have established themselves with their education and in their careers. So they do want to have children. They do want to work. They do want to be married.

If you compare them to women perhaps a generation ahead who were also in the study, those women have had children and 70 per cent of them are working. I think the only area that the young women may be disappointed with is that a larger proportion of them are no longer married. Nobody aspires to be divorced, but it happens. It is not that young women do not want to have children. They do want to have children. I think young women's fertility is sustainable, but we have to recognise that this is going to be in the context of women who work and women who work for the majority of their lives. We have already talked about maintaining people in the work force at the later ends of their lives as well. We really need to be thinking about maintaining people in the work force throughout their lives, allowing for interruptions and allowing for some flexibility and support that allows them to carry out other roles. If we talk about young women, it is roles regarding child care. If we talk about middle age women, often their role is regarding care of older people or care of an older spouse or an older parent. So we

need work force and policy flexibility that allow for those multiple roles that men can bear as well but mostly that women bear.

Ms HALL—Policy initiatives in that area?

Prof. Byles—Well, child care is perhaps the most obvious issue, and flexible work practices. The other big issue—it has been mentioned before—is about superannuation for women so women do not get to the end of a working life that has been very piecemeal and find that at the end of that they have not got enough financial support. The other thing that comes out of the work that we have been doing is in relation to widows. In our study of widows we found that when you lose your spouse, when you lose your husband, there are effects on your physical and mental health but you recover from them. After about two years, you recover from them. What you do not recover from are the financial effects. Now you are on a single income, you often have an ageing car and an ageing house. Traditionally, women have not been as responsible for financial management of the household as men have. Sometimes women need to undergo a whole aspect of re-education in terms of managing money. I think I have lost where I started. This is in terms of implications for women and policy to try to help women to manage financially and to have enough financial resources at the end of life as well.

Ms HALL—The other thing in your submission that I found interesting and refreshing was looking at ageing as a whole of life process and linking that into the issue of research. You have emphasised the importance of research. Would you like to give us an idea of the direction you think research should be going and what you see as government's responsibility in that area.

Prof. Byles—I am on the NHMRC strategic working party on ageing. They have a small amount of funds to fund some strategic research in ageing. Certainly the amount of funds they have had has been limited. But the original emphasis of that committee was a little limited too. My other committee members share this view. We cannot just focus on the biology of ageing. It is important and interesting. But ageing is a process that we are not going to cure. Well, we may, but it is not so likely and nor would we necessarily want to. So research needs to look at ways of encouraging healthy ageing. Some important things there are encouraging health promotion and physical activity. Nutrition is incredibly important and incredibly under-researched and under-recognised. I think we recognise the importance of nutrition. What we do not recognise is the inadequacy of nutrition among our older population. Between 30 and 50 per cent admitted to hospital, depending on their condition and what ward they are being admitted to, will actually be under-nourished. We talked about Australia being No. 2 in terms of healthy ageing. That is great, but we have a problem with malnutrition among our older people. So nutrition is important.

That working party has an emphasis on wound healing. That is very important because a lot of older people have problems with chronic leg ulcers that fail to heal. They need services. We know so very little about it. I tried to find out what the standard protocol for looking after leg ulcers is for older people. There is no standard protocol. Nobody knows anything that works. It is all hit and miss. Another issue that I have been involved with quite a lot and which I think is incredibly important is continence. Continence can really limit a person's ability to participate. We talked about how important participation is. If you are incontinent, you are not going to go out.

Another thing that does exactly the same thing is deafness. If you cannot hear, you are not going to go out and engage socially because you are isolated from things. I am not being very systematic. There are some really big issues. They are not the most exciting things that are going to get written up in *Nature*, but they are so important at a population level because they affect so many people and they affect them in fundamental ways. We do not know a great deal about them. The technology is not great. What we need to know is more about how these things impact at a population level.

The other thing, which is a really big bandwagon, is about evidence for the effectiveness of treatments in older people. We have a huge evidence based medicine movement internationally. Australia has taken up on that. It is quite sophisticated and well developed in terms of its evidence based movement. But there is so little we know about evidence based medicine for older people because mostly the trials exclude them. They are not allowed in. They are too complicated. So a lot of the information we have we just cannot apply to the people who need it most.

Ms HALL—I found the idea of the virtual centre for ageing research rather exciting. Would you like to expand on that and give us some of your ideas there.

Prof. Byles—The ageing research work force is quite small as well. There have been some attempts to quantify it. I do not think they are quite accurate. Even so, it is not a huge group of people. I can go to a national conference and there might be 300 people there and they are not all researchers. A lot of people are just interested in ageing. We are actually talking about a fairly small group of people to deal with what we recognise is an incredibly important issue. We need to be able to develop that research work force. I think we need to be able to network it nationally so that we are not competing with each other. We need to compete to develop each other but we need to be able to cooperate as well. I am not the only person talking about a virtual network. In my thinking about it, it is a way of bringing together the best expertise for any given issue nationally and trying to reduce some of the territorialism that exists when you have things happening in a single state or a single institution within a state level. It is trying to increase the permeability between those institutional walls. It is to get some greater collaboration that is really about bringing to bear the best expertise and the best thinking on any particular issue.

Ms ELLIS—Thanks for being here. It is really terrific to hear your views on these subjects. I take you to the comments you have made about employment. I preface my question by saying that I have a view that all of a sudden as a community we are attempting to revalue older people. It was not that long ago—in fact, it is still happening—that when a corporation or a business of any kind downsized, one of the first to go was the older worker. Now we are seeing governments say, 'We must make people stay at work longer.' So there is a bit of a transition required for the community in that regard. At the same time, we are relying, correctly or not, more and more upon volunteering and participation. You make comments about employed older women being in better health than unemployed older women. Are we talking about paid work or participation in our community generally, be it volunteering or otherwise? Is that right, or is there a difference?

Prof. Byles—For the women who are now in their early 50s, we are talking about paid work in the main. For women in their 70s, who are also in our study, for them it is more a case of volunteering and participating in community organisations. Some of those women do still run

businesses. Certainly for those women their health is outstanding. It is a little bit difficult to say which came first. Obviously, if you are unwell, you are more likely to give up work than if you are in good health and you can keep going. But I think it is a fairly cyclical process. We have women who work on farms. They are 70 years old and they are throwing hay onto the back of tractors and things like that. They have to be fit to do that. But doing it helps to keep them fit. I am not suggesting for a moment that all 70-year-old women should be getting out there and throwing hay on tractors.

Ms ELLIS—I am glad to hear that!

Prof. Byles—Participation in the work force is valuable to the individual and to the population for those reasons. It is also valuable in terms of our productivity. I think it is a difficult message, though. We do not want to be saying to people, 'You have to work.'

Ms ELLIS—Exactly.

Prof. Byles—What we do want to be saying to people is, 'We value your contribution and we need you. We need people like you to be staying in the work force.'

Ms ELLIS—I will consider both genders in the older sector of our community. For the sake of the discussion, let us pick the arbitrary figure of 65 for men and women. What do you think government should do, if anything, or do we need to do anything to encourage that participation? In some cases, it will be continuing paid employment. In some cases right now it would be the re-entry to the work force. In some cases, it would be the exit from the work force and the entry into community participation at another level. Given that they are real situations, particularly in the unpaid area, does government need to do anything to promote that or to make that legitimate, given the language that is going on at the moment about everybody having to work longer? Some people will choose not to. Some people may not need to. Some people may not be able to. But they can have a very healthy participation of another kind. Do we need to recognise that in any way?

Prof. Byles—We do. I think it is fundamental that we recognise it. There are a few things that government can do. One, as I mentioned earlier, is this issue of liability. I think it is diminishing a lot of community activities, both young and old.

Ms ELLIS—Massively.

