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Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

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

FRIDAY, 7 MARCH 2003

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Friday, 7 March 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 Hall, Mr Hartsuyker 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 9.00 a.m.

CHAIR—I declare open this fourth 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 the Department of Employment and Workplace Relations, the Aboriginal and Torres Strait Islander Commission, the Australian Medical Association, the National Aged Care Alliance, the Australian Nursing Federation, Carers Australia, the National Rural Health Alliance, the Federation of Ethnic Communities Councils of Australia and the Pharmacy Guild of Australia. The committee has heard from a number of witnesses in previous public hearings in community forums who have given forthright, open and practical evidence about both positive and negative issues. The committee anticipates that the witnesses appearing today will do the same.

[9.02 a.m.]

ALEXANDROU, Mr Chris, Assistant Director, Department of Employment and Workplace Relations

CARTERS, Mr Graham, Group Manager, Employment Policy Group, Department of Employment and Workplace Relations

COOPER, Ms Shelley Christine, Director, Employment Conditions Section, Workplace Relations Policy and Legal Group, Department of Employment and Workplace Relations

DOUGLAS, Mr Kenneth James, Group Manager, Employment Analysis and Evaluation Group, Department of Employment and Workplace Relations

MATHESON, Mr Scott, Assistant Secretary, Economic and Labour Market Analysis Branch, Employment Analysis and Evaluation Group, Department of Employment and Workplace Relations

CHAIR—I welcome the witnesses from the department of workplace relations 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. 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. Mr Douglas, would you like to make an opening statement before I invite members to proceed with questions?

Mr Douglas—Thank you, Chair. I would like to start by thanking you for the opportunity to appear before the committee and, at the same time, apologise for the delay in lodging our submission, which, as you know, is not yet lodged. We hope to be able to lodge our submission in a very short period of time.

The department has focused on delivering two very important outcomes for the government: an effectively functioning labour market and higher productivity and higher paid workplaces. These two main areas of activity—employment and workplace relations—are focused on in more detail in the delivery of employment services and initiatives together with the provision of policy advice and information supporting workplace relations activities, including support for an effective legislation framework facilitating flexible workplaces.

I thought I might provide a very broad flavour of some of the areas our submission is likely to cover. First and foremost, we are concerned with promoting increased participation in the labour force commensurate with the government's policy goal of ensuring, particularly for families, choices which optimise the balance between work and family. In this regard we are mindful particularly of the Treasurer's Intergenerational Report which points quite markedly to the need for stronger and longer participation of working age population.

On a practical level, the submission is going to describe the range of services designed to assist the increase of labour force participation, in particular noting the government's first tranche of measures in response to the Welfare Reform Reference Group's report, *Participation*

support for a more equitable society. That first tranche of measures is more broadly known as Australians Working Together and the report I refer to is more reasonably known as the McClure report.

The next phase of activity will be the evolution of the delivery of our employment services, Job Network, introduced in May 1998. That next stage of policy reforms is known as the active participation model, which takes effect from 1 July 2003. Our submission will also summarise the broad range of workplace reforms introduced to facilitate greater labour force participation. We have representatives from both sides of the department here this morning and we welcome the opportunity to respond to questions from the committee.

CHAIR—Thank you very much. I will ask you a general question. From the department's point of view what sort of measures do you think are necessary to increase the work force participation amongst mature age workers?

Mr Douglas—It is very hard to be specific about a very broad group of people. I think we are approaching it from two particular perspectives. One is about ensuring that those who are unemployed, or become unemployed, have their chances optimised towards securing an early return to work. In fact the whole of our employment services delivery mechanisms are targeted specifically at that. My colleagues may wish to refer to some of the more specific initiatives that we have taken particularly for mature age people.

The second part of the story, however, is also focused on measures to ensure that mature age people are able to remain in the work force and provide valuable contributions for longer periods of time. As I have noted, many of the government's workplace relations reforms have been in the area of providing greater flexibility to ensure that people who make valuable contributions to the work force can continue to do so for a long period of time.

CHAIR—In the department's view, why do you feel Australia has a lower labour force participation amongst the mature age group compared with comparable countries?

Mr Douglas—It is a fairly difficult question to answer. I suppose if we all knew the answer maybe we would be in the situation where we had that. I think there is probably a broad range of reasons. In many cases it may be down to the aspirations of older age people—the way in which they have been able to organise their affairs or the way in which they elect to organise their affairs to provide an effective balance between work and family life. We know, for example, that people are choosing to have families later in life than occurred during the baby boomer period and consequently people are making choices which provide an effective balance between their work and family life. In many cases there is a sharing of family responsibilities.

There is probably no doubt too that the lower level of educational qualifications possessed by the older age group, and particularly unemployed people, has meant that in the restructuring of various industries and the microeconomic reforms that have occurred over the last 20 years some of those people who currently find themselves unemployed have also become displaced as a result of structural reforms and improvements in the delivery of services that their employer conducts. Consequently they are perhaps the first casualties of the reforms. My colleagues may wish to identify some other reasons, but probably they are the main reasons. The other thing to mention is that it is very easy to become seduced by arguments of homogeneity when this is a

very heterogeneous group. To ascribe a small number of reasons for a diverse experience is a very difficult thing to do, without going too much into the individual details.

CHAIR—What activities is the department currently engaged in to perhaps change the way that businesses think about mature age employees? You mentioned there are two limbs. One limb is unemployed people getting back to work. Is the department engaged in any activities which are trying to change the perceptions of mature age employees?

Mr Carters—The department is working with a number of organisations to attempt to change the perceptions of employers in particular. It is also attempting to change the perceptions of mature age workers. In many cases, mature age workers have a negative view about their own ability to reconnect with the labour force once they have lost what is usually their long-term employment. Discussions have been held with some of the key employer groups such as the Business Council of Australia and the Australian Chamber of Commerce and Industry. There have been discussions with some of the key representative groups for mature age workers such as the Council on the Ageing. We have undertaken a number of external meetings with employer groups and, again, with mature age people in some states, and those meetings are continuing. There are also plans for employer symposiums et cetera into the future.

We also do a lot of work through our Job Network providers. Our Job Network providers are a network of about 200 organisations across Australia. We contract out the employment services to the Job Network providers. We facilitate Job Network providers meeting with employers and meeting with mature age people, utilising those contacts et cetera to achieve positive employment outcomes for mature age people. If you like, I can go through the process by which the Job Network engages with employers to place mature age people.

CHAIR—Yes, thank you.

Mr Carters—When mature age people register with Centrelink we have something called a job seeker classification instrument, which assesses the relative level of disadvantage of all unemployed people including mature age people. That job seeker classification instrument has particular weightings for mature age people, recognising the disadvantages that they face in returning to employment. It effectively over-represents mature age people in terms of their access to the more intensive services that are provided by the Job Network. Through that, the Job Network achieves fairly substantial outcomes for mature age people. Over and above that, we have a number of specific arrangements in place to ensure that the Job Network members have the right skills to assist mature age workers. The Job Network has a lead agency called the National Employment Services Association. It has formed a special interest group of the key providers who get together to pool their resources, best practice methods et cetera to work out ways in which they can better service the needs of mature age workers.

One very positive initiative that has arisen from that is a tool box, which is accessible through our web site to the Job Network providers. It has a whole series of forms of assistance and provides ways in which Job Network members can better assist mature age workers. It looks at opportunities and the sorts of jobs mature age workers respond to, and it better educates mature age workers about the industries that are available. It looks at the local level as well: the occupations that are available and the opportunities for employment. It looks at the characteristics of individuals, as Mr Douglas says.

There is a lot of variation in the characteristics of mature age people. Whether it is women returning to the work force after a long absence through child rearing activities, whether it is people who have been in the same job for a long time and have been retrenched or whether it is people who are moving in and out of casual employment, there are different ways to respond to each of those. The toolbox assists Job Network members with the tools to draw in these people, have focus groups, work with employers and get positive outcomes. They are some of the measures in place.

Mr Douglas mentioned the Australians Working Together initiative. That gives extra resources to Job Network members to utilise for mature age unemployed people. There are a couple of key elements to that. The first one is that a training account of up to $800 is available to spend in addition to the other resources that are available through the intensive support mechanisms of the Job Network member services. Those training accounts are able to be utilised to purchase vocational related training that might be important for mature age workers to retrain them to get them into employment. We have transition to work services, which are basically for a number of different groups, including women returning to the work force, but they are also for mature age workers who have been out of the work force for a while. The focus there, over a number of months, is to basically reunite mature age workers with the concept of a modern work force—particularly developing IT skills, for instance. Basic IT skills are quite critical for those groups, but also any vocationally oriented training which would upgrade the skills—update the skills in particular—to enable them to acquire a job, and a bit of career development and opportunities for brainstorming about what sort of new career paths et cetera might be available.

Mr Douglas—One specific measure that we have been responsible for implementing in response to a recommendation in the Council on the Ageing report was a series of workshops across the country run in conjunction with the Council on the Ageing—we might call it the National Seniors Partnership. We have run a series of free workshops across the country—some have already concluded; some are yet to happen. These workshops explain the changing nature of the labour market and talk about things like portfolio employment—that is, the holding of a number of part-time, casual or contract jobs at the same time, similar to a freelance worker. So we offer the opportunity of achieving effectively the equivalent of a full-time job, with a series of related jobs. Those workshops, without yet the benefit of a formal evaluation, are proving to be quite positive and serve as a platform for further activity.

Ms CORCORAN—I have a number of thoughts that I want to float past you and invite your comment about. I am sorry about the very formal arrangement here—it makes discussion a bit difficult, doesn't it? I heard you talk before about encouraging more flexible workplaces, and that is one thought. I do not quite know what you mean and whom you are aiming at. When we talk about flexible workplaces, usually the first thing that springs to our minds is young mums, but I am hoping we are talking about older workers as well who might need to be in and out of the place for different reasons. Workers also face the problem of having to care for older parents, so perhaps flexible workplaces need to also accommodate people needing to care for older people rather than younger kids.

The other thing that has occurred to me is that it is good to focus on the workers themselves but I think we also need to focus on the community and employers starting to value older workers—so that, if you have turned 50 and you are looking for work, you are not necessarily on the scrap heap. As a community I think there needs to be a little bit of repositioning of our

attitudes, and I do not know if there is a role for your department in that or not, or if you have any comments to make. Tied up with all of that is that, not that long ago, we were all encouraged to leave work at 55. A lot of superannuation funds, for instance, encourage you to leave at 54 and 11 months—I think that is the classic age for getting out and coming back in again the next day. All that sort of stuff is a matter of retraining. I do not know whether you want to respond to that.

Mr Douglas—I will start; Ms Cooper might want to say something about what we mean by workplace flexibilities. As Mr Carters mentioned, a lot of the work that is being done, particularly in relation to job seekers, is delivered through our contracted providers—through Job Network organisations. Many Job Network organisations, in working with prospective employees, work in particular with employers. They talk at a business level about an employer; they talk about the value of the contribution that a particular job seeker can make. They work in particular to dispel many of the myths that abound about older workers having higher absenteeism levels or older workers having learning difficulties or whatever.

There is some experience from the United Kingdom on this matter. In the UK, where they ran a very substantial information campaign targeted at employers to try to redress some of the negative perceptions and myths that abounded, they found that the attitudes went backwards. They found that those stereotypes became further entrenched. The difficulty relates to how to convey this message in such a way that it does not come across like 'big brother'. We have found it to be more effective at the individual workplace level which connects prospective employee with vacancy. That has been very much the focus of our employment programs. Ms Cooper might like to add some comments regarding the workplace relations aspects.

Ms Cooper—When we talk about workplace flexibilities, we are quite often talking about it in the context of agreement making. That is obviously providing lots of opportunities to move away from the sort of structured way in which awards work. All the evidence shows that agreements are providing lots of different ways of working, from regular part-time work through to flexible start and finish times, for example, and also a range of different kinds of leave provisions.

On the other side of that is the work of the Work and Family Unit in the department which, by name, suggests that it is focused on work and family. It is promoting workplaces and providing assistance for business as to how they can make a workplace more family friendly. That is not just in regard to children. As you mentioned, elder care issues are obviously just as much of an issue for many employees as child-care issues. That unit puts out a range of material. There are a couple of guides that they put out. There is one, for example, on elder care issues in the workplace. It refers to some of the issues in regard to elder care—the kinds of things you can put in place in the workplace to help employees deal with that. Another guide is about issues specifically for older workers. It deals with issues such as employees looking for phased retirement. They may have elder care issues—either spouse or parents.

Ms CORCORAN—Mr Douglas, you made the comment that the UK experience showed that when you tried to promote the benefits of older workers, it went backwards. Do we know why?

Mr Douglas—In the discussions that I had with one of the leading international experts who has researched this area—Dr Philip Taylor, from Cambridge University—his suggestion was

that, in the absence of a more formal evaluation, it was probably part of a more typical response by people to messages from government, which tend not necessarily to be as well received.

Ms CORCORAN—Scepticism, perhaps.

Mr Douglas—People telling you what you should be thinking.

Ms HALL—Mr Douglas, my question is also to you. I just need to clarify this in my mind: when you were talking about higher absenteeism of older workers, was that a perception or were you stating that that is a fact?

Mr Douglas—No. I am saying that that perception is held.

Ms HALL—That is just as well, because all overseas research—and I have done a lot of research in that area—indicates the opposite.

Mr Douglas—We would agree completely. There is no doubt about that.

CHAIR—There was also an Access Economics report of January 2001 which showed quite the opposite.

Mr Douglas—That is right.

Ms HALL—I just wanted to clarify that. I would hate to think that the department that was responsible for the employment of older people was under such a misconception .

Mr Douglas—No. I was simply making the point that we find it better for our employment intermediaries to work quite closely with prospective employers to tackle those kinds of myths by pointing out to them that they are wrong and that the evidence is there to support why they are wrong.

Mr HARTSUYKER—Mr Carters mentioned the Transition to Work program. When you think about someone who perhaps has had no exposure to computing in their entire working life and who then does a computing course or something like that to reskill for the new world of employment, do we have enough programs in place to provide them with some real work experience there? As I see it, it is great to do a course, and certainly they will pick up some skills, but ultimately they will be competing in the marketplace with people who have had many years experience in computing, by way of example. Are we looking to provide work experience so that people can take a step from the academic side of being taught to use a computer to the workplace side of actually using a computer to be a productive worker and having to compete with other people in the job market?

Mr Carters—The Transition to Work program itself, as I said, is a program with a fairly short focus. It would provide the basic IT skills; it would not give people the sort of on-the-job work experience which you were referring to. However, the Job Network services which are provided to mature age workers tend to get access to the more intensive services. Job Network services certainly give the opportunity for that to occur. Basically, we contract Job Network providers to provide the services that job seekers need to get them into a job. If the most

appropriate way to get a particular mature age unemployed person into a job was to provide some work experience in an IT capacity then that would certainly be something that the Job Network member would look at at the local level. But that decision is taken and negotiated between the Job Network member and the individual job seeker. Quite a considerable pool of money is available to the Job Network member, and the flexibility to utilise those funds however they might see appropriate. For example, a wage subsidy to an employer might be an appropriate means by which you could get a mature age worker into employment to build on the IT skills that they have learnt in a course. So, basically, we leave it up to the Job Network member to decide with the individual what is the most appropriate way to achieve that experience.

Mr HARTSUYKER—But are there extensive linkages to make that happen as a major part of the program or is that more an isolated occurrence? I have not heard of a lot of people doing much work experience as part of the process. It has not been something that has come to my attention, but certainly it may exist.