Prof. Byles—But the impact for older people is greatest for two reasons. The alternatives are not necessarily there. They cannot necessarily pay for things if they become more expensive because of higher premiums. If that sector of our volunteer work force is removed, who is going to do it? I have heard people say, 'You couldn't afford to pay me to do what I do,' and it is true. We cannot afford to pay. I think that is an incredibly important issue. The other issue is one of, 'If I do it, do I lose benefits down the track?' It might be a case of asking, 'If I am capable, do I lose a disability benefit?' or 'If I do it for my parent, does my parent lose out on some other subsidy somewhere along the line?' I think it is the ability to trade off rather than go off on some of these things. Instead of saying, 'Okay because you have somebody to shower you, you will not get community nursing services,' we say, 'Because you have somebody to shower you, you will get some other service instead.' I think that is another way that policy can go rather

than penalising those people who are able to contribute but using that, if you like, as a way of multiplying the benefits for those people.

Ms ELLIS—That makes a lot of sense. Another comment you make in your submission under the heading of aged care relates to mechanisms to enhance ageing in place. You talk at some length about pilot studies and evaluations like the EACH program, for argument's sake. Could you expand on your views in relation to the whole question of ageing in place?

Prof. Byles—Well, ageing in place is important for a number of reasons. One is that people do like to stay in their environments. If they move, they lose a lot of their social networks, which are very important to maintaining their health and their quality of life. If they move, they can become more passive in relation to their environment. We need to be encouraging people to be empowered to know that they can change their environment and they can adapt it to their needs. That is much easier in their own environments than in a setting where they have been picked up and moved in place somewhere. That is important.

The other thing that is important about ageing in place is the business of planning. If we are going to move everybody into built facilities, we know that we have to have those facilities in this area at this time and we have to invest capital in them and build them. That does not necessarily work because you can try to predict it but you cannot because people move and things change. The lead time is long on that. People already have the capital. They have the homes to live in. So that is another advantage of ageing in place: you do not have to go around building facilities. But you still need some economies of scale that are provided.

At the moment, one of the advantages of having institutions is that you have all your older people together and a smaller work force can provide services for that collective of people. We need to develop ways of having economies of scale even in the way that we provide services to people, even though they are scattered about in the community.

Ms ELLIS—I want to take that a little further. I may be a bit futuristic. There are two parts to the question. There is a lot of talk today—but I do not think enough—about the benefits of adaptable housing. I would like to know your views on to what degree we should promote that more so that it becomes far more the norm under the building standards that are accepted by the country, without having people fear that they are going to build a place that looks like it is a home for a person with a disability necessarily in a negative sense. Going a bit further than that, one anecdotal story has come to me from someone in the aged care sector, where they had heard of a group of people—I have to say I do not know whether it was a family group or a neighbourhood group—who were all baby boomers. There are four or five family units in this group. They decided that they are going to go out and buy or build each their own house to the adaptable standard regime in a cul-de-sac together and make a positive step towards their ageing process. I got quite excited when I heard about this. I thought, 'This is just fantastic. Can't we get everybody to do this?' Do you have a comment on that sort of futuristic look at how we are going to go having regard to the growing numbers of ageing people in the future?

Prof. Byles—It is not my area of expertise, but I see it as an incredibly important part of planning for an older Australia. One of the main reasons that people move out of their house concerns issues of maintenance of that house. They do need houses that are easier to maintain and have easier access. It is not just access because they are often fit, able people who just cannot maintain a house that is large, getting old, has a large garden and those sorts of things. I

think it is the way we design houses so that they meet people's lifestyles instead of some concept of what a house or garden is supposed to look like.

I think that that goes beyond housing. Urban planning is incredibly important as well if we are talking about people feeling safe to walk around the streets. Safe can mean, 'I'm not going to trip over' and safe can mean, 'Somebody is not going to hit me and take my bag.' With respect to the way we design things, transport is important. It is about people being able to walk around. To walk to a shop or to walk to a place to meet somebody and have a cup of coffee or a drink or whatever is part of that ability to get out and socialise, to get out and be part of the community. Houses are important. Urban design is also important. We cannot have people being put in dormitories where you have to get on a bus to go to the shops. We know it is not sustainable because they cannot get on the bus, they cannot afford the bus or the bus does not run to all these routes.

Mr MOSSFIELD—I was interested in your comments that attempts to change Australia's demographic transition may not be necessary or desirable. Have I got your views right? Are we doing this by encouraging families to have more children and importing skilled migrants? Those are two examples of how we have this flow of people. Is that what you are getting at?

Prof. Byles—I am not against encouraging families to have children and I am not against people coming in. I am not sure that we would be successful in doing that. Do we really want to be encouraging people to have big families? Do we think that is socially desirable? It is not necessarily socially desirable because the trade-off is usually that women have to stay home and look after these big families. I do not think as a society we want to be paying for the public care of those children. The other thing about people coming into the country is that it is a short-term solution because those people age as well. So it does not necessarily help our situation in the longer term. I think it is great to bring people into the country but it is not necessarily going to make this problem of an ageing Australian population go away.

Mr MOSSFIELD—I was interested in your explanation that attempting this may not be necessary or desirable. Why wouldn't it be necessary, do you feel?

Prof. Byles—It would not be necessary if we are able to rethink our values so that we are actually prepared to provide for the care of older people and that we actually see older people as important contributors to society instead of a burden on society and that we actually create policies that encourage that contribution, as well as value it. You can have a dependency ratio that says we have some adults that care for a lot of children or you can have a dependency ratio that says we have some young people that care for older people. As a society, we are so incredibly prepared to care for children. There are instances where we do not, but in the main our value system is such that we are very happy to provide care for children. I am suggesting that we need to rethink our value system so that we are just as happy to care for older people.

Mr MOSSFIELD—I will move on to the value of older workers. I think that is a bit of a futuristic decision. It may well happen, but it is not happening at the moment, where people quite young feel as though they are being discriminated against. It might reach the point where, due to the scarcity of skills, the older people's skills will be more valued. As I said, I think it might happen in the future. It is not happening now. What can we do to make it happen now?

Prof. Byles—I think the education of employers is very important. The employers are not to blame because it was not that long ago that we were encouraging early voluntary retirement. We wanted people to leave the work force and make room for younger people. There is a lot of inertia in these messages. We put forward that message and it gets about and people adhere to it. So you have to be able to overturn that attitude and get people to understand that there is not necessarily going to be this great group of younger people coming in with skills that can be replenishing the work force. So the older workers are valuable. They may not be able to do some of the physical things they could do before, but there are other skills they have that can be reapplied.

The other thing is to try to develop methods for people's work lives to evolve. If we just say, 'You have to stay in your job,' that is unsustainable. People cannot. They are going to develop. They are going to have diminished capacity either physically or in some other way to do what they may be currently doing. But we can allow jobs to evolve so that they take account of the changing circumstances of those people but still allow them to contribute.

CHAIR—Professor Byles, on page 2 of your submission you have touched on the implications not just for Australia but for developing countries. Given that Australia is principally involved in overseas development assistance in the South Pacific and part of South-East Asia, does this have any implications for our development dollar?

Prof. Byles—Yes. In some of those countries, their populations are ageing very rapidly. They are ageing in the context that they still have quite a lot of communicable disease. They are increasingly getting chronic disease as well. They are undergoing a social change where the family structures are changing; the one where one generation provides for the next is changing. Those countries are undergoing a much more rapid transition. It is something that looks much more like a crisis than Australia could ever imagine. I have just come back from China. I was at an international meeting there. I was a bit stunned that there was not any discussion on ageing.

We talked about child health. We talked about the rational selection of drugs. We talked about the prevention of domestic violence. They are some incredibly important issues. However, we did not talk about ageing in those regions. I think it needs to be on the agenda of aid agencies. It needs to be on the agenda of foundations. China's population is ageing very rapidly, as is India's population. In 10 or 20 years, 60 per cent of older people in the world will be in developing countries. It is a much bigger issue for developing countries.

CHAIR—There being no further questions, thank you very much for appearing before the committee today.

Prof. Byles—Thank you.

[11.18 a.m.]

ALLANSON, Ms Vivienne, Chief Executive Officer, Maroba

BYRON, Mr Denis, General Manager, Anglican Care

FULLERTON, Mr Andy, Regional Chair (Hunter), Aged and Community Services of NSW and ACT Inc.