Mr Carters—Again, the linkages at the local level are really up to the Job Network provider. We basically guide, facilitate and help Job Network members to develop best practice approaches and so on. This is obviously one of them. But it really is up to the local providers to work with the job seeker to decide whether or not the wage subsidy approach, for instance, is the best approach. Another approach which is quite popular is to do community work on a voluntary basis. That is also a very good opportunity for people to develop such skills as IT skills or familiarisation with a work force—working particularly for community organisations on a voluntary basis to develop the skills that are needed, then to translate them into real work.

Mr Douglas—From our perspective, the Job Network is a structure in which we contract with several hundred organisations to deliver services. The important point we would make is that it is up to each organisation as to how they achieve their outcomes, provided they do it legally, ethically, with good behaviour et cetera. The point I would add to Mr Carters's observations is that there are no barriers for it to occur; whether or not it occurs is a matter for decision by each Job Network member. We know that the practices differ and that each organisation chooses to do different things because they produce outcomes. More importantly, what we find from studying good practices of high performing Job Network members is not necessarily that they do things differently but that they do them better than the lesser performing organisations. Often we hear about the fact that you do not hear about it; but that does not mean it is not happening, because generally it tends to be more one-on-one type stuff rather than a big bang approach.

Ms HALL—What incentives are being put in place within the Public Service to encourage the Public Service to act as a positive role model for other employers in the community? Is there a policy within the Public Service to encourage the employment of older workers? If so, can you give me examples?

Mr Douglas—I think that is a question you would have to direct to the Australian Public Service Commission.

Ms HALL—Okay.

Mr Matheson—I could add that one thing that certainly has been done is the abolition of compulsory retirement in the Public Service. That has been an important change which has taken place.

Ms HALL—As the department responsible for employment, have you got a strategy in place for employing older workers?

Mr Douglas—I am not aware that we have a particular strategy, but I would make the observation—without having any facts or figures in front of me—that, of the 45 or 50 graduates we recruit each year as part of our annual graduate intake, we are increasingly seeing higher proportions of mature age graduates, reflecting the change in the dimension of the graduate market.

Ms HALL—I note that the Prime Minister said—I think this was back in 2000 or 2001—that he wanted to increase the participation rate of older workers in the work force by 10 to 15 per cent. That could be looking at targets within different departments for employing a certain number of people who are aged 50-plus. He was talking about the over-50s. I know that Centrelink recently employed a worker who is 70, which was quite innovative. As you are the department responsible for employment, have you done any research or looked at any of the programs in place in countries such as Japan and in the Scandinavian countries and considered how they could be introduced and applied within the Australian environment?

Mr Douglas—We continually scan what is happening overseas. As a member of the OECD, Australia benefits from participation in OECD forums where many of the best practices are emerging. One of the things that the OECD is conducting at the moment is what it calls a thematic review of older workers. Australia is to be one of the countries to be studied in that thematic review, which is scheduled to happen later this year and into early next year. Once that review from the OECD is completed we will be in a position to have more information and research about Australia's experience in comparison with that of many other countries.

Ms HALL—Japan is the country with probably the biggest problem with an ageing population and it has the highest participation rate of older workers. That is why I mentioned Japan. Do you think more of a hands-on approach could be adopted by the department rather than a stand-off, laissez faire approach where you are leaving it to best practice within Job Network's providers to lead to the employment of older workers? Do you think there could be a case for a bit more direction so that those workers who have so much to offer our Australian community have a better opportunity to get in there?

Mr Douglas—The actions that are taking place now are policy decisions taken by the government. We are implementing those policy directions. What we think is somewhat immaterial in that regard, because it is a decision for policy setting of government.

Ms HALL—That is good; thank you.

Mr Carters—You are no doubt aware that there is a demographic change task force in operation and an interdepartmental task force headed by Treasury. Certainly the development of policy in those is looking at areas such as how we can further promote mature age workers in the community et cetera more generally. As Mr Douglas says, it is a policy issue about which we will need to wait and see.

CHAIR—You also mentioned that you did not have the specific policy or figures in an earlier question. Could I ask that you take them on notice.

Mr Douglas—Is this about the department's mature age employment level?

CHAIR—Yes.

Mr Douglas—Yes.

Ms CORCORAN—Let us change tack. I know that you said before that you had not yet put your submission in, so what I am going to ask may be coming. I want to look at the composition of the work force and where you see it going over the next 40 years in terms of skilled, unskilled or professional people. I do not quite know what proportion of the work force is skilled or unskilled at the moment, but is that going to move and change over the next 40 years?

Mr Douglas—We have not necessarily looked at that. Most of the information that we would be using is, in particular, based on information contained in the Treasurer's Intergenerational Report, which is more broadly based. We have some analysis which we could report on, however.

Mr Matheson—I could add to what Mr Douglas has said in that, if you look at what has happened to particular occupational groups over about the last two decades, some fairly clear trends have emerged, driven largely by structural change in the economy. I think it would be a fair expectation that those very strong trends are likely to continue into the future. When you look at some of the key occupational groups at a fairly broad level, we have had very strong growth in employment of professionals—that is, higher skilled occupations. I think you can imagine that we will continue to see strong growth in professionals and paraprofessionals.

We have also seen strong growth in middle-skilled clerical, sales and service workers, reflecting the fact there has been quite a substantial shift in the economy towards service sector industries. We have seen fairly strong growth in those, and I think you can imagine that those sorts of trends will continue. We have seen less growth in some of the trades areas, reflecting the fact that there has not been strong growth in manufacturing employment. Certainly it is a different picture if you look at output, but there is not the same growth in, say, manufacturing employment over the last 20 years. You may well expect to see a similar trend occur there. With some of the labourers and related workers, those in the least skilled occupations, again there is relatively low growth compared to some of those more skilled occupations. Those are fairly strong trends which are being driven by changes in industry. I think we would expect to see that kind of pattern continue into the future.

CHAIR—I wanted to conclude with a question. We have had figures saying that labour force growth will gradually slow over the next 40 years to the point where it is only 0.1 per cent in 2042. Forty years is a long time for parliamentary committees to look at. Do you think businesses are becoming aware that we can already expect the labour force growth to contract significantly, in 20 years time?

Mr Douglas—I do not know whether we feel qualified enough to answer on behalf of business.

Mr Matheson—One thing we could say is that as business realise that the supply of labour is growing less slowly they are going to have to take steps to encourage, attract and retain labour. We have spoken a fair bit about policy and program interventions but the other factor that is going to be very important as the next 20 years plays out is that unless business do change their recruitment policies, their attitudes and their practices in the workplace and so on, it will become increasingly difficult to attract people. If, for example, a larger proportion of the work force are mature aged and would like more flexible arrangements to phase into retirement or to have a bit of time off or more recreation or whatever, business are going to have to respond to that if they want to continue to attract and retain staff.

CHAIR—Does the department have any forecast of the projected composition of the mature age work force over the next 40 years, in terms of skilled, unskilled, professional and so on?

Mr Douglas—No, we do not. As Mr Matheson has indicated, our focus has been on looking at trends and then trying to see what those past trends might be saying to us for the future, but not forecasting them.

CHAIR—The Intergenerational Report projected unemployment to fall to five per cent and stay there. Presumably that is because it is very difficult to forecast with any sort of time frame. Do you expect that, as labour force growth slows, that will help to reduce unemployment?

Mr Douglas—Once again, we would take the position that we do not forecast unemployment rates; we rely on Treasury models. We try to ensure that the levels of disadvantage are minimised and that as much as possible there is strong and increasing participation in the labour force.

CHAIR—Thank you for your time. We look forward to receiving your submission.

[9.43 a.m.]

EMERSON, Ms Fran, Acting Manager, Health and Welfare, Aboriginal and Torres Strait Islander Commission

GOODA, Mr Michael, Acting Executive Coordinator, Aboriginal and Torres Strait Islander Commission

GOOK, Mr Geoffrey Adrian, Manager, Information Analysis and Research Unit, Aboriginal and Torres Strait Islander Commission

HANSEN, Mr Glen, Executive Policy Officer, Education, Social Participation and Gender, Aboriginal and Torres Strait Islander Commission

NELSON, Ms Kerrie Anne, Acting Assistant Manger, Economic and Social Participation Policy Group, Aboriginal and Torres Strait Islander Commission

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

Mr Gooda—I will make a brief statement. On behalf of the ATSIC board, I would like to thank the committee for its invitation to contribute to this very important inquiry. We originally planned that Commissioner Terry Whitby from the Pilbara would be here, but he sends his apologies. There are cyclones in his territory at the moment, so he decided to stay home.

We have developed a comprehensive submission which we expect will be signed off today and will be sent to the committee very shortly afterwards. The submission outlines the key differences in the demographic profile between Aboriginal and Torres Strait Island peoples and the general Australian population. It also contains 16 important recommendations to assist the committee in its deliberations, associated with the development of long-term strategies to address the ageing of the Australian population over the next 40 years.

The different demographic profile provides both risks and opportunities for Aboriginal and Torres Strait Islander peoples. In 2042 we estimate there will be about 1.2 million Aboriginal and Torres Strait Islander people. Most of these people will be of working age during a time when Australia will be demanding a young, skilled and highly productive work force. In rural and regional Australia, Aboriginal and Torres Strait Islander people, we estimate, will comprise about one-third of the population.

A key recommendation of the ATSIC submission is the need for capacity building to occur in Aboriginal and Torres Strait Islander communities and in governments. We have already provided a submission to the capacity building inquiry of HORSCATSIA. Kerrie Nelson will be able to elaborate on that, if the committee wishes. ATSIC urges the committee to recommend

this developmental approach rather than portfolio specific measures in relation to long-term measures to improve outcomes for Aboriginal and Torres Strait Islander peoples.

Chair, that concludes my brief opening statement. Mr Gook, Ms Nelson, Ms Emerson, Mr Hansen and I will be able to elaborate on the demographics of the health area and some of the key issues that we see coming up. We would probably prefer to move straight to questions.

CHAIR—What is being done to assist rural and remote communities with the provision of community based aged care services?

Mr Gooda—The Department of Health and Ageing is the department with responsibility for providing aged care facilities. We have facilities around the country. I would have to take on notice how many aged care facilities there are around the country. We generally work closely with that department to try to reap the best benefits for the community. Aboriginal Hostels has a fairly big input not only into the development but also the ongoing administration of most of those facilities. The Department of Health and Ageing has developed close cooperation with us and, more specifically, with Aboriginal Hostels.

CHAIR—Do you find that there are any difficulties in servicing the aged care needs of rural and remote communities? I understand that it is not an ATSIC matter but I suppose it is something that would concern ATSIC.

Mr Gooda—As you would imagine, most of our effort goes into the remote and rural areas of Australia because they are places where our people do not participate in the economy in much of a way. There is no labour market. So most of our programs are starting to head towards providing support in those areas. We look at the agencies responsible for the carers payment, the carers allowance.

With respect to Aboriginal affairs, I remember that when we first started putting aged care facilities in communities it was put to me that that was a bit of a misnomer because we were isolating the old people from the community and putting them in their own facility. Our whole culture is based around respect for our elders, and we should have had a way of integrating the care of these people into the community rather than having separate facilities. But as we are committed to self-determination, we left that up to the communities to decide. Most of the communities wanted a specific place for their aged people to go and have a break from some of the community pressures. The payment of the allowances, and particularly the carers allowance, we think would be a way of making sure our old people are well looked after.

My personal experience—and it is from my mother's perspective—is that the Home and Community Care program is one that provides a great level of service for our elders in the community. It is a way of allowing them to participate. My mum lived in Rockhampton before she passed away, and I know that in that town the informal feedback was: 'You take it from your mum; she really appreciated that service.' I have observed that around the country. So there are those services in remote and rural communities, but we do not have a specific strategy for the aged at the moment. We have an area that is starting to look into that. In the last week, the board has developed its committee structure. Looking at aged care issues is one of the key issues in Ms Emerson's area. Maybe she wants to comment on that.

Ms Emerson—One of the main issues when it comes to caring for the aged in Indigenous communities is the fact that Indigenous people are not going into the caring professions at a great rate at all. The average age of an Aboriginal health care worker is now about 45. You know about the difference in life expectancy being 19 years. With the average age of Aboriginal health care workers being 45 to 50, that means that there are not a lot around. They are getting fewer and fewer. Fewer Aboriginal people are going into the caring professions, and people in Indigenous communities like to be cared for by their own, so the work force issues in Indigenous communities are getting to a crisis point at the moment, especially in caring for the aged. That life expectancy issue means that Indigenous people age faster, if that is a concept that you can understand. They develop chronic conditions younger, they suffer a higher level of morbidity, and type 2 diabetes is nine times higher than in the non-Indigenous population, so a lot of caring is required without the Indigenous work force to provide it. I guess that is one of the main issues.

Ms HALL—I was fortunate to be on the committee that was involved with *Health is life: report on the inquiry into Indigenous health*. We did research into Indigenous health and we brought down a report. One issue that was very apparent was that of older people in remote communities. There is a facility at Docker River which was designed in a very different way from the standard aged care facility. It was experiencing problems because it was sensitive to the needs of the people who lived in the community rather than to meeting all the standards and the issues relating to them. So I have been very fortunate to see first-hand some of the issues and the problems that there are in remote communities. I suppose my first question is very broad ranging. In your position, what policies would you like us to put in place to look at the needs of ageing Indigenous people in Australia? That is a pretty big question, I know.

Mr Gooda—To understand that we really need to go through the demographics, and I will refer to our submission. For instance, our school age population is to increase both absolutely and in proportion to the total population so we are doing some work around our legal services. It is no surprise to anyone that once our kids hit their teenage years they start to have contact with the criminal justice system. We are doing some demographic work around planning for those explosions in certain parts of the country and how we deliver our services.

Our working age population is likely to remain young and relatively less educated than the rest of the population. Our young adult to middle age population is more likely to suffer ill health with consequences for employment, income, housing and retirement incomes. The proportion of older people in our population is generally unlikely to change markedly from today because of the issues of a lower life expectancy.

With respect to the economic prospects, if we took CDEP out of the equation and counted those people as unemployed, our unemployment would be about 40 per cent. We have a bit over 35,000 people on CDEP at the moment, generally in places where there are very few labour market opportunities. We have to look at ways of encouraging greater participation of older people in the work force. The current trend away from older people—and I note the Prime Minister has been making statements about older people staying in the work force—is even more of an issue with us. We have probably got a couple of generations without any work experience at all, and that is one of the challenges facing us in the reform of our programs like CDEP—and if I have time I could probably talk a little bit about that.

While encouraging greater participation of older people in the work force, the evidence suggests that that work force is made up of a fairly high level of self-funded retirees. That is not really the case with us. Given the situation at the moment, keeping non-Aboriginal people in the work force does not reduce the burden on government payment of welfare type payments and it does not raise productivity too much. If our people stayed in the work force longer it would do both—it would lower the level of dependence on the welfare system and increase national productivity.

About one-third of the rural and remote population in 2042 will be Aboriginal people so we have to start planning around some responses for the services there. A couple of months back I went to a graduation of a rural leadership program and, if I had blindfolded myself, I could have thought I was listening to our rural and remote population talking. They were talking about services, doctors, education, how to keep our kids in these towns, and what attraction we have—they are the same questions our people have been asking for years. We have developed a bit of thinking around some of those.

Capacity building in our communities is going to be a very important issue. We have always taken a two-pronged approach of self-determination and self-management, and the evidence is showing now not only in the Aboriginal community but also among the general population that people have more of an input into the responses to certain problems they face out there. There is better commitment and you end up with a better service. We are finding our people do not have the capacity to participate too much in a meaningful way, so capacity building is going to be a very important part of our approach.