CHAIR—Good morning and welcome. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Mr Fullerton, would you like to make an opening statement before members proceed with questions?

Mr Fullerton—ACS has submitted a submission to the inquiry. We are here from the Hunter branch to give some insight into what is happening in the Hunter from an aged care provider's point of view. Some of the issues that we are facing at the moment are administrative ones, such as the onerous paperwork on our staff, certification concerns and accreditation. I listened with interest to Dr Ward's presentation about GPs, community aged care packages and ageing in place. With regard to the aged care assessment team, we have some concerns in that area. There is the complexity of dealing with different people within the industry from a government point of view, a department's point of view. Sometimes it can get a bit onerous. Our role is really to provide care for the aged. Sometimes we are fairly hamstrung in that regard. In one case in particular in my own organisation, we were recently awarded 20 community aged care packages out of the last funding round. However, we are unable to take them up at the moment because no-one wants to cover our public liability on the packages. So we are trying to find an insurance firm that will cover it. That means there is a delay within the local area regarding 20 packages.

CHAIR—Who was your insurer?

Mr Fullerton—It was EIG Ansvar.

CHAIR—They are not—

Mr Fullerton—They are not prepared to take on the extra liability. Zurich are looking at it at the moment for us. But little things like that affect the coalface. I think all our facilities at one stage or another passed certification. Miraculously, they have then all failed without us changing one single thing. Nothing has changed, yet we have all undergone inspections and our certification scores are nowhere near what they were. In my own case, we had to do about $6½ million worth of upgrades to get them up to the certification level. That is going to be very hard considering the reduced funding capacity that we have as a standalone provider. It was interesting that you are looking at aged care within 40 years. A lot of standalone providers, in my opinion, may not be here in 40 years because we represent a not-for-profit organisation, charitable organisations and churches. We are not in the business to make money. We are there to provide a service, yet we are being asked to find humungous sums of money to do things to meet a standard that at one stage we passed.

CHAIR—On the certification, can you give me some more information on that.

Mr Fullerton—My facility was certified in 1997 with a high score. We realised that some of it may not have been as correct as it should have been so we contracted some architects to do an assessment based on the latest instrument. There were a number of areas that we needed to improve on and we began to improve on them. The department offered a free certification inspection. We were strongly advised to take it up. We took it up. We failed the certification. So we are now on a deadline to meet things, yet, as I said, the building had not changed one iota.

CHAIR—I see. How many beds does your facility have?

Mr Fullerton—It has 79 beds.

CHAIR—And it will cost $6½ million?

Mr Fullerton—I have to build some new wings and retro-upgrade some of the existing wings to meet the scores.

Ms CORCORAN—I am interested in the gap. You had a high score. You suspected things were not quite as rosy as that. You got the architects to come in and have a look through your facilities to match it against presumably current standards. Then the inspection took place and you did not do as well as you thought. There is a gap there. Were you surprised at your low score? Were the architects using the wrong standards? What happened?

Mr Fullerton—Our architects identified what a lot of the last score did but we had already improved a lot of it. I guess I am saying that the first round of certification was not as good as it should have been. My board was operating thinking, 'Yes, we know; we can go.'

Ms Allanson—In the case of Maroba, we had certification in 1997 of our over 40-year-old nursing home. We achieved a very high score of 79. We believe that was accurate. We had followed to the letter every fire safety requirement and all other requirements. We had a refurbishment and corridors widened in 1995. This time around, we failed our certification with the free audit. We are spending tens of thousands of dollars making those improvements, yet the building was deemed to be safe by all the various authorities. There are things like the distance of a fire hose reel from the door; suddenly I fail on that. However, in 1997 it was installed under the advice of the fire department. That is now not adequate. I am not going to rip out the fire hose and move it because all fire training tells us that we do not touch the fire hoses anyway. Yet I drop a score on that. So there just does not seem to be a lot of sense as to how it has been approached. It has been confusing.

In terms of the long-term future of aged care or ageing services, this is the sort of thing that is strangling the industry. I guess that is the point I would like to put across today. We do not want to just whinge about the current aged care system. For us, we really want to be there for the long haul. We want to be there offering a quality service with quality buildings.

However, we are being strangled on all sides by bureaucratic process and various departments. They do not talk to one another. Only two weeks ago we had our accreditation. We did exceptionally well. We had a four-day audit across the nursing home and hostel. At the beginning of that audit by the accreditation agency, we had a call from the RCS validation team,

saying, 'We are coming to you this week.' We said, 'Hang on. We are in the middle of our accreditation audit.' They said, 'Well, that is too bad. Well, I suppose we could come the following week.' So we went from an absolute high, with staff morale lifted—it was great for our organisation—to the following week having 19 residents assessed; 17 of them, I am sure, would have been put down. We will not have the final result. That just results in, again, a drop in morale. There was no time to celebrate the great accreditation result. That department could not care less about morale yet the government keeps peddling out all these issues about work force and valuing and doing something.

The day-to-day wheels keep turning to actually turn people over. They do not actually move to enhance the system or build up the work force and the low morale amongst nursing and management staff. So that sort of thing creates a sense of failure within the work force, particularly among senior managers. It brings low morale and it places unrealistic expectations. I do not know of any other industry that has as much bureaucratic process as this industry. You can be an intensive-care patient and you will not have as much written about you as our people do, and they are not supposed to be patients. They are just residents. If the system continues in that way for the next 40 years, I do not care whether you are private, for-profit or charitable, there is a strangulation of the system because of the bureaucratic and administrative processes.

CHAIR—Do you have any alternative suggestion?

Ms Allanson—I think the departments need to talk to each other. There needs to be a genuine move from government policy and rhetoric down to a departmental level, where people actually act out of concern. We have seen a dramatic improvement in the complaints resolution scheme. We have seen Rob Knowles's involvement. Suddenly, dealing with complaints has changed. There is a more effective process, a more conciliatory process taking place. One man actually has the will to see it change because it has moved from policy to action, whereas in the other departments there is lots of talk and all these committees about nursing work force and morale, but they do not actually translate to the departmental level where an auditor can come in.

We are told that we have to rely on the aged care assessment team. Who funds that? The Commonwealth. Okay, the RCS validation team, also funded by the Commonwealth, comes to our organisation and says, 'Well, you can't rely on the 2624. You know what aged care assessment teams are like.' Yet we have to rely on them. If they say that that person is always incontinent, we have to rely on that to form the basis of our assessment and care plan. So there is contradiction all the time. The practical way of dealing with it is to get people heading up those departments that have a will to change.

Ms CORCORAN—I want to pick up the point you made about the validation. You talked about 17 out of 19 patients being put down. I assume you meant their scores being lowered.

Ms Allanson—We have not come to that yet. That will be seen, I am sure. We are talking about 40 years time.

Ms CORCORAN—It has been raised with us, but we will not go down that track at this point. To be serious about the point you made, though, if 17 out of the 19 had their scores lowered, again, that raises a question in my mind of whether there is an element of surprise in there.

Ms Allanson—Yes.

Mr Fullerton—Yes.

Ms CORCORAN—Huge surprise?

Ms Allanson—The way the validators come in seems to be different every time. When you master the system and get an understanding of what they want for the next time, they realise that. Then the next time there is something else. This time it was this triangulation of data. You need an assessment to say there is a care need, and then it needs to be on the care plan and reflected in the notes. That is quite a complex system. We are talking about untrained people doing these nursing records, assessments and care plans. You have one RN for, say, 35 people and seven or eight staff under them. So you are talking about untrained people. It is very complex.

This validator says to the director of nursing, 'Well, obviously you are going to have to go out at hand-over and direct the actual documentation.' Now the director of nursing, as you can imagine, is fairly busy in an 80-bed facility recruiting staff, preparing the accreditation, doing financial reports, doing rosters et cetera. She cannot sit in the three wards at hand-over directing how the notes are written. So there is an expectation that we have perfect staff, highly qualified staff, people with plenty of time that can actually get that triangulation of data right. They just physically cannot do it.

Ms CORCORAN—I have two more questions. Firstly, I was going to ask you about staffing, and you have moved very nicely into that. We are hearing from other people that staffing is a problem or an issue. Is that your experience?

Ms Allanson—Yes. It is a major problem.

Mr Fullerton—One thing is that my staff spend too much time on paperwork and not on caring. They all got into the industry because they had a genuine love for and concern about care for the elderly. Now we are starting to lose staff because they are doing more paperwork than actual resident contact.

Mr Byron—We have done some research on that. We are losing approximately one hour per day for every registered nurse purely supporting the RCS system. I am not talking about care plans or anything like that. They are spending one hour a day just writing up paperwork to support the RCS. They are our most valuable and our most expensive resources. That is why people are leaving the industry. That is not what they were trained for. They are there to provide the best possible care and they are constantly under scrutiny about their ethical stance regarding the levels of documentation they are preparing. The worst part about these RCS reviews is that when they do downgrade you, they go back six months. As not-for-profit organisations, we live from hand to mouth. If someone takes six months worth of funding from you, we have had directors of nursing offering their resignation because they feel just totally devastated. They feel responsible for it. They are doing their best. When you have those sorts of people just cutting your professional ethics to pieces, that is why we are finding all sorts of trouble retaining quality staff.

Ms CORCORAN—It sounds like you feel you are out of control in the situation?

Ms Allanson—Our director of nursing, on the Friday afternoon of this review, wrote up her board report. In that board report she articulated that the board needs to review her position because she was willing to hand in her resignation because of those results. That woman is an exceptional nurse and carer, an educator, a quality manager. She is everything, yet personally she took that on herself and said, 'Well, I think you should sack me because of that result.' There has been no fraudulent intent. If someone is trying to defraud the Commonwealth, they are not going to offer their resignation. They will keep thinking of the next best way to do it. These people are genuine in their endeavours. Yet the week before we had a team of two people come in and say, 'We can see that the care is being done here. The place doesn't smell. Everybody is in clean clothes. There are no mucky eyes. Everybody looks fantastic.' Their skin integrity is what they haven't seen in a long time. Yet we then get people come in and say, 'You are not writing this care up properly so you can't possibly be giving it.'

CHAIR—How often does the accreditation team visit your facility?

Ms Allanson—Every three years.

Mr Fullerton—If you get three-year accreditation.

CHAIR—So that would be a very unusual circumstance to have the accreditation team there during the same week as the RCS team?

Ms Allanson—Yes. But the Commonwealth knows when they rolled out accreditation. They know when they rolled it out.

CHAIR—I understand. I am saying that they are there for one week or four days every three years, if you have three-year accreditation. Your facility has three-year accreditation?

Mr Fullerton—You will also get during your three-period two site visits and a number of phone contacts as well to make sure that you are still—

CHAIR—I understand.

Ms Allanson—Then you have state health, the NRB, if you are an enrolled nurse training provider, and local government. Everybody is inspecting you all the time.

CHAIR—I see.

Mr Byron—I am actually an assessor who works for an agency. There appears to be a fundamental schism. Part of our role as an assessor is to ensure that the service has in place systems to guarantee that the relevant care and management systems are in place. I think that is a very strong system and works well. We accept it as a valid assumption that if the service has adequate systems in place, it is delivering the care. Then we have this other argument brought to you by the RCS validators who are now questioning the whole system and saying, 'It's regardless of whether that system is working to deliver care and you are maintaining your organisation properly.' The RCS validators are coming from a completely different angle and they are questioning the systems which the assessors have just said are working properly. That makes it totally dysfunctional.

CHAIR—I can see how frustrating that would be for an operator.

Ms ELLIS—How often do the validation teams come in?

Ms Allanson—Whenever they like.

Ms ELLIS—What notice do they give?

Mr Byron—Five minutes.

Ms Allanson—They rang us on the Monday to say they were coming on Thursday and Friday. We managed to put them off until the following week. Naturally, you do not know who they are going to assess until that morning. Then you only get told who they are going to do that day. Then the next morning you get another list; and the next morning you get another list.

Ms ELLIS—Is there any rhythm at all? Can you assume that they are going to come in and assess the dozen most recently accepted residents, or is the way the residents are examined purely ad hoc?

Ms Allanson—They say it is ad hoc. But it keeps coming up that they randomly select all the ones that are a couple of points over the next level of category.

Ms ELLIS—And how long have the validation teams been visiting? When did they first visit?

Ms Allanson—They have been visiting for years.

Mr Fullerton—Since 1997.

Ms ELLIS—They came in at the same time.

Mr Fullerton—Having said that, our facility has not had a validation for two years.

Ms ELLIS—You have not had anybody come in and do this for two years?

Mr Fullerton—And we are on tenterhooks because we are expecting a knock on the door any time.

Ms ELLIS—You might not be able to answer this. I am sorry I was not here when you started. You are all from three different provider groups. Can you give us any indication as to the range or percentage of withdrawal of funds that you have received as a result of the validation process?

Ms Allanson—In our hostel last year, we probably lost $14,000 in one audit. In a small hostel, that is very significant. That is two-thirds of a person's wage.

Mr Fullerton—It is a staff member.

Mr Byron—I can give you one—Toronto nursing home. They might not be dead accurate. It is an 80-bed nursing home with a $55,000 pull-back.

Ms ELLIS—In one go?

Mr Byron—As a result of a validation.

Ms ELLIS—Do you have anything to add to that?

Mr Fullerton—The first one we had, we had five pull-backs and that cost us about $10,000.

Ms ELLIS—When you say that they go back six months, can you explain what you mean by that?

Mr Byron—That is the legislation.

Ms ELLIS—Does that mean they take money back that you have already got?

Ms Allanson—Yes.

Ms ELLIS—I want to get on the record what you mean by that.

Mr Byron—I pointed that out a little earlier. As I understand it, as I said before, we live from hand to mouth. We have spent that money. About 70 per cent of our expenditure relates to salaries and wages. We have to pay our staff. We have to pay our suppliers. In the Toronto nursing home case, we then had to find $55,000 to balance the books.

Ms ELLIS—That you have basically spent?

Mr Byron—That money had left Anglican Care. It was already spent and had been pushed back into the community.

Ms ELLIS—Again, apologies if you have already answered this, but I want to get this on the record as well. When the validation team comes in and sits down with the staff, the senior nurse or whoever, let us say that they go through 12 residents. They do not see one of those residents?

Ms Allanson—No.

Ms ELLIS—Fascinating, isn't it?

Ms Allanson—It is fascinating. Everything else in the quality systems is outcome based yet the RCS is not outcome based.

Ms ELLIS—Is it a box ticking exercise?

Ms Allanson—Yes.

Ms ELLIS—Virtually?

Ms Allanson—To actually make the claim.

Ms ELLIS—What about the validation?

Ms Allanson—No. They read through all the notes and try to fathom what they can. We are dealing with an imperfect, untrained person.

Ms ELLIS—They certainly do not see any of the residents they are validating?

Ms Allanson—No. In fact, the validator last week said, 'I was almost tempted to look at this resident.' I said, 'Well, we wish you would. You will see what we're actually doing for her.'

Mr Byron—I will go back to the accreditation process. Under the accreditation process legislation, the assessors have to see 10 per cent of the residents. So we have just got these two systems. They are so dysfunctional that it is just ridiculous. As you did an assessment of an aged care facility, you must speak to 10 per cent of the residents as a minimum to find out what they think—

Ms ELLIS—That is for the accreditation process?

Mr Byron—The accreditation process. Yet, as I say, this RCS validation process seems to be working totally against what the accreditation process is about.

Ms ELLIS—We assume you are all putting submissions either independently or through ACS into the RCS review?

Ms Allanson—We do not have time. We would all love to do submissions for everything, but we just do not have the time.

Ms ELLIS—But all these sorts of comments are going into the general peak body?

Mr Byron—Yes.

Ms Allanson—I go back to the intensive care example. You show me which intensive care unit lost funding because the nurse did not put down exactly what she did according to the care plan. You tell me which one, and there is not one in this country.