We would encourage a whole-of-government approach. We mentioned integration of aged care services in the general communities particularly in the remote and rural areas. Our old people are not separate from the rest of the community. The services provided to the old people will have an impact on the general population of those communities. In taking a whole-of government approach—and we are committed to a whole-of-government approach at the moment—we really have to get the state involved and local governments. A bloke told me a while back that our mob on the ground out there do not make any distinction between state and federal funding—they are just looking for services. So the whole-of-government approach to providing community services is going to be a very important one.

As I said, we have 35,000 participants on CDEP these days. CDEP is exempt from the superannuation guarantee, so we have some concerns about how those participants can be more independent when they reach retirement age, because they will not have superannuation like the rest of the population. We are a little worried about the impact that is going to have on our communities. The mere fact that it is estimated by the Grants Commission that the average Australian male retiring at 55 would have 21 years of access to their superannuation, while the average for Aboriginal men is one year, suggests that we have to start looking at those sorts of issues as well. The averages for superannuation access between non-Aboriginal and Aboriginal women are not quite as stark as that, but there is a fairly big difference. We are looking at the areas where we can make a difference and start planning for the future, and a lot of it concerns those issues.

We also want to mention the issue of health, which we know is of particular interest because it is the focus especially of people approaching retirement age. We do not have responsibility for health; but we do have responsibility for environmental health in our remote communities,

which includes water, power and waste disposal. We spend up to $257 million a year on providing services that state governments generally do not provide. We have taken it up in different forums, like at the recent inquiry by the Commonwealth Grants Commission on the cost shifting exercise. Providing these services reduces ATSIC's capacity—of course, we always get told about the $1.1 million that we have in ATSIC—to address some of the issues we would like to explore, because we are spending a great majority of our money on things like providing services that most Australians would take—and we would consider—as citizenship entitlements. So this cost shifting by the states reduces our capacity to address some of these very important issues.

CHAIR—I wanted to ask about cost shifting, so I am glad you have addressed it.

Ms HALL—You said you wanted to talk a little more about CDEP. I wonder if you would like to touch on that now.

Mr Gooda—We are reforming our CDEP. We get the general view that CDEP is a massive failure because most people see it as a work transition or labour market program when, in fact, we estimate that 80 per cent of our people on CDEP are in areas where there are no labour markets or very few labour markets. We are now having some thoughts about how we can change that. We think there will be different versions of CDEP in different parts of the country. Where there is a labour market, we will be joining with DEWR to look at the work transition aspect of CDEP. For instance, we think that in Perth and Brisbane there should be a labour market program where we are getting people into permanent work outside CDEP. In our remote communities we are looking at it more as a community participation project along the lines of: 'How do you contribute to what is happening in your community?'

With our board committee we are now developing a policy on social and economic participation. Because CDEP is a regional council program, the 35 regional councils around the country actually set the program and decide what is done on the program. We have basically been driven by organisations coming to us and saying, 'Here is a work plan,' and most of the time we just give it a tick. We are now encouraging regional councils to say, 'Hang on. How can we use CDEP in a community participation type mode so that the council actually articulates what it wants out of it?'

We were in Cape York the week before last talking to the Peninsula Regional Council. They were saying to us, 'We are worried about what we are doing with CDEP'—and I will talk about cost shifting in respect of Queensland later. So the regional council said, 'This is what we want out of our CDEP,' and some of the things they are coming up to us with include increased school attendance, addressing issues of family violence in communities, addressing issues of asset maintenance, such as looking after houses, and things like that. It will be very easy for them to build in to that issues such as, 'How do we actually look after the aged people and put a focus on aged care?' We are looking at ways of getting those sorts of things down to regional council level. It is almost a shifting of self-determination from a community level up to a regional council level where their regional councils are saying—and they are fulfilling their statutory responsibilities to develop regional plans for the regions they represent—'This is what we want.' I do not need to say it here but ATSIC is the most scrutinised agency in the Commonwealth when it comes to financial accountability, and there have been a lot of reports saying we concentrate on financial accountability at the expense of accountability for outcomes.

We are really trying to move the communities and the CDEP away from 'let's just tick and flick and make sure you spent the money properly' to 'let us look at what we are getting for the dollars we spend'. We will always say we are a supplementary funder but in some of these communities we have to take prime responsibility. The remote communities do not have any management. We did a study in the west in Cue, a little shire of about 800 people just inland from Geraldton. It gets about $1.2 million through the Commonwealth Grants Commission for its administration. Jigalong has more than that and I think we provide them with about $200,000. We provide that, not the Commonwealth Grants Commission. We really need to say that in some of these communities we are accepting the responsibility and use that as the basis for negotiating with other agencies by saying, 'That is not a signal for you to withdraw services. We have provided the base management and governance structures within the community. You come in and do the other stuff that is needed here.'

I want to talk about cost shifting in relation to the DOGIT communities in Queensland. Our CDEP basically supports them. If we pulled CDEP out of the cape, the whole place would collapse. We are in negotiations with the Queensland government to see how we can actually make better use of CDEP. There are recommendations in our submission. I would be interested in starting to get agreement at the national level that these are some priority focus areas and then look at the provision of services to our elders in those communities. That is one of the things we would like to have implemented via the regional planning process.

Ms CORCORAN—I was interested in your comment earlier about how the demographics of your communities are changing and how they seem to be different from those of white Australians. Will your submission discuss that? You commented that the school-age population is going to increase and that the working population is going to increase, although it will perhaps be less skilled or not as skilled as you would like it to be. Will your submission have those projections?

Mr Gooda—Yes.

Mr Hansen—Just to put that in the context of the questions that have already come from you, our low-series projections are based on an Aboriginal and Torres Strait Islander population of 1.2 million people, and 30,000 of those 1.2 million people are expected to be aged over 65.

Ms CORCORAN—At what point in time?

Mr Hansen—In 2042.

Ms Nelson—I wish to go back to Ms Hall's earlier question about what policy changes we would like to see. I would like to make a couple of broad comments about that. With Health and Ageing being the main department that looks after that, one policy change we would like to see is the building of the internal capacity of that agency to deal with Indigenous people and develop a closer working relationship with ATSIC.

At the community level we would like to see a recognition by policy makers of the diversity of circumstances so that policy is flexible and responsive to local needs, whatever they are, whether they are urban, rural, remote or metropolitan. With regard to whole of government that Mr Gooda just referred to, the task force is doing a lot of work on how governments can be more coordinated in response to local needs. And somewhere in there there has to be a balance

that allows community solutions to emerge with the support of external expertise. One other policy change I would like to see is encouraging a long-term view. You are looking at the demographics around ageing. I think we have to take not a short-term electoral kind of view about the issues to do with Indigenous people but a much longer term view—10 to 20 years—in terms of seeing what impact our policies will have.

Ms HALL—This is the inquiry to put those long-term policy ideas to, because we are looking at 40 years.

Ms Nelson—Good.

Mr HARTSUYKER—My question is probably best directed to Fran Emerson. Do you see the improved delivery of health services and health education as a means of deferring the early onset of ageing issues and age related problems?

Ms Emerson—Yes, I think that is absolutely the key. CDEP goes a long way to ameliorate a lot of the health and welfare needs of rural and remote communities but, in the end, expertise is required from Indigenous people themselves. In our submission we have given you the differences in life expectancy between Indigenous and non-Indigenous in the US, New Zealand and Canada. In the US it is 3.5 years, as opposed to our 19 years. In the US—

Mr HARTSUYKER—I am sorry to interrupt but we do not have a copy of the submission yet.

Ms Emerson—Okay. There is a huge difference: it is 3.5 years for the US, five to six years for New Zealand and seven years for Canada. That is indicative of the amount of investment that those countries have put into the education of their indigenous people to get them into the professions that will assist their own people. That is a very key factor. I go to the comments made by the deputy chair about the flexible arrangements for looking after elderly people. I am reminded of an instance I had while working in New South Wales of an aged care facility that would not allow an Indigenous elder to go barefoot in the accommodation or to sleep outside, which is where that person was used to sleeping. It was very distressful and had a very detrimental effect on his health. So, yes, a key factor is that policy of making sure we inject a lot of resources investment into building up the expertise in health.

The Indigenous Doctors Association, the Indigenous Nurses Association and all the deans of the universities are trying to figure out what sort of strategies they can use to get Indigenous kids to want to go into the health professions, because the kids just do not want to. They are thinking of going in and being mentors and models and giving them talks, but that requires time and money as well. Everybody is aware of the drastic issue, but it is just finding the time and the money to do that.

Mr HARTSUYKER—With regard to health education for the individuals concerned, in my electorate one of the schools runs a specific program on nutrition for the Indigenous students. They find that very valuable, and some of the parents are encouraged to come along too and be part of that process.

Ms Emerson—That is a key factor. If you can get the Indigenous children to go to school on a regular basis you will then improve their health because they will become aware of those

issues, and it just goes on and on and they grow up becoming more aware of their bodies and how to make themselves healthy. So, yes, it is very good to have preventative education.

CHAIR—With respect to the differences in life expectancy rates in the US, New Zealand and Canada compared with Australia, you mentioned initiatives to encourage more Indigenous health care workers. I think you also mentioned that more resources should be allocated to Indigenous education. What does ATSIC see as the reasons for that stark difference? I have referred to some of the initiatives that you have mentioned. What sort of responses do you think are required to improve the life expectancy rates of Indigenous people so that they are much more comparable with those of the rest of the population, as they are in those other English speaking countries?

Mr Gooda—Our chairman has written to all of the commissioners. We have a board meeting later this week. He has suggested—and we have to confirm it at the next board meeting—that the development and protection of our children will be a priority. We are taking a long-term view of that, looking after the generation that is basically being born today. It gets us into the field of things that generally we do not get into, such as education and health. Because we do not fund those areas, we do not generally have that much to say about those matters. We will be doing that from now on because we have now constructed an organisation and an elected committee system that will allow us to address issues, in an in-depth way, related to areas that we do not fund.

We think it is almost like the Jesuits saying that, by the time a kid reaches the age of five, you can almost map out what they will do for the rest of their life. Educationalists would say that as well: by the time a child reaches the first year of school, their life has basically been predetermined. We have to start looking at a whole range of things—too many to cover here. We think taking that approach at least provides a long-term view in starting to address some of these issues.

In conjunction with that, COAG will very shortly sign off on a set of indicators of Aboriginal disadvantage. We have done a lot of work on this. I might ask Mr Gook to talk about that. It focuses on what the indicators are that tell us about the wellbeing of the Aboriginal community. They will be agreed by COAG—across the states and the Commonwealth. For the first time it will give us comparable data across each state so that we can measure how we are going. ATSIC has been involved fairly intimately with the development of those benchmarks. We see those sorts of things as being very important, and not just in setting benchmarks. My personal view is that we need also to look at the benchmarks and start to set some targets somewhere down the track. It is one thing to measure how bad we are; we should be starting to articulate where we want to be.

I refer to capacity building in our communities. For instance—and I know it is not an area that you are looking at—in Jigalong in WA, which is the setting for *Rabbit Proof Fence*, we have never had a kid go to year 10. So something is falling down there. We are saying that once you build the capacity of that person in an individual sense and give them the education, they will start making choices that are different from those of today. Maybe they will not end up living in places like Jigalong; maybe they will. We think at this stage those kids do not have the capacity to make a choice.

We want to start looking at how we get people to make choices. That goes for old people as well. They have lived in a system where they do not have any concept of what is out there. The world is getting smaller and smaller in an information sense but we have people who do not know what the options are as to where they can go. We are starting to develop this long-term view about where we want to be; hence this concentration on the generation being born now. That is not to say we are not going to do anything about other people; we also have to look at the people who are around now who will need services. But we take the long-term view. There are a few of us who have been around in this area for a number of years. We think that if we do not take the long-term view, somewhere along the track our grandkids will be sitting here talking to your grandkids about the same things. When you do that, and you take the long-term view, you have to make some choices yourselves about how much pain you have to put up with in moving to a long-term view.

I was in Cairns about six months ago. A project is happening in Cairns, in the peninsula area, after Tony Fitzgerald reported on family violence issues up there, to sit down with a community and say, 'We're taking this long-term view and we want to start looking at where you want to be in 20 years,' and someone from the community says: 'I can't get bread on my table today. What are you going to do about that?' That is the balance that you have to get. It is a terrible decision to have to make. Where do you actually start concentrating effort?

CHAIR—In that approach, will you be targeting maternal health as well?

Mr Gooda—I will defer to Mr Gook to talk about the headline indicators because he knows a bit more than I do.

Mr Gook—First, I will make a comment about the difference in international comparisons. I think that the 19 years or 20 years, or whatever it is in Australia, compared to New Zealand and other similar countries, is the most starkly different statistical comparison that we have. It is not matched quite as badly in most other indicators. Australia's main socioeconomic measures in the Indigenous community are worse, but not as badly worse as other countries, which suggests to me that some of the issues that Ms Emerson was raising about the nature of the employment, governance, and all those kinds of things, are probably different overseas. For example, the number of doctors, nurses, and so forth in New Zealand and other countries is probably much greater in terms of the Indigenous input. That particular statistic is a perplexing one.

The Productivity Commission is doing some work commissioned by COAG. The structure that it is taking on board, which was originally developed by the Ministerial Council for Aboriginal and Torres Strait Islander Affairs, is an approach which looks at headline indicators, including life expectancy and about 20 different indicators. Underneath that, it looks at what are called strategic change areas. That is an age based model which tries to look at what are the causal pathways that lead to high unemployment, lower life expectancy and that kind of thing, and tries to identify what they are in the life cycle and in the environment to guide policy direction. Most of the research shows that a person's life chances are greatly influenced by, basically, their first five years of life, and that is something important in that approach. The model takes account of the life cycle throughout. It also looks at other stages, but it is particularly focused on young people.

The other half of that model tries to pick up on what is called the specific Indigenous environment that is different to the rest of the country. That includes things such as the

community environment, the cultural environment, the environmental environment, particularly in remote areas, and also the economic environment, which is a little different to the rest of the country and is particularly focused on business development and the like. The model is an attempt to look at the indicator process in a strategic way and not in a linear way that attributes life expectancy to the health department, for example. It is an attempt to say, 'What can we determine to be the main factors that are specific to problems?' and then deal with that in an overall manner.

Ms CORCORAN—I do not quite know how to phrase this, but you talked before about the reluctance of Indigenous people to go specifically into health professions. Later on Mr Gooda talked about kids not even getting to year 10. Is that a reluctance to get into health professions or a reluctance to get into professions full stop—maybe not a reluctance but an inability? Is it something specific about health professions that is causing a problem?

Ms Emerson—The reluctance of Indigenous young people to go into health professions is probably endemic across Australia, with young people not wanting to go into nursing, full stop, because it is seen as lackey work, it is dirty, it is this, that and the other thing. It just does not appeal to today's youngsters. Compounded by that are the educational barriers for Indigenous people to get into university or into TAFE or to achieve those goals. It is a double-pronged effect.

Ms CORCORAN—So there is no cultural barrier to getting into health; it is a general thing we are experiencing all round?

Ms Emerson—That is right, and it is difficult to get into health. Obviously, it is not difficult to get into the nursing profession, but it definitely is difficult to become a doctor because you have to have very high grades et cetera. Although the universities are trying to accommodate Indigenous people in certain areas to make sure they get into university to do doctors degrees, there are still not nearly enough to actually make a difference. It is the same with nursing. We need to offer more incentives all the way around starting in primary school with the modelling to which I referred earlier.

Ms HALL—I want to go back to the comments you made about education and not getting to year 10, and the fact that that probably is not something that the committee would be interested in. We are looking at people in 40 years time. Obviously, there is a connection between education expectations, quality of life issues, health disadvantage and what that all means for 'old age'. Because there is a higher number of children per family in Indigenous families, we are also interested in what that could mean. You touched on it a little earlier when you mentioned that about a third of the population in rural communities would be Indigenous over the period of this report. Offering proper education et cetera is a way of balancing the work force. Could you comment on any of the propositions I have put forward?

Mr Gooda—We are working closely with the Department of Transport and Regional Services in the Kimberley, for instance, on one of their pilots on sustainable regions. It is fully appropriate that it is the Kimberley because it is a definable area, and the Kimberley people self-identify. We are looking at ways of integrating our services there. Aboriginal affairs type funding would account for nearly 50 per cent of funding in that area, so we really need to start integrating our services with mainstream services.

It is amazing how this comes up at some of the meetings we go to. There was one meeting where someone was a specialist in mail delivery. I remember going to a South-East Queensland 2010 committee meeting in Brisbane a few years ago. Someone was talking specifically about mail delivery and the expansion of rural type properties and how much the three- or four-acre plots were going to affect the delivery of mail. It took me nearly all the meeting to realise we actually do all of this in Aboriginal affairs. We are now starting to get mainstream shires coming to us and saying, 'How did you influence the state government to do these things?' I think those integrated approaches with the whole of the community have to start taking into account Aboriginal interests and not treat us as an add-on. As you say, with our estimates of having a third of the population in rural areas because of the decline in the general population in those areas, the services to our people are going to be of the utmost importance. We have been working on it for quite a few years and now we are starting to build some alliances around the place that help us address it in a meaningful way. But going back to the educational issues—

Ms HALL—In answering that, could you have in mind how the retention rate for Aboriginal students could have a positive impact on health and aged care needs within Indigenous communities.

Mr Gooda—It is an approach that we are definitely taking. If people are more educated they can make better choices. There are simple lifestyle issues of whether we are going to look at things like more traditional food or if it is easier to go down to the shops to buy a packet of chips and a can of coke. I have worked with communities in the Torres Strait where you see kids walking out at lunchtime with a packet of Twisties and, like I say, a can of coke. You wonder what the long-term effects of that will be. There is going to be an explosion in our communities shortly of the type 2 diabetes that Fran spoke about. We see that education is going to play a very important part. While you are not addressing those issues, as you said it does affect the area that you are talking about. If a person is 10 years old today and they get to be 50 in 2042 and have not been appropriately educated, it will continue on in the same way. We will not be able to move forward. I have worked with the chair and a couple of others to start taking that long-term view about education because—I will go back to what I have said a couple of times—if they do not have the education and do not make the choices, it affects not only whether they get a job but also their lifestyle.

In the last two to three years, I undertook a review of Aboriginal education in WA. To go back to the whole of government response, the first line of the report said that we have to realise that the education of Aboriginal children is the responsibility of everyone in this department, not just an Aboriginal unit that sits over there. Again, it was a fairly important approach. It was a way of making people responsible for the whole thing. Sometimes that is what we get stuck with. People say, 'It's an Aboriginal problem; just go to ATSIC.' In fact, we want to say: 'Hang on. Aboriginal people are citizens of this country, they also have hospitals. Not only do medical services that are funded have a responsibility but hospitals have a responsibility to provide an appropriate service.' Getting down to education, it is a view that is becoming more prevalent with our elected arm and in the community generally that we have to make some fairly big commitments organisationally in ATSIC and we also have to try to get the message out there that education is so important to people. If we do not educate kids today I hate to think what they will be doing in 40 years time.

Mr Hansen—Could I add that one of the concerns that we had with the Intergenerational Report was that it highlighted some key areas where the slackening of demand in the education

sector would mean that some of the resources from the education sector could be transferred to the health and aged care sector. That is quite a dilemma for Aboriginal and Torres Strait Islander people because we obviously need the resources in the health and aged care sector but we also need the resources in the education areas. I note that the Intergenerational Report also said that there is likely to be greater expenditure per student through the next few years. Being able to pass that greater expenditure on to Indigenous students will be all the more important for the future development of Aboriginal and Torres Strait Islander people.

CHAIR—Thank you very much for attending. We are anticipating your submission as well.

Proceedings suspended from 10.34 a.m. to 10.53 a.m.

HAIKERWAL, Dr Mukesh Chandra, Chair, Australian Medical Association Committee on Care of Older People; President, Australian Medical Association, Victoria

RICHARDSON, Dr Susan Elaine, Member, Australian Medical Association Committee on Care of Older People

RIVETT, Dr David Christopher, Member, Australian Medical Association Committee on Care of Older People; Chair, Australian Medical Association Council of General Practice

SHAW, Mr Bruce Victor, Senior Policy Adviser, Australian Medical Association

CHAIR—Good morning and welcome. I remind you that the evidence you give at this public hearing is considered to be a part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The Australian Medical Association has made a submission, No. 86, to the inquiry, and copies are available from the committee secretariat. Dr Haikerwal, would you like to make an opening statement before I invite members to ask questions?

Dr Haikerwal—Thank you, I would like to take that opportunity. I would like to thank the committee for their time in allowing us to present to you. The role of medical practitioners in providing quality health care to older Australians is a vital one for their wellbeing. As the peak body representing medical practitioners in Australia, the Australian Medical Association has an important advocacy role regarding the care of older Australians. Our submission outlines some of the issues we need to address and puts forward some recommendations that we commend to the committee for consideration.

In focusing on the human dimensions of our ageing society, one of our biggest challenges is to try to ensure that we have care and funding arrangements that work in 40 years time. In this brief opening statement we will seek to focus on some of the short- and long-term goals we see as vital if we are to achieve this outcome.

The fundamental issue looming for aged care, along with most aspects of health care, is the ageing population. I do not see this as being a negative aspect; it shows the success of our public health campaigns and the individual health of the nation. There is also a need for government to continue to fund programs through taxation as opposed to savings and insurance. These issues are well established on the political agenda and I shall not dwell on them here.

The AMA is concerned at the disincentives and barriers that currently make it difficult for GPs, geriatricians, nurses, other health professionals and carers to operate in the aged care sector. These disincentives include, for instance, an inequitable fee structure for doctors and inequitable wages for nurses and other staff involved in the care of elderly people. For example, the Medical Benefits Schedule needs to more realistically allow for comprehensive medical assessment of aged care residents, taking into account their complex health needs. However, we are not talking about just money. There are other, environmental, factors which make it difficult for health professionals to participate effectively in the care of older Australians. These include: the many non-face-to-face administrative tasks and huge amounts of red tape expected of GPs and care staff; the lack of integration of medical services in the aged care system; and an

absence in many residential facilities of things like consultation rooms with adequate treatment facilities, and computer facilities that would facilitate access to patient records and things like electronic prescribing, which improves the accuracy of health records and prescribing, which is a major issue.

We need mechanisms to encourage medical practitioners, nurses and other health professionals back into both residential aged care facilities and community based care. Many disincentives include the myths that surround the accreditation system and the increased burden of paperwork that is produced to induce people to work within aged care facilities which actually bears no resemblance to the accreditation requirements. We might talk about that a little later.

Better continuity of care must be achieved by conscious policies and strategies aimed at enhancing integration and communication. The different government agencies responsible for their silo of health care, whether it be acute health, nonacute, subacute, community care, pharmaceutical benefits—and the lexicon goes on and on; one of the things we have to do is clear up that lexicon—are often too concerned only with their own individual bottom line and not how their program impacts on other silos and the overall health outcomes for Australians. Australia needs to break down the silos on several levels, including political, professional and institutional. Together we, as decision and policy makers, have an opportunity to develop a model for seamless flexible care if we think outside the current boundaries and work together.

Transitional care is one of those lexicons I spoke of, and we believe there is now some movement towards defining a couple of those levels. One level of transitional care is subacute care, which is deemed to be the active rehabilitation of people who may well be on their way back to their own homes rather than into community care. Transitional care, however, is more the transition into residential aged care where people may not actually be able to be facilitated. Getting through this lexicon is something that I have found of great difficulty in taking on the chair of the AMA's committee, and I commend you for your efforts in trying to do the same thing. The AMA, together with the rest of the aged care sector, is very keen to explore with government the various options for expanding the variety of transitional care services available.

I would like to take this opportunity to broaden recommendations 7 and 8 in our submission. These are on psychogeriatric care. The care of people with dementia should be part of the expected skills set in all aged care facilities and services. Challenging behaviour as a result of dementia, psychiatric illness, developmental disability or other causes such as head injury require specialised staff and facilities to complement geriatric services. This is an area of intense need and requires urgent attention.

Our long-term goals would include the establishment of teaching nursing homes. This would involve better integration of training and education between educational institutions such as universities and aged care facilities and the various carers of older people in these facilities. The teaching nursing home concept is something we have floated before, and we certainly have a great deal of respect for that idea.

The expansion of the hospital in the home range of acute hospital substitution models, where the patient's GP can be responsible for creating and managing the care plan and ensuring continuity of care, provides a model for both appropriate and cost-effective care for older people. The system of silos is a major issue here because current hospital in the home situations

are state funded while aged care is federally funded—Medicare is federally funded—and there are problems about GPs seeing people under a hospital in the home or hospital-nursing home type of facility.

Regarding ageing in place, our architects should be encouraged to design 'smart' houses and residential aged care facilities which are adaptable and have multiple uses and which utilise medical and communications technology which can help in the monitoring of an individual's needs. We had an opportunity to take my committee to Ballarat at the end of January and one of the nursing homes there had the most up-to-date facilities for looking after disabled people which were simply gobsmacking.

In conclusion, the AMA is committed to working with other stakeholders, including government, to ensure that the needs of older people are recognised. They must receive the care that they are entitled to expect in an accessible and timely manner within a quality framework preserving dignity and promoting wellness. Issues around the huge levels of paperwork for both medical staff and staff within facilities, duplication of activity, including drug sheets and the like, the concerns about wrong drugs being given or substituted and the issues surrounding the treatment of veterans in these facilities are of great importance to us. My comembers will discuss those with you in a moment. We appreciate the opportunity to appear before you and to answer any questions.

CHAIR—Thank you, and thank you for your detailed submission and recommendations. I want to ask you about recommendations 7 and 8. As you said in your submission, with longevity increasing we can expect the incidence of neurodegenerative diseases to increase. Would you care to expand on those recommendations? You have mentioned, principally, the skills that will be required for treating people with dementia and also the need for specialised staff. Do you have any view about whether you need specific dementia units within residential aged care facilities? What is the most appropriate model to make sure dementia and other neurodegenerative diseases are appropriately treated?

Dr Haikerwal—The benefit of being the AMA is that we can encompass all parts of our medical community. Dr Richardson is a geriatrician with an interest in this area. I think she is the expert to advise you.

Dr Richardson—One of the things that needs to be remembered with people with a dementing illness is that they change over time, and in particular their needs change over time. Not all people with dementia have extremely challenging behaviour but a significant number of them have moderately challenging behaviour. For each of those stages a person moves through with that illness they require a different skill set, possibly even require a different type of environment with various levels of expertise being put in, depending on the level and difficulty of that challenging behaviour. There would be no person with a dementing illness that would continue to have static needs.

CHAIR—Do you have any view on the sort of numbers we should be looking at over the next 40 years? We expect the number of people over 80 or 85 to quadruple over the next 40 years. Do you expect a proportionate rise in the number of people with neurodegenerative diseases as well?

Dr Richardson—Because the rapidly ageing population is over 85 we are automatically going to have a rapidly increasing number of people with a dementing illness and challenging behaviour. If we look at the conservative figures, right now, living in the community, not in residential aged care facilities, one in four people over the age of 85 have a dementia. It is probably a lot more than that; it is a very hidden illness. The numbers are quite worrying.

Dr Haikerwal—There were two other issues associated with that. One is that we do have a new generation of medications that actually reduce the severity of incidence, if not the incidence, of these illnesses. The other is that, looking into the future, 40 years hence, hopefully we will have some more forms of treatment through genetic engineering and so on. But obviously at this moment in time your question is very relevant—it is going to be an escalating problem.

CHAIR—Do you have a view on whether it is more appropriate that people with dementia be treated in community or residential situations or ageing in place, or do you think it is a matter of tailoring it to each individual?

Dr Richardson—The majority of people with dementia I am sure would like to remain at home, just like anyone else. But there does come a time with a person's illness, as with any illness, when it is not possible to support that person in their own home. We are asking a great deal of carers. The burden of caring for people with dementia is extremely high, and we see that resultant depression is quite a significant issue in caring for people with dementia. Therefore there comes a time when the majority of demented people would have to move into an aged care facility.

We know this because if we look at the number of people with dementia or at least qualitative impairment, because unfortunately many have not yet been properly diagnosed, at least 80 or 90 per cent of people in high-level care facilities have a dementing illness or qualitative impairment. The conservative figure in low-level care facilities, which are hostels—which used to just be considered lifestyle alternatives—is now reaching 30, 40 or 50 per cent. Quite a significant number of people do end up in the facilities. At the same time, the majority of older people are living in the community—I think fewer than 10 per cent are in care at any one point in time. But the likelihood of people over the age of 85 needing residential care is extremely high.

Dr Haikerwal—That is correct. The tailor made option is what is ideal. A lot of people are still in the community and, although it is a burden, their relatives would prefer to look after them. If they want to do that, we certainly need to be able to support the relatives, with the opportunity for respite and bailing-out time, and then, if enough is enough, the opportunity needs to be there for them to be cared for in a residential type of facility. So we do need to be aware of the transitional nature of the illness.

Ms HALL—Thank you very much for a very in-depth, detailed submission with lots of good ideas in it. I would like to ask about a couple of the issues you have raised. In the part of your submission relating to GP services to residential aged care facilities, you talk a bit about the residential classification scale. You talk about how it does not seem to have been as effective as it was first thought to be, and a little further on you talk about involving GPs in comprehensive medical assessment care plans and integrating them into the care plan. I was wondering if you would like to talk a bit more about those two issues. Also, we were just talking about hostels

and how their role in our community has changed so that, whereas someone with an RCS classification of 8 does not attract any funding, they are being pushing towards a situation where they are going to be taking more residents with dementia and more complex health problems.

Dr Haikerwal—I might open on this and then ask David to follow up. The actual residential aged care facility index we find is very complex. In terms of delivering care, from our point of view it makes not an awful lot of difference, but it does for the people in the facilities that we visit. They are constantly trying to maximise what they can achieve with these people, and if they actually improve the status they then get less reimbursement. We think that situation is very undesirable. It is important to maintain the actual level of care that is required not just to maintain somebody but to improve them. When they do improve them, people should be rewarded; it should not go the other way. That is a major problem with the current system.

Ms HALL—So you are saying that there is a reward for illness rather than wellness?

Dr Haikerwal—There is no reward for improving the situation, which is what we would think health and welfare is really all about. We think that is an anomalous situation. With regard to general practitioners and nursing home facilities, admission to such a facility is a major change in people's lives and we are now seeing that more people—especially in outer suburban areas—do not have facilities near their families so they are being admitted to facilities at a distance from their families and also from their previous caring doctor. From the point of view of continuing care, if you can get a doctor to look after you in the area you are doing well, but for that to be your own doctor is getting less and less likely. That is partly because of the distance, but also the fact that there are many disincentives in where people access aged care services.