Ms HALL—Within the validation process, once a resident has been downgraded, then you can request that it be reviewed. What percentage of residents when they are reviewed are returned to the previous level? Of those that are returned to the previous level, what percentage of them are assessed again in the validation process maybe the next time around?

Ms Allanson—When this person said, 'I was almost tempted to look at this lady,' she has appeared because she is a category 1 and now will be a category 2 or 3. Every time there is an RCS validation, her name seems to come up randomly. Each time she is put back down. Yet she is absolutely a 1. She is in our secure dementia unit. What was the first part of the question?

Ms HALL—Those that go to review.

Ms Allanson—A lot of facilities actually do not have the heart to appeal. Whilst we desperately need the funding, I think it would break the heart of our director of nursing to have to turn around and try to claw back the money from the Commonwealth that the Commonwealth clawed back from us. It is again another level that is just so hard. I know Denis's organisation has done it and really fought tooth and nail to get one or two back.

Mr Byron—Again, it is focused against the operator. I am not sure of the time frames, but we have something like 24 days or 35 days or something like that to appeal the validation. We then go to the Administrative Appeals Tribunal, and we wrote to them after 108 days and said, 'Could we please have a response?' You just think, 'Is it worthwhile? What is the opportunity cost of doing that?'

Ms ELLIS—That is through the AAT?

Mr Byron—I am not sure of the time frame, but it just took so long. We are lucky that we are a large organisation. We run three nursing homes and eight hostels. We can do that. But some of the smaller operators just do not get that opportunity.

Mr Fullerton—We could not.

Ms Allanson—We could not.

Ms CORCORAN—Once someone has been put down—your terminology—

Ms Allanson—A category change.

Ms ELLIS—Downgraded.

Ms CORCORAN—To apply for a review, do you have to go through the AAT?

Ms Allanson—You can appeal back to the department. That is very time consuming and stressful, particularly if you get knocked back. It just keeps knocking another layer off the morale.

Ms CORCORAN—Your DON might find it reassuring that you are backing her up by appealing, perhaps.

Ms Allanson—Well, it is her call, as to whether she feels that she has the energy to do it, the time to do it and the data to do it. But it is just like saying, 'Well, you've got us.'

Ms CORCORAN—So where does the AAT come into that process? Your first appeal is back to the department?

Ms ELLIS—Back to the department.

Ms CORCORAN—Then you go to the AAT?

Mr Byron—That is exactly right.

CHAIR—And then the Federal Court?

Mr Byron—We have not got that far.

CHAIR—But that is a possible area?

Mr Byron—Yes. But by the same token, the commitment of resources to tackle something like that far outweighs the benefit and the time.

Ms CORCORAN—I want to move on to something else that is totally different. There is this formula of 50:40:10. I have forgotten which is high care or low care or which way around it goes. If you could just wave your wand now, what would your formula be?

Mr Byron—I will kick off first. Ten people for every 1,000 over the age of 70 for community care packages is absolutely ludicrous. It is totally inadequate. The Hunter got 40 community care packages in the funding round in 2002. I guess you are looking at the two large ones because Andy got 10 and I got 10.

Mr Fullerton—And I got 10 under the national.

Mr Byron—For all of the Hunter, that is just ridiculous. To put up the Chinese wall between high care and low care and say 50:40 is just ridiculous. That has to be removed. We have to talk about community care and residential care. With respect to the amount of administration that goes into making our system more dysfunctional by looking at hostels and nursing homes as different services, we are wasting so much money on that. You have to get ACAT approvals to go from a hostel to a nursing home. It is just ridiculous. I do not have the numbers in front of me. The number of high-care residents in what we call hostels or low care is increasing. I do not have the percentages, but it is becoming high. We need residential care and community care.

Ms CORCORAN—You have residential and community care. Now give me the proportions.

Mr Byron—I will hand over to Viv.

Ms Allanson—We do not do community care only because we are a small provider and I keep getting the sense that we would have a lot of trouble getting it within our area. I do not apply, so I do not give a lot of thought to the numbers. But I know that it ought to be increased.

Mr Fullerton—I think you indicated earlier that you wanted more local council input into planning regions. I feel that is where you would get more information on the numbers. As I said, we were successful in getting 20 community aged care packages. I know in the Maitland local government area we will have no problem filling them once we can get up and running.

Ms CORCORAN—But that is a number thing. I am talking about percentages.

Mr Fullerton—But the local government would have more input into the actual specific needs in the areas for community care.

Mr Byron—Can I venture a number. On a gut feeling, there are about 75 per cent community care packages. That is going to be the area over the next 40 years. You heard Professor Byles talk about more and more people wanting to stay in their own homes. There is no doubt about that. The people moving into residential care will be those people suffering from lots and lots of morbidities or behavioural problems. Frail and aged people will not be able to get into residential care facilities. That is just going to be the nature of the beast. But community care is going to be so in demand because people are going to be living in the community with increased disabilities, increased ageing and those things. So I am thinking 25 per cent.

CHAIR—Obviously we have received a lot of comments about the 50:40:10. One of the issues we face in the next 40 years is that the actual numbers of people over 85 are going to quadruple from about a quarter of a million to over a million. It is thought that that group is likely to be high users of residential aged care. I suppose the Treasury's best guess is that, in terms of community care and residential care, the proportions of the economy that we spend on them will double in both cases. Both would obviously grow. I thought I would add that in there. We can say that the growth should be all in community care, but in the future there will be many more people over 85.

Ms Allanson—I think it is going back up—that need for community. But we need to be flexible in how that is delivered. In our facility, I would like to knock over our nursing home, build a ground level nursing home with apartments, like self-care or assisted living apartments three or four storeys high. I suggested to a representative of the Commonwealth that I would like to deliver care services upwards instead of having all the costs of running around in cars and time lost on the road and workers compensation issues et cetera. I would like to have an efficient service. I was told, 'Oh, no. We couldn't support that. It would be a monopoly if we funded you to provide services within your complex.' Four weeks later, I see they are now having a pilot of community aged care packages within retirement villages, which is what I was getting at. I thought that made good sense for the future.

People do want to have community care and live in their own environment, whether that is buying into a residential or a self-care unit type environment, be it a terrace, a house, a villa or an apartment. Whatever it is, that is still a flexible house and is still delivering to the community. It just happens that that community is on top of a nursing home, where they can then follow ageing in place within the same building.

Ms HALL—I want to be very clear in my mind about the high care and low care. What you are advocating is streamlining it and not having high care and low care but just one level of care?

Ms Allanson—That is right. Residential care.

Ms HALL—The other issue that I want to raise in relation to that is whether you think residential care should be assessed separately from the community care packages. That would move you away from the need to have 75:25 and 50: 40: 10. You would have two separate categories, each looked at on a needs basis.

Mr Byron—Yes. I think we would support that. People who live in the community have different support mechanisms. How the ACAT team goes through and assesses—I am not sure of the numbers in the Hunter—is just not perfect. We are the victims of that lack of perfection

sometimes because people will tick a box to get them into residential care for the sake of getting them in there. It is probably not the best place for them to be. They could be supported better in the community.

Mr MOSSFIELD—I am trying to project into the future a little. We know there is a major difficulty in funding aged care. All we are talking about now is staggering through and staggering on. I cannot see any suggestions about how we will catch up. Do you have any ideas of what we have to look at since we are looking at a 40-year plan? Is there any chance that people can invest in an aged care facility in advance before their needs are there so that when the needs do come they can move in? Perhaps there has been some additional finance put into the establishment in advance.

Ms Allanson—I think that would be wonderful. What we want to see as an industry is genuine innovation that is not capped and strangled all the time. We want to be here. We are a small facility. I am going to be marketing Maroba as a boutique facility because I cannot compete with the big guys. We are going to market ourselves as something unique. I want to be innovative and flexible and I do not want to be strangled at every turn when I try to do something. I would like to do things like that. Where a user can pay, I would like to let them pay so they can have a choice. Until you are 55, you should have choice and the community demands it. But when you become a retiree, suddenly, if you do not fit into that box, that is too bad. We have people coming into our nursing homes that want to pay but we cannot take a bond. But they want to. They are willing to do anything to get in there, but we cannot do that. If there are means of prior investment or whatever, I think we would all be willing to look at it.