What we see as being a major benefit is if we did get some form of proper enhanced primary care kind of item which rewards properly the taking of a proper comprehensive medical record on admission. We would see that as being part of the admission process with the nursing staff, the allied health staff and the administrative staff within an aged care facility, so that everybody gets in there and talks about the admission, gets information from everywhere else and you have that very comprehensive admission criteria. That would be a very good start to that person's time in the facility. That is part of the teamwork as well.

One step towards that, which I understand is in the offing, is something called the residential medication management review, which is currently under discussion. We see that as being a very positive step in that direction, where there will be an implementation of a scheme whereby people are encouraged to discuss with relatives, past carers and the hospital what sorts of medication has been dispensed and prescribed in the past and why. It is a chance for that to be reviewed in collaboration again with all those carers in the aged care facility and the community pharmacist. We are very much about building those teams, and very much about the holistic care of the patient, comprehensively and carefully.

Dr Rivett—All these units dovetail in that they all basically enhance one another. The comprehensive medical assessment is going to take considerable time. Only 16 per cent of GPs are now visiting aged care facilities and often that 16 per cent is not seeing their own patients in those facilities. Most of these patients are new patients. There are 40,000 new patients a year going into residential aged care facilities, so it is a fairly low cost item for government to

implement. It is a one-off assessment by that GP when they enter the facility. The patient is often new to that GP and the GP has to be rewarded for doing that properly, otherwise the medication management review will also be second class and fall by the wayside. It is a chance to cut back on PBS costs and make sure that medications are targeted correctly for those elderly patients they do not know well. It is an opportunity to save costs and dovetail treatment for each individual patient, with a thorough assessment guiding that, and it is not going to be hugely costly to government.

The medication management review has really hit a rock. We had an initial meeting with government less than a month ago, when they wanted to try and get this up and running in a week. They allowed 10 minutes of GP time, basically to do the assessment of a patient and medication management review, which was quite improper. We asked them to go away and look at that again. They said that they would get back to us within a week. That was over three weeks ago and we have heard nothing. So there is little progress here and a lot of frustration. The number of GPs attending residential aged care facilities are declining. Even though the number of beds rises each year, we see the number of GP visits each year going down. It is certainly a loss leader, along with home visits, for GPs, and it is something that GPs are not keen to do.

Dr Haikerwal—To stress that point, it is so important that we do get GPs back into aged care facilities. We have a paper which I believe is being submitted to you about the many disincentives that occur in that process. The benefits of proper medication management cannot be overemphasised. It is one of the biggest causes of what are counted as unnecessary admissions to hospital. That is why we are talking about silos: when you prescribe on the PBS, it is federal; when you come out of the aged care facility, it is federal; if you go into hospital, it is state—and that becomes a problem as well. When you look at the individual, it is a big problem to them because they have been bounced out of where they are comfortable in their new home and they may have been in an ambulance on an unnecessary journey. That is wasting time and resources—and their health. That is why, by comprehensively organising care and not worrying too much about those boundaries, things can actually work better for the individual.

Mr Shaw—These are the difficulties—the disincentives, we call them—for doctors to participate at the local level in care management. At a federal level, from a policy perspective, we find it a little difficult to get those sorts of issues raised because, for reasons that we do not quite understand, the AMA is not involved in all of the consultative bodies that the government has. There is the Aged Care Advisory Committee, as I think it is called now—it used to be called the Aged Care Working Group—which we are not on. We are not represented on the consultation mechanism of the accreditation agency either. So it is a little difficult for us to raise those sorts of issues through the appropriate channels.

CHAIR—Has that been a gradual change? Dr Rivett mentioned 16 per cent of general practitioners visiting an aged care facility. Has it been due to economic forces, if you like? It is a change from the model of general practitioners visiting their patients in an aged care facility.

Dr Haikerwal—It is incredible that with an ageing population and more aged care beds, eventually people are going in with more complex illnesses. They are actually sicker when they are in aged care facilities. But the number of consultations is actually dropping and the percentage of GPs doing that work has dropped down to 16 per cent. Not only that, but the levels have also altered. Your question specifically is why, and the answer is that it does not make business sense to do that—and general practice is a small business. Also, even people who

would not mind taking a bit of a hit, because they are cross-subsidising within their practice, have problems with other impediments when they go in, in terms of getting support, of getting requests for information and paperwork, of being accredited by the home or the supplier of the home facility—and for what? We were told a lot of things like 'you have to sign every single prescription' are due to their accreditation process. It is the big stick the aged care facilities have hanging over their heads. It is not necessarily true. There are many myths within aged care facilities that we have to live with in providing care because we would rather not rock the boat and we do not want them to lose their accreditation status. In fact, they are putting more barriers both for themselves as providers of care and for us to visit them. Reviewing comprehensively what is required and knowing what are the real requirements and what are myths would ease up on some of that administrative work for all concerned.

CHAIR—Would it be viable in your opinion for larger facilities to have a GP on a sessional basis or something like that?

Dr Haikerwal—One of the recommendations that we have is for an aged care facility adviser. The role of that adviser is not to diminish the patient's access to their own GP, which we believe is a fundamental right, but to facilitate that line of communication between the aged care facility, GPs visiting and pharmacists, and to get into that scheme of things specialist opinion from a geriatrician and to bring in other people that are relevant in a very systematic way rather than ad hoc. That is how an adviser would help in those processes. It takes quite a significant time to get things right. If you have 12 aged care facilities in a given area that you visit, you might need 12 GPs to sit on 12 committees. That is a waste of time. We could have one for a facility and one for an area. That is why we think this is a very reasonable model not only to reduce costs but also to improve quality of care because you have a template to use on a long-term basis.

Mr Shaw—We have a discussion paper which we attached to our submission.

CHAIR—Yes, I have got that.

Mr Shaw—We also included that idea in our federal budget submission this year. We have suggested that there might be an allocation of $20 million which would allow that concept to be trialled in various homes around the country.

Ms HALL—I noticed in your presentation today that you were talking about the things you thought were important for GPs and facilities and you thought that a consulting room facility was important and that you needed computer facilities. As part of any approval of residential facilities, do you think this should be incorporated in it and should it be one of those items?

Mr Shaw—We have not suggested that at this stage but it is an idea that we would like to float, yes.

Dr Haikerwal—Following up on that comment, it is important to us that these facilities are there, because then the job can be done better. We have to be very conscious of the requirements that aged care facilities already have. However, it would not just be for medical purposes; it could quite easily be for the allied health and everything else going into the facility. It is actually a beneficial thing—rather than a big stick, it is a carrot.

Ms HALL—You devoted a section of your submission to flexible housing. Would you like to elaborate on that? You made some specific recommendations.

Dr Haikerwal—The significance of the housing is in the cost of access to facilities that allow people with disabilities to move around, in comfort and in incorporating new technologies. We have gone into some detail about things that were looking more into the future—auto analysers and the like—and I think we are a fair way from that. But the concept of modular housing can be adapted as you move through your retirement. Initially, you may not need any facilities but, if you do, you can install things like sinks that adjust so they can be reached, toilet bars and a whole variety of things, as we saw beautifully illustrated at the Ballarat facility. They are the sorts of things that, if done in bulk, can be a lot cheaper. The system we saw in Ballarat cost $10,000 to $15,000 for a room, and that is just outrageous; but if you had that in a modular system built in a factory and done more sensibly, it would work well. Similarly, with things like housing solar power, the cost reductions that you can make from energy efficient housing would actually make things a lot more comfortable and affordable in the long term, because the longevity would be enhanced by using materials that have a suitable lifespan.

Ms HALL—You talked about houses that are more easily relocated. Are you thinking of houses similar to the types of housing that are in relocatable home villages? I do not mean caravans as caravans, but the quite luxurious houses that are sometimes in those types of places.

Dr Haikerwal—Other than caravans, there are a variety of homes that are movable, including Victorian cottages. Where they are located is the important thing. For instance, where there are relatives willing to take on some care, relocation could be onto or close to the relatives' property. So there is the possibility of being flexible and movable. The building materials, of course, need to be responsive to temperature and so on, and remain solid. That is what the technology of the architecture role has a lot to do with.

Ms CORCORAN—One of your recommendations talks about the need to find alternative facilities for younger people who are presently in aged care facilities. You talked about reallocating the bed licences to a different facility—perhaps you mean extra bed licences. I am not too sure, because there seems to me to be a shortage of the bed licences already. That leads to the concept of ageing in place. I understand it means a resident coming in and staying in the facility for the rest of their lives, and that facility changes the care it gives that resident. I have had different comments: some people think it is a really good idea; a couple of nursing homes in my electorate have made the point that some of the other residents do not like to be living with somebody who is becoming more demented and that sort of thing. Would you like to respond on that?

Dr Haikerwal—I might talk about young people and ask Sue to talk about ageing in place. Young disabled people who need full nursing support in aged care facilities find it extraordinarily hard to live with people who are not in their age group. There is a big movement going on to highlighted this crisis. I cannot give you the exact numbers of people, but I am sure the figures are available of how many such people are in aged care facilities. First of all, it means that these younger folk do not have their specific needs met or, if they are, it is actually at the expense of the older folk living there. As you said, in Victoria we have a marked shortage, of around 5,000, in available aged care facility beds.

That is why we need to make sure that the beds are available for older folk and that we meet the specific housing needs of people with disabilities who are younger, whether it is in communities or in individual houses, where they can have proper supervised care. That is certainly an issue for both sides of the care spectrum—both the older and younger folk, and their carers—that have great difficulty dealing with the situation.

Dr Richardson—Ageing in place, particularly for people with dementia, should really be quite easy. We now have drugs available to us that will put off the time you need to go into care by between 12 and 18 months. We now have three drugs available in Australia that have been shown in studies time and time again to do this, both overseas and in Australia. Dilemmas relate to the number of people who do not have access to those drugs under a subsidised system. A dilemma I see all the time in trying to provide patients with medications such as these, and other medications for their multiple medical illnesses, is that one of the things that disappears very early with dementia is the ability to take medications appropriately. You need supervision of your medication within 12 to 18 months of developing early dementia. This is one of our higher functional abilities. In effect, my main barrier to treating people and attempting to keep them well with a number of preventative medications that we can now use is the fact that there is no-one there once or twice a day to give that person a tablet. This is an exceedingly frustrating scenario that I face every day—that I now have very safe and effective drugs available to me as a medical specialist but I do not have a person to hand them out.

Ms CORCORAN—I also wanted to test the concept of ageing in place in a facility. My understanding is that back in the good old days you had a low-care facility and a nursing home, and you would move from one to the next. The trend now is to have one facility that you move into as a low-care patient—to use the old terminology—but you stay there as you become a higher care patient. I am interested in your attitude to that, because I am getting a mixed reaction. Some people say that it is very good from the residents' point of view—it is great that they move in and see this place as being their home; it is not temporary. I am also getting comments that other residents who are fitter do not like being in the same facility as residents who are needing lots of high care.

Dr Richardson—That is an issue. I honestly believe that, with regard to aged care facilities, that is going to become less of an issue. In effect, the people now entering even low-level care need a fair amount of high-level and low-level care. Increasingly, you are going to have fairly functionally disabled or cognitively disabled people in low-level care facilities. Therefore, in all honesty, it is not going to have quite as much impact as it is now having in some facilities where we still have people who moved in quite a number of years ago as a lifestyle option. We still have that cohort of people going through. It is less of an issue for the facility staff. The issue for the facility staff, I understand, is the fact that they now do not have very many reasonably well, capable people. They are overwhelmed in terms of who they can and cannot take based on their staffing and building design needs. That is the issue in low-level care. There are very few people who go in there without moderate needs. Of the odd couple who do go in, there might be one well person, but well people do not go into facilities anymore.

Ms CORCORAN—My last question is about the physical siting of aged care beds. Again, I am getting mixed reactions. Some people say it is best for a resident to be able to go into an aged care facility in their own neighbourhood so that neighbours can come to see them and they still feel that they are living where they have always lived. Other people are saying that they are better off being near family, who might be 10 suburbs away. The question probably has no

answer, but do you see a preference emerging? It has to do with where we put aged care facilities in years to come. Do we put them near the young communities because that is where the young families are and mum can move near them, or do we put them in the older areas?

Dr Haikerwal—It is a very hard question because the cost of housing and land in older areas is greater—

Ms CORCORAN—That is another issue.

Dr Haikerwal—than in areas such as mine which are more outer suburban and where you get more access and the chance of building a bigger, better and brighter facility with less access. It really is a balancing game between getting access to friends, neighbours and possibly relatives or getting access to relatives but losing a lot of social contacts. As an example, our practice is right in between a residential village on one side and an aged care facility on the other. There is an aged care day centre where people from the village can go. But—and this has happened—a husband who has moved into the aged care facility across from there cannot go and visit the day centre with his wife. That is just in the same area. So there are some really crazy situations, even though this is in the same area. With regard to access, I think that in this day and age people do not have much of a problem with travelling to visit relatives. They are happy to do that. I am sure that having a better facility would be a more important driver than having a smaller facility that may be inefficient and may not be able to survive in an older area where the land value is much greater for other uses.

Mr HARTSUYKER—With regard to recommendation 19 and the issue of younger people in disabled facilities, representations have been made to me on the psychological effect of a young person in an aged care facility who befriends people and those friends pass away on a regular basis. That has certainly had a very negative effect on a number of people who have been brought to my attention. Do you have a model that you believe could be used in regional and rural areas where the only possible accommodation for such people is an aged care facility?

Dr Haikerwal—It is interesting. We have an advisory committee on aged care which includes people from the disability side of the sector. One idea that was floated which sounded quite good was to have individual units with two or three people in clumps. However, that was then seen as being a move backwards to institutional care. It was not really, but it was seen to be. I think that there are lots of nuances in the way in which it is perceived that we have to work through. But it is important that people are with people of their own age and interests and are not having the negative experience of people around them dying all the time. It is going to happen, but it is not quite so common. I have no firm view on it. I do not know if anybody has a firm view on which is the best way of doing it, but we certainly identify it as being a major area of need to address, because there are increasing numbers of people in this predicament who are not of an older age.

Mr Shaw—We do consult with stakeholders in the sector and we would be happy to be involved in consultations with government to seek to address those sorts of issues, but there is no easy answer and there is probably no single right answer either.

Mr HARTSUYKER—It has been brought to my attention that, when people are living out in the community and pass away or need to go into care, when relatives move into the house they find an absolute treasure trove of vast amounts of unused medications, which obviously

indicates some form of overprescribing or overuse of medicines which is not optimal. Have we a strategy to address this inability to plan your own medications as you age?

Dr Haikerwal—I will ask David to follow up on what I have to say, but obviously quality prescribing is a key factor in medicine and general practice in particular. I believe that general practice prescribing is done judiciously. The problem of course is in compliance, in the way in which medications are actually then used and in the way in which the safety net is sometimes accessed inappropriately.

Dr Rivett—This is an area for great waste and misadventure. Recently the government has brought in an initiative with domiciliary medication management reviews where pharmacists go to the house and check through the medications in their entirety, whether they are complementary medicines or mainstream medicines. Unfortunately, initial surveys are showing that most of those reviews are being done in the pharmacy—something like 90 per cent of the initial survey—which is extremely alarming to us as GPs. It is not what we wanted to see. One of the big advantages, if it was to be done this way, was that the pharmacists would actually go to the home and check what was in the cupboards.

Mr Shaw—The other thing that the committee may be aware of is that the Australian Pharmaceutical Advisory Council has just recently, in the last month or so, set up a working group to develop guidelines for medication management in the community, which is not specifically for elderly people but is primarily for elderly people.

Ms HALL—In your submission, you mention the issue of elder abuse. I am wondering what sort of evidence you have of that and what sort of research and strategies you would like to see in that area.

Dr Richardson—I think one of the problems in the care of the elderly, simply, is that we have always said as geriatricians we are 20 years behind the paediatricians. I understand that, in most states throughout Australia, we now have fairly mandatory child abuse reporting without any comeback for doctors. Elder abuse is very much more hidden. Not only is there no education on it but at various state levels there is absolutely no enthusiasm to make it very similar to child abuse. It probably is a major issue that would make most of us feel fairly awful. It is just that it is hidden and not recognised. We are not just talking about physical abuse; we are talking about emotional or, for example, financial abuse. I have often been brought in to provide determinations on a person's competence, particularly in terms of financial abuse. It is a growing problem and, increasingly, it takes up a lot of my time. I was a little upset—and maybe others can talk to you about it later—that COTA had hoped to push this issue much further and they are getting nowhere. The issue is certainly there, we have no research on it, and we do not know the numbers—and we are 20 years behind the paediatricians.

Ms HALL—What research would you like to see and how would you like to see it introduced?

Dr Richardson—It is very hard and if we do not have any education about what to look for in regard to elder abuse, we are not going to pick it. I am one of those who believe that if you do have mandatory reporting, as occurs with child abuse, we will then actually be doing the research. We will then know where the problems are, and we can target education, including the

education of carers. It is not necessarily a punitive system; it is a matter of educating our society as to the problem.

CHAIR—Dr Richardson, in the press release from the AMA you mention that social isolation is a reality for many older people. We do actually find that in our community forums and so on, though very few of the submissions have provided concrete solutions to address social isolation, which I presume requires a response from the community, family and individuals as much as from the government. Do you have a view on the sorts of things that would be helpful in addressing the problem of social isolation?

Dr Richardson—It is very difficult. Unfortunately, a number of older people are not physically well or cognitively well, and both of those combine to reduce a person's ability to socialise. We know, for example, even in the early stages of dementia that social isolation is a symptom of early dementia in a number of people. I guess the problem is a hidden problem because these people are not making a noise. I do not know how you find that hidden group of people and do something about it, except to make people more aware that social isolation is probably the start of other problems, and that we should get in early at that stage as medical professionals, for example, and do something about it.

People talk about having community aged care packages and how that might improve social isolation, or using day care facilities or whatever, but I think, in all honesty, if you talk to the majority of older people, it is very hard to get them there and it is very hard to get the right kind of support into houses. From what older people tell me, it is actually the volunteers who have the most success, especially in things like early dementia. They are not seen as being intrusive—as health professionals coming in and dominating the older person's life—even when people do not realise they have a need for that. There are obviously many organisations that can be tapped into once there is a rising awareness that we have a population that we could have the potential to keep for quite a long time.

Dr Haikerwal—There are many programs in this area that work particularly well. In my own experience in outer metropolitan Western Melbourne, the aged care centres have programs for people with different linguistic needs, and they are very useful. Once you have managed to persuade someone that they are old, and that they may like to go and meet other people in the same category, they do very well in encouraging those community groups that are taking the initiative to look after their own communities as they age. That is one specific way in which we can do that. They need not be linguistically based; they can be based on area or on other sorts of interests. People in the community are living longer. We need to encourage them when they are well to do things and then they will carry on doing them and be supported by the same group when they are older. I can think of one example of a Latvian choirman who is 89 and still living on his own in supported accommodation—and still singing.

CHAIR—There being no further questions, I thank you very much for your submission and also for your evidence today.

[11.43 a.m.]

GRAY, Mr Richard Nelson Worsley, Delegate, National Aged Care Alliance

HAIKERWAL, Dr Mukesh Chandra, Australian Medical Association Delegate, National Aged Care Alliance

ILIFFE, Ms Jill, Member, National Aged Care Alliance

REES, Mr Glenn, Member, National Aged Care Alliance

REEVE, Ms Patricia, Council on the Ageing National Seniors Delegate, National Aged Care Alliance

YOUNG, Mr Rodney Paul, Delegate, National Aged Care Alliance

CHAIR—Welcome. I remind you that the evidence 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. The National Aged Care Alliance has provided a submission, No. 88, to the inquiry, and copies are available from the committee secretariat. Mr Gray, would you like to make an opening statement before I invite members to proceed with questions?

Mr Gray—I will make a very brief opening statement and ask each of my colleagues also to make a very brief opening statement, with your indulgence.

CHAIR—Certainly.

Mr Gray—The alliance is a unique organisation. It was formed in April 2000 as a result of a concern by a number of organisations, stakeholders within the aged care sector, following the adverse publicity about the addition of kerosene to the baths of residents of Riverside Nursing Home. As a result of coming together in a forum, we agreed to form the National Aged Care Alliance with 17 members. Now we have 23.

We are not an incorporated body. We have no office-bearers. We employ no staff. Our process is a facilitated consensual process and we meet three times per year. Through that process we arrive at the decisions of the alliance regarding our positions on various aspects of the provision of aged care services. As a result, we have issued a number of publications. We have issued, to government, federal budget submissions on at least two occasions and we also produced position statements during the last federal election. We have produced 13 recommendations in our submission to this inquiry. With regard to those recommendations, we also have the endorsement of all the members of the National Aged Care Alliance for the content. Because of our structure, this may constrain us in making comments or answering questions on matters not contained in our submission, but I will leave that to the delegates. We do have a web site, which is www.naca.asn.au, and we welcome the opportunity to make a presentation to this inquiry.

CHAIR—Do any other members wish to make a statement?

Dr Haikerwal—The Australian Medical Association is very proud to be part of the National Aged Care Alliance. Together with our partners in this, we feel that the sector needs to work cooperatively, and that is why the association works well with this group. Medical care is something very central to our part of NACA. The care of people in aged care facilities is significant, but the care of people in their own homes and in the community is something that we feel is woefully neglected, not for want of trying to address it. We have mentioned in the Australian Medical Association's submission the disincentives to people working in aged care facilities, including not only general practitioners and specialists but also people from other specialist work forces.

We also believe that the ageing of people who are healthy in the population is something that gives us an opportunity to develop and maintain their good health so that they can stay in the community as long as they possibly can. Those living in the community may or may not be in need of support but people who have acute health care needs in hospital and aged care facilities need very specialised, recognised care. This is specialised care that needs to be adequately valued.

Ms Iliffe—The Australian Nursing Federation is also very committed to the way in which the alliance operates and to the work of the alliance. The focus of my comments relates to the provision of residential aged care, community aged care packages and extended aged care at home. My comments specifically relate—which is no surprise, I imagine—to work force issues. To be able to provide quality aged care, providers must be able to attract and retain quality staff. To attract and retain quality staff, you must be able to pay them competitive wages, provide a supportive work environment and ensure that they have the necessary skills and education to meet the needs of the clients. As an example, nurses' wages in the aged care sector are currently $123.06 less on average nationally than those of nurses working in the public sector. Despite the allocation of $211 million in the last federal budget to close the wages gap in aged care, the gap in nurses' wages has in fact widened.

Wages comprise about 78 per cent of the costs of high care in residential aged care facilities, and the provision of high care in aged care facilities is increasing. The aged care sector does not have the same opportunities for improving productivity as the public sector does in the use of technology or in reducing lengths of stay. The percentage increase in nurses' wages alone, over the past 12 months, was one percentage point higher than the average annualised wage increases for other sectors.

It is the view of the alliance that the current indexation formula for aged care funding does not compensate aged care providers for wage costs or allow them to offer competitive wages to attract staff. This results directly in less available staff; increased workloads for existing staff, making it harder to retain them; inappropriate skill mixes for the increasing complexity of care; and potentially compromises the quality of care and increases the likelihood of injuries to staff. Additionally, the type and range of care being provided demands a well-educated work force, particularly in the areas of palliative care and respite care, because of the changing nature of care. All this costs. I think the recommendations that the alliance has put forward in its submission point to the fact that the funding in the aged care needs to be examined very closely if we are to provide quality care in the future by quality staff.

Mr Young—I would like to address the committee particularly on the issue of the infrastructure investment within the sector. A reasonably conservative estimate these days of the investment in residential facilities runs in excess of $20 billion. The actual investment being made in the sector over the current 10-year cycle, commencing from 1997, is about $8.4 billion. That is a very substantial investment. When we look at the projected demographic changes over the next 30 to 40 years and the doubling of the population in the older age group and extrapolate an assumption that a similar investment is going to be required, the numbers are fairly dramatic. However, I impress upon the committee the need to look at the likely usage that will be made by the community of a variety of support services, including physical infrastructure such as housing and residential care. If we try and draw some lessons from the last 15 years, there has been an enormous change simply in how residential care is used, the volume of services and the type of services being provided in the community through the fairly rapid expansion of community aged care packages and the expansion of HACC programs. The assumption is that it is very likely we will continue to expand those sorts of services into the future.

It is, I think, a motherhood statement that all of us would prefer to be cared for in the home rather than having to be moved into an outside service provision situation, such as a residential care facility. In which case, my concern relates to: what is the likely impact, if we do some modelling for the future, upon the fairly significant investment we have in bricks and mortar and the physical stock that is available within our sector? In the last 15 years, a changing demographic has occurred. As you would already be fully aware, I am sure, the average age of residents now is 83 years and climbing. The average age for admission is in excess of 80 years. In 15 years, there has been an approximately 4½- to five-year change in average age at admission. Therefore, we need to be very conscious about how we plan for the future. We need to do some in-depth analysis of what the model might look like and what the demands, particularly of the current baby boomers, on future generations will be for service requirements. We need to ensure that we plan adequately and do not assume that the current 100 places per thousand people over 70 is an adequate reflection of what the future requirements will be.

Mr Rees—It is important to Alzheimers Australia to be part of the National Aged Care Alliance because dementia is a mainstream issue. One of the messages I would like to suggest is that aged care is dementia care, because some 90 per cent of people in high care and some 60 per cent of people in low care will have cognitive impairment. Dementia is a terrible disease. It is already the second largest cause of disability burden in Australia. By 2016 it will be the most important and will overtake depression.

I do not want to talk to you about statistics because they are a bit depressing. You are talking about the future. We believe the future for dementia can be positive and we very much hope your committee will be positive. There are three recommendations in the NACA submission that we would like to draw to your attention. The first is research, which is recommendation 2.9. Without investment in research there will be no quality of life for the half a million Australians who will have a diagnosis of dementia by 2050. Research is vital in terms of service delivery, of cure and of finding cause.

The second recommendation I would draw your attention to is community services, which is recommendation 2.6. I believe there is a gross imbalance in investment between the residential and the community sectors. In terms of dementia, only 16 per cent of community expenditure on services goes to dementia. We believe that area is much underfunded. The third recommendation I would draw your attention to is 2.5. As I have said, we believe that all

residential care should be quality dementia care. But we also think that, within residential care, the word 'mainstream' has allowed people to forget that some people have special needs at various times in their journey with the disease, because it does change at times over the eight- or 10-year period that they may have dementia and it changes with the cause of dementia. The recommendation for dementia-specific care in the NACA submission is very strongly supported because there will be a need, not all the time but maybe for a short time for some people, for special care.

CHAIR—Thank you.

Ms Reeve—COTA National Seniors is the first step of a new partnership and an ultimate merger between Council on the Ageing and National Seniors, so we now have over one-quarter of a million older people and 1,500 seniors organisations directly within our membership. As an organisation that is committed to the wellbeing of all older people, we think it is really important to work in an alliance with professionals and providers of services to a proportion of older people. The range of aged care services, if we take it from preventative and rehabilitation services through to services that deal with acute episodes of health need and on to residential care, covers a span of people that have a very wide range of needs and also very different needs, so there is not a 'one answer fits all' solution. And I would like to remind everyone that, particularly when we are talking about residential care, we are not talking about people being there because of their age. They are very old, but they are there because they are very sick. So especially in high care, and increasingly in low care, what we are talking about is part of the health care system. These are ill people.

We have made a broader submission to you over lots of areas of your interest. In relation to what we are focusing on in the alliance, we see a need to build up the prevention, rehabilitation and community care services both for individual older people and for support for those who provide informal care, the majority of whom are themselves old. These are situations where people care for spouses, brothers or sisters or, in many cases, where there are two generations both of whom are old—for example, a 70-year-old daughter with a 90-year-old mother—so it is quite a complex area. That would do two things: it would meet people's preferences to remain within their own established relationships in families and communities and get the services they require; it would also reduce the demand on very expensive residential aged care, which is for a minority of people but they are the most vulnerable because of illness and chronic disability.

We have put forward to you suggestions about increasing the Home and Community Care program, which does provide a basis of support for many people but gets pooled to meet many needs in our community, and also expanding the aged care packages that are available to people. We have made a specific recommendation also about respite care, which is very difficult for people to access because of a number of constraints in the system. So we see all of those as underpinning action in the residential care area.

From the consumer perspective, what drives us in the provision of all of these services is a wish that anybody who needs it should be able to get access to high-quality care irrespective of where they live or their individual capacity to pay. So we are looking at getting some government attention to that and some way to deal with that. As we have already heard from other people, the age of entry is getting up to over 80 and is, on average, 83. Many of those people are single, older women who are not distributed evenly across income distribution in our society. In the over 80s, people are increasingly clustered in the lower end of the income scale.

Single women are also likely to be in the lower areas of income. So we are not looking at a complete cross-section in that idea.

CHAIR—I will kick off and ask Mr Young a question. You briefly mentioned that you felt the allocation of places needed a review. Do you have any preliminary ideas on what the breakdown should be or are you more interested in having it open to community debate and seeing what emerges?

Mr Young—I was mainly talking on behalf of the alliance in wanting to raise a certain issue. There is certainly now clear evidence, the most recent being the AIHW report from last year, looking at the distribution of resident classification across the system. Of all residents in the system, 63.8 per cent now are classified in high-care categories 1 to 4. We are aware that nearly 25 per cent of all residents in low-care facilities are in fact of a high-care classification, and there are many facilities with in excess of 40 per cent of their residents in high-care categories. Those figures in themselves indicate that the current planning ratios of 10 per cent community care, 40 per cent high care and 50 low care really do not match the reality of the services that have been provided on the ground. In fact, the numbers almost need to be reversed to something like 60-plus per cent for high care—which reflects the 63.8 per cent actual as at the end of last financial year—and a much lower proportion of low-care places. That leads on to a secondary issue, which is: is there any logic in maintaining a high-care, low-care separation in the future because of the reality? The reality is that nearly 65 per cent of all residents are high care anyway.

Mr Gray—Also, pre 1 October 1997 approved beds are able to take in both high-care and low-care residents. So it really is irrelevant now whether they were previously nursing homes or hostels prior to 1 October 1997, because they are able to admit either level of care.

CHAIR—I would like to explore that one step further. What do you think are the shifts which mean that this ratio no longer reflects what is going on? Is it more that people who 15 or 20 years ago were likely to end up in low care are now receiving HACC or community aged care packages or ageing in place? Is that one of the shifts that is occurring?

Mr Young—I think that is certainly one of the shifts that is occurring. We also have to look at the numbers. If you go back to 1992, there were less than 2,000 community aged care packages available. The government target at the moment is to have 40,000 available by 2006, which will be one in five places. That is a very rapid shift in policy which I think everybody here would support. That has certainly been reflected by its uptake and by the acceptance of those who are using the system. What I was leading to a while ago was that nobody has actually reviewed what impact that quite rapid change in community places is having on the need and the medium- to long-term planning for residential places. The worst thing we could do would be to go on building residential places into the future when maybe we do not need them. We need to be very clear about what our plan is.