Mr Byron—The other thing, particularly in residential care, is that we must have a lot of work done in our nursing homes to meet the 2008 certification standards. There is no capital funding coming for those things. They are going to be significant for all of us. Yet, as Viv said, there are lots of lots of people that are in high care or nursing homes that are willing and able to pay what we would call accommodation bonds in hostel or low care but legislation prevents us from charging that. We desperately need accommodation bonds or access to capital to be able to maintain our nursing homes.

Ms Allanson—I need $12 million to rebuild my nursing home and I do not have it.

Ms HALL—I have two questions. You have made a lot of comments about the ACAT team. Would you like to expand on that and share with us some of the issues relating to the ACAT team and how it impacts on you?

Mr Fullerton—I operate under a different ACAT team from Viv and Denis. I operate under the rural ACAT. One of my bugbears since coming into aged care six years ago is that the ACAT can assess somebody as requiring residential care.

When they come to us with a valid 2624 and we do an RCS on them, we find that they are an 8. That suddenly means we have no funding. Yet the ACAT has been able to say that they require residential care. My concern is that there are two different assessment tools. We assess under the RCS, the resident classification scale. The ACAT assess under a 2624. The two do not marry up. The local rural ACAT is responsible for as far away as Murrurundi, Dungog, Cessnock, Tuncurry and Maitland. There are not many staff. Because we are practising ageing in place, when we have somebody who we assess under the RCS as going to a 4 or higher, we

need to get an ACAT reassessment to assess them as high care. Currently, I have four residents waiting for reassessment. We have assessed them as 4 or greater. Because we have no ACAT person able to come in to do that assessment, we are losing money because the department is only paying us at a 5 or their previous classification. From my point of view, I feel that the local ACAT that looks after us is understaffed, overworked and assesses on an inappropriate basis because of the tool they use.

Ms Allanson—My concern is that we can keep arguing about and being critical of the aged care assessment teams but they can only be as good as they are funded. But that has an impact on the future. That is my concern today. We keep getting back to the future. If we continue to stay with a system like this that just does not marry up in any way and is inefficient, that is just going to remove resources from us for the future. We want to build for the future, not just worry about yesterday and today. That is what the ACAT seems to do. It just cripples us. There are some wonderful people in ACAT. As I said, if they are underfunded, they cannot meet the objective of the Aged Care Act.

Ms HALL—You briefly touched on work force issues. I understand that there are a number of work force issues within your organisations. Would you like to expand on them across the whole range?

Mr Byron—One thing we are identifying is that there is a lot of collegiality between the providers in the Hunter. We are finding it bit bizarre, with levels of unemployment higher than the national average, that we are struggling in the Hunter to find an adequate work force. I think eight of us have banded together to create what we are calling a Hunter employment strategy person for aged care. It is basically a job. We would like to do it in conjunction with the university to remove some of the negativity that surrounds aged care as a profession. We are competing very hard for registered nurses in particular. There are sharper employment opportunities for them in a public hospital system and the acute care system, and the aged care system has not been marketed well. That is one thing we are looking at. That is one thing that we are working on. We have another meeting just to develop that strategy.

The other thing we can do—these guys know about it—is train the long-term unemployed. Some of these people have been unemployed for 12, 15 or 18 months. These people will be trained. They are not qualified but we sink training into them. There is an opportunity there. We have recruited over 20 people over the last 12 months who have been long-term unemployed. They have been put through courses that run up to about 14 weeks. We have set up strategic alliances with Salvation Army Plus. Those people are the most loyal and dedicated employees that we have. If they have the dedication, the enthusiasm and desire, we will give them the skills.

But remember that these people get paid only about $12.54 an hour. That is a pretty tragic wage. We deal with those sorts of things. It is awfully hard to try to get people off the unemployment mentality for $12.54. It is a big thing. We have had a couple of issues. We have lost some people because it is easier for them, given the rates we pay, to look for alternative employment at Coles and Woolies, and that is a real shame.

We now also have to look at their employment and their literacy. Viv was talking about the RCS. That these people have the ability to read and write coherently, meaningfully and succinctly is something that I as an employer have assumed. When the RCS validators come

through and say, 'You haven't written the right word,' that can actually mean a reduction in funding. We might have put, 'I placed the knife in their hand' rather than 'assisted them to cut the meat' or something like that. That is what it comes down to. They are some of the employment strategies that we are looking at and we are sharing them across the Hunter.

Ms HALL—Can I just put in a word for the Two Bishops Trust. They have just started an AIN course at Windale. They are 35 women who are long-term unemployed and hopefully will be a source for the industry.

Mr Byron—I might hop on a hobby horse. Again, it will come back to transport for a lot of these things. We require these people to be working in our nursing homes and facilities at six o'clock in the morning. I do not know how well you know the geography here, but people living at Windale have to get to Viv's organisation at Waratah or Andy's at Maitland by six o'clock in the morning.

Ms ELLIS—A big disincentive.

Ms HALL—Certainly it is a big disincentive.

Mr Byron—I guess the lack of transport infrastructure creates problems for those sorts of things because of the times at which we need these people to start work. We have lots of employment opportunities. We can employ them on a part-time basis. It fits in with their other responsibilities.

Ms ELLIS—I am conscious of the time. I have two very quick questions. What about spot checks of facilities? Can each of you tell me how you see them and how often you have had them?

Ms Allanson—By the Commonwealth or the state?

Ms ELLIS—By the Commonwealth.

Mr Fullerton—We have not had them. I have heard of one facility in the Maitland area that had one. It was not very nice.

Ms ELLIS—Anybody else?

Ms Allanson—We have not had a Commonwealth spot check.

Mr Byron—We had one from the accreditation agency as a result of a complaint.

Ms ELLIS—Other than that?

Mr Byron—No. Probably we have more of a problem with the state Department of Health with the spot checks.

Ms ELLIS—What about the benchmark of care? What is your opinion on the need for a benchmark of care in facilities and in CACPs packages? Do you think we should have two different types of benchmark of care, one for community care and one for facility care?

Mr Byron—I think community care will move towards an accreditation sort of process because there is no accreditation for that at the moment.

Ms ELLIS—But a benchmark of care as well?

Mr Byron—Yes. It will have to come. We need to know that we are delivering a good service. I need to compare with Viv and Andy. We do that in the Hunter. I do believe it needs to come. It is not the solution. It will tell us each area we need to look at as managers and will not give us the solutions, but that is fine.

Ms ELLIS—Do you see it as an indicator of funding as well? At the moment, money is put into aged care with no benchmark of care, which is like the cart before the horse in some people's minds. Whereas if you have a benchmark, then you say, 'There are the numbers. That is the level, the minimum level,' and fund accordingly the other way. Is there an implication there?

Ms Allanson—There are implications whichever way the system goes. While people are working towards a benchmark of care, they can often be putting in more resources than those who may have already achieved that benchmark of care. So their funding might be reduced because they have not yet reached it. Yet in principle we would like to see a benchmark of care that is funded. But the scary point there is: who is going to say how much would be funded? The way we are funded now is an absolute farce. If a benchmark of care is set and then there is this farcical funding again, we are in a situation that is no better.

Ms ELLIS—Okay. But we agree that there should be a benchmark for facilities and for community care?

Ms Allanson—Yes.

Ms ELLIS—Thank you.

CHAIR—Any further questions?

Ms ELLIS—I have one comment. What I would like to see over the next number of years is a national program that would value aged care facilities as having a significant role in the future needs of older Australians. There needs to be a national valuing—not just a few election-time pieces of rhetoric flying around but real, genuine community or public education and awareness that it is a valuable service. It should not be a case of saying, 'Oh, you have never sent anybody there.' Until that occurs we will always be fighting an uphill battle to attract quality people into this sector and keep quality managers in this sector. I think it would be really valuable to have a national promotion.

CHAIR—Thank you very much.

[12.09 p.m.]

DUNN, Mrs Laraine (Private capacity)

CHAIR—Welcome to today's public hearing. Do you have any comment to make on the capacity in which you appear?

Mrs Dunn—I am here to help to promote exercise as a way of implementing positive ageing strategies for the next 40 years.

CHAIR—I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of the parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Mrs Dunn has made a submission to the inquiry, submission No. 124. Copies are available from the committee secretariat. Mrs Dunn, would you like to make an opening statement before I invite members to proceed with questions?

Mrs Dunn—I will just read this statement. Healthy ageing encompasses far more than health promotion. It includes infrastructures necessary to facilitate and promote older people's participation and independence, including access to transport, housing and a capacity for necessary employment, education and community services. The current older generation is different from their parents and from any previous generation of aged people. The current aged society is pioneering a new social and political structure, questioning image and status.

Research suggests that the provision of specialised exercise programs appropriate to the needs of seniors will enhance their capacity to live a full, healthy and extended life. Links have been established between exercise and positive ageing. Exploring the importance of these links is required in planning for the health of the ageing population. Recognition that exercise is beneficial to older people is fairly recent. Studies are needed to record interactive explorations of how older people who exercise see themselves and are seen by others in relation to ageing, exercise and empowerment. Telling their own story about the lived experience of exercise in older age by older people themselves will add to the knowledge of how older people live their lives in an increasing older population in a rapidly changing society. This will identify what individual, community and government actions can be taken to facilitate change towards positive ageing and proactive health policy strategies.

Infrastructure needs to be implemented for the provision of exercise programs for the facilitation, education and promotion of healthy ageing. People's cultural and linguistic backgrounds are crucial elements to be considered in determining appropriate healthy ageing strategies. There are some categories of people within Australia who require special attention to facilitate healthy ageing. Strategies need to be developed for the implementation of instructor training and education for the fitness industry and consultation for the health services industry.

Older adults need to participate in exercise programs designed to extend their physical and psychological boundaries around ageing, to change dominant perceptions and images of ageing, to provide a role model for other older people and to promote quality of life. Far-reaching implications are that it provides physical, social and psychological challenges and choices with

the possibilities of positive improvements and changes in the participants' lives. Ageing is a natural lifecycle process, and proactive health services are vital if there is to be wellness throughout the lifecycle. My work with seniors is towards positive changes of health at a personal level, and the growing concern at a community level about finding ways of enabling older people to enhance their capacity to stay wealthy, independent and maintain quality of life. The impact of exercise on ageing is dynamic, proactive and positive, yet hugely underestimated in its potential for improving and maintaining longer, healthier and more productive lives of all older Australians. By bringing in exercise programs that are appropriate to all facets or all parts of the ageing population, the government will save not millions but billions of dollars.

CHAIR—Thank you very much. I will start with questions. In the fourth paragraph, you quite correctly say that it will require individual, community and government actions. Does something like Active Australia have any relationship to older Australians?

Mrs Dunn—Active Australia encourages all Australians to exercise. Their strategy is put together by government bodies to encourage all Australians to exercise, so it does not specifically target older Australians but blankets everyone.

CHAIR—Are you seeing as a practitioner and fitness leader any benefits on the ground? What is the current state of play at the moment?

Mrs Dunn—There is a groundswell from older people themselves. They realise that if they are going to age and age well, they need to start exercising. There is promotion and education out there by way of advertising et cetera. Governments and councils are realising the cost that is going to be involved. They are now putting together some sort of facilities and promotion to encourage people to exercise. There is a groundswell from the fitness industry, which will actually be the main provider. There is a groundswell there because business owners in the fitness industry realise there is a huge market out there to tap into. So they are now changing their attitudes and developing programs and making older people welcome in their facilities. They are removing the barriers to the older person and to exercise. That is slowly changing, which is great to see.

CHAIR—I agree with your submission about the benefits of exercise being enormous. What do you see as the role of government in this? What do you think is the role of the industry?

Mrs Dunn—The role of government is, in my opinion, to implement models of exercise that can be distributed to every residential or community care facility. There are so many stages and ages of older age but there are very few ages to which exercise is not appropriate. We need to actually identify all the different stages of older age. You have the fit, active and well older people. They are still out there. They are able to go to a health centre and participate in the general community classes. Then you have people with disease and special needs who may be well but they may have a chronic condition such as diabetes or heart disease. You need to have programs available for them. You need then to have programs available for the frail, who are in nursing homes and who have conditions where movement may hurt them. It is still beneficial for them to exercise, so they need to have programs available to be designed and then implemented for all the varying ages and stages of older age.

Ms CORCORAN—It seems to me that many older people have many things to contribute to society.

Mrs Dunn—Absolutely, and we are not actually taking advantage of that.

Ms CORCORAN—I am wondering if you see a role for government or some organisation in actually making us aware that we should be using those experiences of older people and the work they can still do in the community.

Mrs Dunn—Definitely. I see the government's role as possibly setting up satellite stations throughout Australia where the needs of the older person are really looked at, such as isolation. Exercise classes and exercise programs are a positive way to get older people together, whether they can or cannot participate or whatever level they participate in. They come along and they are supported by other people who encourage them. They are with like-minded people. An older woman who is widowed may spend something like 76 per cent of her time alone. For her to actually go out and take part in the community where she has a voice, she is listened to and heard, that is also part and parcel of positive ageing. Those satellites need to be there. The government can look at the whole package of what an older person needs—physical, psychological, mental et cetera—so that they are challenged, so that they learn new skills, so that they are accepted, so that they can grow and still feel that they are contributing. Healthy ageing is about all of this. Does that answer your question?

Ms CORCORAN—It goes part of the way, thank you.

Mr MOSSFIELD—Apart from straight-out exercise, which sometimes people find boring, what other activities would you recommend to the older community that might be beneficial to their physical condition?

Mrs Dunn—Exercise is seen by the general community in a physical box. Exercise is movement. Activities could involve actually taking your senior participants away on a fun weekend, where the whole structure is around a 7 a.m. gentle exercise class, and then they might have a kids' game where they realise that, despite being older, they still need to maintain a sense of having fun. A lot of older people stop having fun because they think that they are not being responsible or they are not caring. So it is still having access to fun. Maybe in an older person's life there is not the opportunity to have fun or to actually play. How many people do you know who are still actively playing? They seem to think they have to have structured exercise, but not the fun, enjoyment, play and sense of activity.

Examples of activity include the health camps that were notorious in England in the 1960s. It is about having facilities like that available where an older person can go, where they actually play and have a sense of achievement, where they are given opportunities to come out of their comfort zone, such as going down a flying fox or a water slide and are given opportunities they do not usually have. Things like that could be set up within older people's groups. Possibly things like that could be run from time to time with accredited staff who provide safe, effective and fun programs that add to the quality of life of older people.

Mr MOSSFIELD—I had someone mention to me the other day that people in their 70s climb the Harbour Bridge.

Mrs Dunn—Absolutely. So encouraging older people to actually go out—

Mr MOSSFIELD—Innovative types of activities, yes.

Mrs Dunn—Absolutely, so that they are being challenged all the time.

Ms ELLIS—When we are talking about exercise, we know what we mean. But I am sure you would agree that we mean mental exercise as well. Other people have talked to us about what they term lifelong learning. The best example, I guess, in the most obvious way would be U3A.

Mrs Dunn—Absolutely.

Ms ELLIS—Do you have a view on how much better we could promote and resource that part of exercise?

Mrs Dunn—Using a similar model to U3A?

Ms ELLIS—U3A or anything else, for that matter, that comes to mind.

Mrs Dunn—U3A actually do involve some of their older participants or members in running gentle exercise classes, yoga classes and tai chi. So they are already doing things like that, which is great to see. It is older people being taught by older people.

Ms ELLIS—Do you see mental activity as being almost as important as physical activity? Need it be through something as formal as U3A, or can it be through other means?

Mrs Dunn—It can be through other means. Exercise is part of the package with mental wellbeing that goes to the whole wellness. Exercise is only one small part. There need to be programs that encompass all of mental wellbeing. If somebody comes to an exercise program, they learn, by mastering a move, a sense of achievement. They are learning a new skill. That in turn gives them a sense of achievement and a sense of purpose. But exercise is one part of total wellness.