I think there are secondary issues happening that are quite difficult to define, and they also need to be explored. Obviously, the population is living longer. Our acute medicine services are able to maintain people in better health. Our lifestyle and recognition of wellness activities are changing and improving. So this is delaying, along with HACC and various other programs, the entry requirement into residential care. As Patricia said a minute ago, almost invariably these days there is admission because of illness not because of any social or lifestyle type decisions

being made. The criteria for admission at the gatekeeper point—the role of ACATs—has also changed quite considerably. If we go back and look at the criteria in the mid-eighties as to opposed to the criteria today, there has been a very significant change in how people gain admission and the criteria being used.

CHAIR—In the Intergenerational Report, the Treasury forecast that Commonwealth government spending on both residential aged care and community aged care would double as a percentage of GDP and that their growth rates were similar—they were really extrapolating from past growth trends. Does the alliance have any view on whether that is right? If we are planning for 40 years in the future, do we expect the demand for residential aged care and community aged to grow about the same? What do you think?

Mr Young—I am not sure the alliance has formed a view on this at the moment. It is one of the things that we do have on our agenda for later this year. If we offered comments, they would probably be personal ones.

Ms Iliffe—We have published three reports. The latest one is to be released next week. It talks about the funding that we are receiving now in residential aged care. You can use that as a guide to what may be required in the future. It gives some options for improving the funding. It might be very worth while if we make a copy of that report available.

CHAIR—Thank you, we would like that. We can make that an exhibit for our inquiry as well.

Mr Young—It specifically looks at the whole indexation issue and its deficiency in funding the residential care system, in particular up until 30 June last financial year. It does not really look at the future. You could use it and extrapolate forward projections, but the report itself simply looks at the history and not the forward estimate component.

Mr Gray—The Intergenerational Report actually took the current planning ratios and extrapolated the current expenditure into the future based on those. It really did not identify any shifts or changes in policy, so that would be an issue.

Ms Iliffe—The other issue too, in line with the fact that community care is increasing, is that you also have to factor into the future that, when people do come into residential care, the sort of care they will be receiving will be different from the care they are receiving now. That supports what Patricia and Rod both said.

Mr Young—Another report that we might also make available to the committee concerns long-term funding. We put together a summary of the recent writings in Australia about future possibilities for long-term funding and also a summary of the British royal commission and the German changes. We tried to consolidate that—though it still runs to 50-odd pages—into a document which the alliance could use basically as our own educational tool to inform us about those alternatives and how they might operate in the future. We can make that available to the committee also, if you wish.

CHAIR—Thank you, but we may already have it.

Mr Gray—I think it was sent to you as a hard copy exhibit.

CHAIR—Yes, we have it.

Ms HALL—I have a couple of questions. They probably relate a little to what has just been referred to—that is, the funding issue. I noticed in your submission, and in the attachments, some innovative approaches to funding. Would you like to discuss the issue of funding? From what I have heard here today, you are looking at the issue of wages and making sure that we have adequate care. These matters seem to raise the issue of funding and how we are going to fund for the future. I would be very interested to hear some of your suggestions.

Mr Gray—I think the first point about adequate funding for aged care is establishing a proper benchmark of care and defining—

Ms HALL—That was my next question, if you would like to incorporate that in your answer. I was going to ask you about the issue of benchmark of care.

Mr Gray—At the moment, the way the system is funded is that it is based on the history of the funding of the system rather than actually establishing a proper benchmark and what the elements are that comprise that benchmark, based on a quality system with adequate skilled staff to deliver quality care. That is the point: we have to start with a basis for what it is that will deliver quality care to people in residential aged care and establish that benchmark, and then establish the cost of that benchmark. Clearly, it is not just one level of a mix of things; it is a more complex thing than that, because you have numbers of residents with individual needs. If we are talking about person centred care as the basis of how the system should be funded, we have to look at what the needs of that individual are in terms of quality care and adequately skilled staff to provide that care, and that becomes the benchmark.

Ms HALL—With respect to the funding proposals in your submission, would you like to talk about them a little?

Mr Gray—Certainly we have said in our submission that using that benchmark of care should be the basis for determining the funding level. Clearly, we currently have a system of government contribution as well as resident contribution, consumer contribution, and we are not suggesting that that should change. Clearly, it is accepted by the community that aged care is a common good and people do need and are entitled to appropriate levels of care as and when they need them. That should be the basis for government and personal contribution in terms of funding of the system.

Ms HALL—My next question relates to the RCS. What is the alliance's opinion of the RCS and how effective it is? Do you think there need to be changes?

Mr Young—The alliance has certainly considered the issue but has not got an absolutely formal position, other than a clear agreement that the existing relationship between the RCS as the funding tool and the validation processes that currently exist create an inordinate amount of unnecessary documentation that impacts upon the ability to supply the required staff on the floor, attracting sufficient qualified nurses to the sector and retaining those nurses in the sector. There is general agreement that we need to break that nexus between the RCS as a funding tool and the validation processes that are used by the department of health for accounting for the public expenditure of aged care dollars.

Ms Iliffe—One of the difficulties for staff has been that, because of the need to justify the claim and the classification and the amount of documentation that they have thought to be necessary and which has proved to be necessary when the validators come in, they are focusing on that funding tool and using it as a pseudo care plan. I think some of these issues have been addressed with the RCS review, on which most members of the alliance have been represented. The other issue with documentation is that we tend to fall the other way, when we look at something and think it is excessive and that we should reduce the documentation. You do need a certain amount of documentation for the safety of the resident, the safety of the provider and the safety of the staff. So we have to find a happy medium.

The focus of the alliance has been on quality. You will see in our submission that we talk about quality buildings, quality staff, quality funding, quality accreditation and a quality complaints system. We have to find the balance between what is the right amount of documentation and what is excessive documentation, so that we can deliver services on the ground.

Ms HALL—My final question relates to research. I noted that Mr Rees identified that research was needed in the area of Alzheimer's and dementia generally. What other areas do you think need research? Do you, as a group, have a suggested policy on research and the amount of money that needs to be put into research in ageing and aged care?

Mr Rees—I think it would be common ground in NACA that there is very little research in Australia into the delivery of services. That is a pity because Australia has a world-class care system. We will all tell you it could be better but, relatively, it is a good system. In the area of dementia, there would only be one other country, in my view—which is Sweden—that is looking at psychosocial interventions with dementia in the sophisticated way that Australia is. We have got some very good researchers who are starting to show the quality of life improvements for families and people with dementia that can result from those kinds of interventions. While I would not put all my eggs in the research basket in terms of service delivery, I think it is a critical area for Australia.

Another area that I would look at is one where we have some very good researchers at the ANU, Monash and elsewhere, and that is longitudinal research, which would be very helpful in more effectively teasing out the causes of chronic disease, including dementia, among the ageing population. And from my point of view it is positive that, to the extent to which Australia invests in research in this area at all, there is a priority for looking at some of the biomedical issues. We do have very good researchers there. I think the quantum of research is simply too small.

Dr Haikerwal—The mechanism through which this would be achieved would be the teaching nursing home concept, because you need to have something on the ground from which to work. When you get the different craft groups and professions together in a teaching environment, not only is teaching possible but so is learning. That and the good links with local universities and other facilities would make that a much more amenable possibility.

Ms Iliffe—One of the things that Richard said was that we needed to establish a benchmark of care, and to do that you have to do some research. The alliance has a research subcommittee that established some research priorities. We could make those available to the committee.

Ms HALL—We would appreciate that.

Ms Reeve—The other practice issue is what are the most important things you can do to support people in their own homes. We have a range of packages and Home and Community Care funding, but finding out what are the critical points and services that people need to remain confident and able to stay in their own homes is a piece of practice research that is well needed.

Mr Young—One of the models that I have found attractive is the hospital demonstration project, where a particular agreed project—usually a consortium of hospitals or other health care providers come together and develop a real life project—gets demonstrated on the ground. There is potential application of a similar funding model for the aged care sector. That ties into Mukesh's suggestion of the teaching nursing home because you can then use that as your foundation to bring consortia together. The consortia then have a responsibility to educate the facilities that are not involved directly in the demonstration project about its positive results.

Ms CORCORAN—A question was asked earlier of you, Rod, about the 50/40/10 split and I think you made comments about the need to not have the 50/40 split anymore. In the ideal world, in the allocation of places would you leave community care at 10 or would you bump it up to something else?

Mr Young—If we think forward three years to 2006, the number of places currently planned to be available is 40,000—that is 20 per cent, one in five. At this stage there is no indication that there are vacant CACPs in the system. In fact, there is every indication that there is capacity to expand it even further. If that is the case, then I do not know what the number is—probably nobody does. But certainly, projecting to 2006, we need to start thinking about what is the optimum number. As I said earlier, that really does impact quite significantly upon what you are providing by way of building stock and beds within facilities. So we need to be rethinking what are the numbers and how do we plan for the appropriate community and residential places in the future.

Mr Gray—We identified in our report that the current number of allocated places as at 30 June 2002 is 108.4, representing principally high- and low-care places that had not come onstream as operational. It has principally got to 108.4 because of an accelerated number of community aged care packages that have been coming onstream.

Ms Reeve—I could add to that. I do not believe you can look at the packages without looking at HACC, because community aged care packages actually deliver less service to many consumers than HACC can deliver. We sort of have it in our heads that you have HACC and then, if you have a higher order, you have one of the packages, but it does not work that way. If you have quite complex and high-level needs, a package cannot buy enough services in many cases for those people. You need to look at HACC and the packages to see what is possible.

Dr Haikerwal—That is quite an important point to stress because the providers of packages struggle and they do cross-subsidise from one holder of a package to another. That is not necessarily an ideal situation.

Ms Reeve—On average, an aged care package produces about five hours of service a week, which—if you think that is keeping a person out of residential care—is a startlingly low number.

Ms CORCORAN—My next question follows on from what Richard was saying about the actual allocation of aged care places. I want to get a couple of points into this question. Firstly, there is the point I raised before with the earlier group was: do we put aged care facilities in the neighbourhood that the resident has lived in all their life or do we put them down the road next to their family? I want to talk about that, but also the business of having aged care places allocated but not yet built. I accept there is going to be a gap between the allocation and the actual number of beds on the ground, if you like. Do you have thoughts about what we can do to minimise that and stop some people having licences that do not turn into beds?

Mr Gray—This is not something that the alliance has spent a lot of time looking at and developing a policy on. If you look at a bit of history in terms of the disability sector and the aged care sector, the International Year of Disabled Persons, 1981, saw a change in philosophy with the delivery of services to people with disabilities. Principally, that change in philosophy meant downscaling congregate—what were deemed institutional type—residential care facilities to younger people with disabilities and having them live in the community in smaller homes, such as you and I would live in, and being supported in those homes to enable them to have full access to community services.

On the other hand, aged care has tended to grow in larger and larger congregate living environments simply because the economics of the funding of the aged care system has increasingly forced fewer, but larger, residential aged care services. That has meant the closure of some facilities—the smaller ones—in many suburbs and communities and people increasingly have to move further afield to gain access to the larger congregate style residential aged care services. To some extent, people being able to access community care and stay in their own home longer than previously has also been part of that process. The increasing dependency level of people in residential aged care has to some extent also led to that process. But I would have to say that it principally comes back to the funding system that applies in residential aged care. That has been the main driver of fewer and fewer owners of residential aged care services and, increasingly, the facilities growing larger and larger to achieve the economies of scale to be able to operate within the funding environment. I am not sure whether that answered all of your questions.

Ms Reeve—On the issue of where you plan to put facilities, they have to go where the owners and builders believe that the market can pay for them. But insofar as we are thinking about planning, we cannot tell, because the mobility of families means that they might not be where you expect them to be when it comes to that point. There would be a very big difference between one person in a couple going in and wanting to retain closeness to the other person versus a single person going in. With regard to planning, there are huge questions about whether we are actually going to face a need in the retirement coastal communities. When one of the partners dies—usually the husband—will the women stay there or move back to be near families? These are some of the things that bedevil long-term planning. The mobility of families is now a huge issue—to know where the family will be.

Mr Young—There is some indication of that occurring. There is a high retirement area on the Central Coast of New South Wales, for instance, where you would expect that the take-up of residential care will be substantial when the people in that area get to the point of requiring it. But there is some evidence starting to develop that they are moving back into metropolitan aged care facilities because that is where their families are. There is little substantive evidence to

date, other than a lot of anecdotal experience, to confirm that as clear evidence of what might be happening.

Mr Gray—The census statistics on the 70-plus population, which are used as the basis for the planning ratios, do not accord with the reality of the changing patterns of families. Here in the ACT, demand for nursing home type care seriously outstrips the supply of beds because of the fact that the younger family members want their older relatives who need the residential aged care to shift into the ACT to access that residential aged care. Those patterns are not picked up in the census lag time as part of the planning process.

Mr Rees—I would like to make two points. Firstly, wherever nursing homes or hostels are, access for people with dementia tends to be difficult. That was documented in the government's two-year review—Professor Gray's document. Secondly, there is absolutely nothing in the planning guidelines about dementia-specific care, so the distribution of that is completely random, according to the ability of different providers to provide it or their interest in doing so. That is a serious problem.

Mr Young—In response to your question on the two-year building time frame of bringing beds on line, it is almost impossible, if you are building a 50- or 100-bed facility and you receive your approval at 1 January this year, to have that on line by 31 December 2004 if at that stage you have to go through your planning approvals for the LGA. LGAs are, in the main, very difficult to deal with for residential care for historical reasons, mostly because they do not understand what modern nursing home services are about; but many of them will delay the process of approval for months, if not longer. To get that approval and build a 100-bed facility within a two-year time frame is almost impossible. It has been done on a few occasions, but not many. The reality is that we should be looking at a time frame, or a different way of allocating places, which is longer term.

Ms CORCORAN—It has been suggested to us in different forums that part of the approval process is that you have to have your LGA approvals in place before you apply for your licence.

Mr Young—That would be one way to proceed in the future.

Ms CORCORAN—My next question is about the quality assurance point that you made. Maybe that is the reason that brought this group together in the first place after Riverside—I am not sure about that. Could you talk a bit more about the point you make about quality assurance and the need to build that into government funding. Are there examples around that have driven this?

Mr Gray—Part of the issue with the current accreditation process is the fact that the cost of complying with the accreditation process was never really built into the current funding of residential aged care. I was talking to the manager-secretary of a 31-bed hostel in a rural area just the other day. He estimated that it has cost them $50,000 over 12 months to comply with accreditation requirements, with severe impositions on the few staff that they have. I might also add that this 31-bed facility is in a town of 150 people. When you drive into the town you see the sign 'Population 150' and 31 of them actually live in the approved hostel. That hostel would not survive if it was not for the fact that they actually own land on which local farmers provide volunteer labour to crop or graze that land, which produces revenue that keeps this hostel surviving under the current funding regime.

The issue is that the accreditation process has been designed for and identifies with larger organisations that have multiple facilities and the capacity to have in place a quality management system. It does not necessarily meet the needs of the small rural and remote facilities that rely very heavily on basically having only one care staff person who also takes on a management role, and any other management is done by volunteers who sit on the committee of management. That is an issue that needs to be addressed. We support accreditation and we support quality processes, but a one size fits all does not necessarily meet the needs of a diverse residential aged care system where the basic need is to provide for the care of individuals as close as possible to where they live.

Dr Haikerwal—I think what is scary about the current system is that by 2008 many good aged care facilities will be under threat. There is a need to implement that accreditation process but in a more flexible manner. Because of the age of the facilities and so on, it is hard to bring them up to speed. It will happen, but there is a need for some flexibility in the way that is being implemented.