Ms HALL—Thanks for your presentation and for the excellent submission that you have sent us. It is very good. You have a long background working in the industry and working with older people and not just in the area of exercise.

Mrs Dunn—That is correct. I was actually involved in a research program with Dr Arn Sprogis in 1987. As a result of experience there, I decided to change direction and take up a new career. In my very first class, a lady was there who had emphysema and lymphatic cancer et cetera. She would go home and ring her family and say, 'I have been to aerobics.' The learning for me was that it does not matter at what age or stage of life you have reached; you still need a sense of achievement. From that point in 1987, I realised that exercise was not in the physical box. The fitness industry is slowly realising that as they are working with older people on exercise. They realise how rewarding it is.

I then became involved with the training of fitness leaders. Now I am doing a PhD on the promotion of proactive health measures and perceptions of ageing. That is where I am at. I was awarded National Fitness Leader of the Year a couple of years ago for the contribution of actually widening the horizons of the fitness industry from just the body beautifuls in the lycra

and the image of health and fitness to include the whole community. Older people are out there and they need to be working their bodies.

Ms HALL—You are part of the Hunter area health service team. The programs that you run are accredited programs?

Mrs Dunn—That is correct.

Ms HALL—Tell us a little about the programs.

Mrs Dunn—Hunter area health has an Active Over 50 program. The aged education team see their role as providing support for instructors. So we provide more specialised training and in-house training at subsidised cost to the instructors so that in the fitness industry there is the actual accreditation of what you need to do and how to teach safe and effective exercise, but it does not encompass all the needs and population groups out there. So the Active Over 50 in Newcastle, in the Hunter area, is supplying services that actually educate the instructors in practical work and in theory. We supply a newsletter. We try to cover all the issues like insurance, accreditation, being not accredited and within a class having to address so many various aspects of health, wellness and disease so that each person in that class can go away feeling a sense of achievement and feeling that they have a right to be there regardless of their health. So we are a support system. We educate and we try to promote Active Over 50 in a way that benefits everybody.

Ms HALL—I will move a little towards what you were talking about regarding exercise not being in a box. That is a whole of life, whole of person approach that you take. It is looking at breaking down stereotypes, looking at health outcomes and looking at the socio-psychological issues associated with that. Would you like to expand on that a little for the committee, please.

Mrs Dunn—I guess, working with older people, when I first started there was very little information out there. My whole learning about exercise and older people has been from them. We would try something. If it did not work, we would go back to the drawing board. I have come to realise that exercise is not just moving the body. It is tapping into an older person. They come to the class. They realise that not only are they now learning to appreciate their body; they are learning to do new things. They might come along feeling that they are older and they do not have a lot to offer, but a lot of programs now realise the value of an older person or they teach that a leg that may have varicose veins and a wobbly knee is far more wondrous than a shapely 18-year-old leg that has only done a little bit of mileage. It is not only learning about the physical things; it is learning that bodies are great regardless of the age and stage and valuing their own lives and their own bodies and taking responsibility.

A lot of older people realise when they start to exercise that things do change. Doctors are in a really difficult position. They deal with people to cure whereas exercise and health need to come in as a prevention or to actually delay or change. When a lot of older people start to exercise, they are able to use things again that they have not used for a long time. With that comes a valuing and an empowerment. They learn new skills. So it is the skill making as well. It is not just physical. They learn about coordination. They learn that they feel better about themselves, that they can take control, and they are able to then actively participate in their own life, which is a great learning curve. You see older people come along. After a few months, they

go out and they really find a new purpose in their lives. There are not many things for an older person that can impact on their life quite as powerfully as that.

Ms HALL—You have spoken to me before about growing old disgracefully. You might like to share that with the committee.

Mrs Dunn—There is a perception of how older people should act and behave. That may be governed by their culture or their belief system or mindset. It might be influenced by their family. Sometimes you could be at a wedding. Grandma is up there doing the chicken dance and the family will say, 'Oh, mum, act your age.' So people then come back and think, 'How should an older person act?' An older person should act the way they want to. If they want to run around in a circle and blow bubbles and be silly, being silly and being childlike is being different from being childish.

You see people in the supermarkets. They have the gold lame tights and the little gold slippers and the fluoro cashmere top and the fluoro tangerine lipstick and the shock of orange hair. If an older person wants to be like that, why should age be the deciding factor? It should be a matter of taste, not age. We put older people in boxes because we perceive they should behave in a certain way and dress in a certain way. It should not be age that determines that. If they feel like doing that, if they feel dynamic and bright on the outside, they should be able to express it without being judged. I think that is where a lot of barriers come in with regard to ageing. We keep older people down. They should be allowed to act disgracefully if they want to. Why shouldn't an older person wear a G-string? Why should they not be so proud of their bodies, of the lumps, the bumps, the wrinkles and the varicose veins? Their body is far more wondrous than our perceived beautiful 18-year-old. Why shouldn't they wear a crocheted bikini or whatever? Age should not be the deciding factor.

Ms ELLIS—Finally, you mentioned research. In what areas do you think there is a need for research? How would you like to see that funded?

Mrs Dunn—There is a lot of research out there. It has been going on for a little while. It is quantitative research, where we are measuring. We are still learning how fast an 80-year-old can swim and how far. So that is the quantitative research and it is out there and there are long-term studies going on. There is not a lot of qualitative research out there on older people and their stories—how they feel about ageing, what effect that has had on their life. So there needs to be qualitative research on older people and what their perceptions are of every single issue that you have heard about this morning and that you are hearing about in all your committees. We need to hear what the older people's stories are, how they feel about things and what they would like to see happen. There needs to be qualitative research.

CHAIR—I want to ask a couple of further questions. In your view, how can training be facilitated for fitness instructors?

Mrs Dunn—The fitness industry is fairly new in that it is probably only in the last 20 years that accreditation has become necessary or valid. The fitness industry is on the verge of a huge new wave. There are two sorts of people in the fitness industry. There is the person who goes and takes a class and teaches a class and then fits it in with the rest of her life, such as a young mum or a university student. Then there are other people like myself who actually then turn it into their business. So you have lots of levels in the fitness industry. Because there is not a lot of

long-term or full-time work, the cost of accreditation is huge. Possibly you could subsidise accreditation. For example, for a nurse in a nursing home or an occupational therapist to teach exercise, getting training and quality assurance for them is probably quite expensive for one class or two classes a week. Those problems need to be addressed. The government could address that possibly by having a model that is written for all the different levels and stages. People in the community dealing with older people have access to that training.

CHAIR—Lastly, I wanted to ask how easy you find it to get information from government departments about the funding and support that is available.

Mrs Dunn—I think on the Internet there is quite a lot of information out there. As far as funding goes, I personally have never received any, even though during the last 16 years I have been totally learning and promoting and training and educating, simply because I am deemed to be making a profit. I am earning money and it is my income, but with respect to funding, it is not that it has been denied, but I do not meet the criteria because I am deemed to be profit making. With Active Over 50, we have just applied for funding. So it is quite a fine line.

CHAIR—Thanks for that.

Ms HALL—There is the issue of insurance. I know in this area it has been quite an issue. Public liability is being denied to organisations where people aged 70-plus have been involved. Would you like to talk a little about that.

Mrs Dunn—The fitness industry has supported accredited and registered instructors by providing insurance policies. But in my experience I have recently had to leave a church hall that I have had for the last five years because they no longer wanted me to use the hall because of insurance. They may be sued. I have $10 million public liability insurance—I had to increase it from $5 million to $10 million—to use a public hall, and $5 million public indemnity. I tried at least 17 different venues, such as RSLs and other halls that are available in the community that are vacant. They are only for their members, because of the insurance.

CHAIR—Are there any further questions?

Ms ELLIS—No. That was terrific.

CHAIR—Thank you very much. I wish to thank all of the witnesses who appeared before the committee today.

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

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 12.39 p.m.