Ms CORCORAN—My last question changes the direction again. I think Patricia made the point in her opening remarks about the need to maintain health in our community. It has been put to us before that older people have skills and resources which we are not taking advantage of as a community.

Ms Reeve—I was thinking to myself during the previous presentation that a lot of older people have a lot of skills and knowledge. Basically, how we support the needs of these people and maintain their participation in the community and prevent their isolation and depression is about general community building initiatives rather than specific aged care programs. How you deal with older people and how they remain connected depends on how your community operates as a total: what community transport you have, what networks of non-government organisations you have, how you support people to do that, how you reimburse people for voluntary work if they need reimbursing so that people on very low incomes can contribute like that in communities. I think that is a huge set of issues. By and large, we do not value the knowledge and the skills that are tied up in older people.

Our community is very ageist and dismissive of old knowledge. Perhaps that is because we have been going through rapid change. People do not find it difficult to see an individual in a situation in a community as a key person in a sporting club or in meals on wheels or on the board of a hostel, and they are not called ‘old’ when they are doing that, whereas as soon as you talk about ‘old people’ the tendency in our community is to regard them as useless. So I think it is a very important issue to make the prevention and rehab things work.

The other thing is that we need to be much more optimistic about a lot of the potential for rehab and for prevention, not of illness but of anything else. Often, older people get written off much too early in services rather than taking a really optimistic approach to what may be necessary. We do not want to go on anecdotes but I personally know someone who was discharged from rehab when she could not lift her arm more than halfway up. I am sure they would not do that with you or me, but this woman was in her 80s. I do not know whether they thought that you did need to lift your arm any higher to live by yourself when you are in your 80s. Those sorts of anecdotes just abound, and I think it is because of this pessimism we have about what might be possible with people at different ages. As we know, most of our disabilities and illnesses occur close to death, but they can occur over a very wide age span. We do need to

keep people working, keep people engaged in voluntary work, keep an optimistic view that people would want to, and we need to find ways to facilitate that.

CHAIR—Thank you for appearing before the committee and also for your submission. Thank you also as representatives of organisations that have made submissions.

Proceedings suspended from 12.36 p.m. to 1.19 p.m.

GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance

LIPSCOMBE, Ms Joan Margaret, Consultant, National Rural Health Alliance

SMALLWOOD, Ms Lexia, Executive Assistant, National Rural Health Alliance

CHAIR—Welcome. I remind you that the evidence you give at this public hearing is considered to be part of the proceedings of parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The National Rural Health Alliance has made a submission, No. 128, to the inquiry and copies are available from the committee secretariat. Mr Gregory, would you like to make an opening statement before I invite members to proceed with questions?

Mr Gregory—I have supplied a copy of the opening statement. Thank you for allowing extra time for the National Rural Health Alliance to prepare a submission and thank you also for the invitation to appear today. The National Rural Health Alliance comprises 24 national organisations involved as providers and consumers of health and related services in rural, regional and remote areas. Our work on this submission met with an unprecedented level of interest from our stakeholders. All the member bodies of the alliance were involved, as well as a significant number of individuals and organisations who are members of the friends of the alliance. I am pleased to say that today I am wearing the badge of the friends of the alliance; members of parliament can become friends of the alliance. This level of interest attests to the importance of the committee's work.

The alliance takes a very broad view of health and wellbeing. We therefore have an interest in the wide range of issues which impact on elderly people. It is our firm view that governments, the private sector and the community need to find greater success in reinvigorating country communities, otherwise all the good work undertaken for older Australians will fall on stony ground.

The alliance also makes the point that policies and programs for the elderly should not alienate other groups in society, although there does need to be a greater focus on the needs of older people and this may require a redistribution of resources. The situation with older Australians is the same as for many other groups. We need better data, it needs to be more up to date and it needs to be shared more widely with older people themselves.

In the submission we focus on issues which are particularly rural. This is, of course, our mandate. However, it is clear that some generic changes, such as support for greater participation of the elderly in the work force and attitudinal change towards the elderly, will impact on older people in country areas as well as in the capital cities. We make the point that country areas are extremely diverse. Overall, however, Australia's trend towards an ageing population is more pronounced in rural and remote areas than in the cities. The key rural issues are around accessibility. There is significant underresourcing in aged care places, notwithstanding some targeted funding over the last few years. The standard approach in place for aged care institutions to acquire capital resources for maintenance and accreditation does not fit well with rural and remote areas.

We list a number of strategies and, under each, some specific priority actions. The Treasury's Intergenerational Report has been useful in focusing public and policy attention on the next 40 years, but successors to the first IGR will no doubt be based on more sophisticated and robust assumptions. This is an important debate and one which we must have in Australia.

To become completely contemporary, nearly 1,000 people attended the seventh National Rural Health Conference in Hobart this very week. One of the priority recommendations from the conference relates to aged care and other services for the elderly. It reads:

Conference calls for increased national effort, including through the National Strategy for an Ageing Australia, to develop a comprehensive system of aged care and other services for the elderly in rural and remote areas, giving particular attention to the needs of those with dementia and their carers.

I have reported some further comments on the conference and I would like to run through them quickly because I think they are usefully illustrative. The first is a transcription of an overhead projection report to the workshop that was held after the conference, on Wednesday this week, so the comments are less than 48 hours old. First of all—and this shows more the sense of humour of those at the conference than anything else—someone put up a slide simply saying, 'We are old and we vote.' I do not need to remind you good people of that, I am sure.

What are we trying to achieve? A comprehensive system for older Australians, which includes an assessment of needs, not just eligibility for services; which is culturally appropriate; which is streamlined; which provides services when needed—the question of accessibility; which consists of a collaborative approach to service delivery; which is based on collaborative and flexible funding models; which has well-prepared service providers; and which involves support for carers. The next seven points will hopefully be useful because they are specific suggestions about how to move forward.

The first point is an assertion that we need to showcase local solutions and successes, as well as failures, in rural and remote areas and we need to showcase the innovative models, including carer respite options and dementia care, which are working in some areas. The second point is that the issues for rural and remote areas should be considered when further developing the national strategy. It is significant that in the many submissions that we had, as is recorded in our submission to you, there were very few references to the national strategy.

The third point is that we intend to ask the Department of Health and Ageing for a rural and remote report set against the national strategy. The fourth point is that there needs to be a wellness approach at a community level and at a national level—for instance, encouraging older people to keep working and acting as volunteers. The fifth point is that there should be a government strategy for carers. The sixth point is that the alliance has been asked to advocate for carers to a greater extent than we currently do. The last point is that the alliance has been asked to contact the Department of Health and Ageing about its community care review and their rural and remote performance indicators.

Very quickly, because I am conscious of the time, there is a selection of quotations from the discussion held not at the main conference, where we had, as I said, nearly 1,000 people, but at a workshop we held on Wednesday which brought together a number of organisations who are in a position to act on the recommendations from the conference. This is a selection of verbatim quotations from around the table:

"In all considerations of aged care policy and assessments, it needs to be taken into account that Aboriginal ageing occurs at a lot younger age."

The next comment was:

'Eligibility' and 'level of need' are not synonymous. Assessments for eligibility do not effectively sort patients into an appropriate order for allocating scarce beds.

Someone said:

We don't have a waiting list. We have to give a bed to anyone who assesses as eligible even if they are low need. This is not always the best option for them.

The next person said:

What about keeping them at home? Overcoming isolation is a major consideration in this case.

Someone else retorted:

Isolation is not a major problem so long as the person, or their partner, has a driving licence. This loss has major significance because the whole demographic of the rural community is changing with the disappearance of the extended family.

Another said:

We need to be better at showcasing solutions and successes in local communities. We can help each other and avoid continually having to re-invent the wheel. It is sometimes good to know about the failures as well.

The next person said:

Client-based funding options could be considered. Germany has a system where the client controls the funding. It can go to the family if they are providing care. Not always the best thing for the caring family.

Another said:

We need to present positive messages in our strategies about keeping the aged active.

The next person said:

Carers are a huge component in disabled and aged care. They should be recognised and supported.

And finally:

It is a worrying fact that morbidity and mortality for carers is worse than it is for the disabled and the aged.

Thank you, Chair.

CHAIR—Thank you very much, Mr Gregory. I would like to begin by assessing the sections of your submission which relate to healthy ageing. You have correctly identified that rural Australia has a much lower health status than the rest of Australia. With respect to older Australians, what sorts of actions do you think need to take place to improve the health of those in rural Australia?

Mr Gregory—The overall health of people in rural Australia? How long have I got?

CHAIR—A lot of it is covered in your submission as well.

Mr Gregory—Let me try to answer the question partially, as it were, by focusing on that question with respect to the older people, who are the main concern of your inquiry. The broad situation is that health resources, for one reason or another, are not currently distributed according to need. They are distributed according to a number of other things, such as where there is a hospital or a doctor or a pharmacy. Everyone agrees, of course, that this does not make any sense. The difficulty is finding agreement about how our overall health dollar could be better distributed—and by that I mean more closely distributed according to need. That is the overarching comment I would make.

Everyone is familiar with the work force issues. We are short of between 700 and 1,200 doctors, depending on who you ask. We are short of a great deal more nurses, which is even more difficult because people are not so well aware of it. We are short of allied health professionals. We are short of good managers. So accessibility to trained health professionals is an issue, as you all well know in your electorates.

For older people—and this was mentioned both in the submission and in my opening statement—the challenge of ageing in place is very much more difficult in rural areas. As I understand the notion, ageing in place means the most desirable circumstance, where you enable a person to go through the various transitions from a well, older person to an older person requiring low levels of care, high levels of care and then maybe palliative care, within the same building, the same home, the same facility or the same room—whatever it is. In rural and especially remote areas this has to be a major challenge because, as the need for care becomes greater, the relative absence of carers and trained health professionals or aged care professionals becomes greater. So ageing in place is a nice notion which will always, I suspect, be hard to operationalise in rural and especially remote areas. Can I ask Joan—no, it is not my job to ask Joan to say anything, is it? She has some thoughts on this, I am sure.

Ms Lipscombe—Another major issue is infrastructure and the difficulty of access that people have. Even assuming that there are services available, often transport is very poor or the roads can be bad, or people may not be able to drive, there is no public transport or there are huge distances to travel. The use of information technology is limited because of the relatively poor infrastructure for telecommunications services. In effect, rural and remote people have a double whammy: resources and services are scarce and accessing those that are there is even more difficult because of the poor infrastructure and so on. There are major challenges facing governments in trying to provide locally based services which are designed around the needs of the local people, without trying to impose metropolitan solutions which do not fit because of all the infrastructure and community issues that exist in rural areas.

Mr Gregory—Some good news is that the Multi Purpose Service system, now renamed, as you know, the Regional Health Service program, is a good program because it enables the pooling of the acute dollar and the aged care dollar, and that is very sensible. But I would have to say that it is not a panacea. It tends to be used sometimes as an excuse: don't worry about all this difficulty in relation to acute services and aged care services because we have got the MPS or Regional Health Service program. It is a good program, but it is not a panacea and it is certainly not able to help with the capital shortage in rural areas. We are aware that there have

been some specific allocations in budgets over the last two or three years for capital for aged care places but we are still dreadfully short. The point I made in the opening statement is that the formula that currently exists for aged care places to acquire capital over years through charging costs does not work in remote areas. That market simply does not exist. People are poorer in rural and remote areas and there is simply not the number of people to generate the surpluses which can be put aside to do the maintenance which is required for the accreditation.

Ms HALL—Thank you very much for your submission and for your presentation. I want to push a little bit further a couple of the issues that have already been discussed. You rightly identified in your submission the fact that people living in rural communities are getting older, and younger people are moving out of rural and remote communities. Then you have got the other side of the equation, particularly in coastal areas, where you have got older people moving to those areas. Concerning those issues of demographic change, what government initiatives do you think need to be put in place to address this?

Ms Lipscombe—One of the suggestions we made in the submission was that there is a need for more effective planning processes in terms of those areas where there is an increasing aged population, such as in coastal areas and major regional centres where people are moving. Often the services follow behind the trends so that the initial people moving in do not have access to those services. Eventually, with a bit of luck, the services perhaps catch up. I think a better process of advance planning, which allows those demographic trends to be predicted and for services to be planned ahead, would be more effective than what seems to happen at the moment, which is to say, 'There is a problem because we have all these elderly people so we have to put some services in place.'

In terms of the areas where the population is ageing because the younger people are leaving, the main issue is probably to put much more effort into sustainability for those communities. This will then attract employment and development and increased opportunities for younger people so that they will be more ready to stay in those areas and that will even out the balance a bit better in terms of the demographic mix. It will also deal with some of the problems around extended families and so on. So if sustainability could be given more emphasis in the areas where, for whatever reason, it is very difficult for those communities to grow, then we will get changes in demographics that go with that. This would assist those communities to provide services themselves but also attract more resources in terms of providing services from governments.

Ms HALL—Do you think there is a role for local initiatives by local communities and capacity building of communities to address those issues?

Mr Gregory—At the conference we have just finished we had 130 or so contributed papers and one of the key themes to come through those was that, when all else is equal—and you will know this as local members—the places where things are not so bad are where there is a good local program that happens to work. Sometimes this is not an evidence based thing. It is very difficult to define what the characteristics of a program need to be for it to work locally. Sometimes you have just got that magic mix of local leaders and local people supported by a government program which fits the bill—and that is why for rural areas those guidelines need to be flexible and the approach needs to be one that fits locally. They work well in that area because of that magic mix which sometimes is the only thing stopping a rural and remote community from being in the most severe situation of deficit.

Ms HALL—Do you think there is a problem with the different levels of government? It was put as having a 'silo mentality' or whatever way you would like to describe it, where the governments are not communicating and with pilot projects in an area proving successful and then being removed.

Mr Gregory—There are a couple of issues there. Yes, the silo mentality is a problem. It is a greater problem still in remote areas because as the funnels get narrower you get less of a dribble. The fact that there are silos makes it very difficult to put into operation those phrases which roll easily off the tongue about a whole of government approach or a joined-up government approach. We have not yet succeeded in doing that even with our most urgent social challenge, which is Indigenous health. So, yes, the silo mentality is a real challenge.

The other issue you mentioned was the pilot programs. There is a lot of evidence—some of which I hope is reflected in our submission—that people get very fed up with pilot programs which generate some local excitement, good things happen for a couple of years and then the taps are turned off. What is the positive thing to say? I suppose we need to evaluate the programs that work well in various circumstances, then build a program which is going to last for a decade, not have another pilot.

Ms HALL—Thank you. That is great. The other issues that I think are very important, particularly in rural and remote areas, are accessibility—I am pleased you made so much of it in your submission—and the fact that there are shortages in resources and staffing. Do you have any ideas about how we can put in place some positive programs that will attract more allied health professionals to your area, as well as ideas about the big issue of transport?

Mr Gregory—It starts, as Joan has reminded us, with rural development policies—that is, while rural areas are subject only to unfettered market forces, there will be a battle. It starts with jobs, incomes and asset values in a rural area. If there are things we can do to build them up—and we believe there are—it will help to spontaneously recruit the people we need, whether they be accountants or doctors. But in the absence of that national, coherent, sustained, long-term approach to building up our rural areas, we will be falling back, as we are now, on useful but ad hoc programs for encouraging particular professions to go to country areas. For instance, at the Commonwealth level we have had for some time some significant programs for the recruitment, retention and support of doctors, and the alliance naturally support them very strongly. We believe, though, that we should now be building more programs for nurses—because, as I said in my opening statement, that is a very serious shortage—and allied health professionals, as well as dentists and managers. In an entirely different portfolio, there is a shortage of vets in rural areas.

We need the basic social, physical and economic infrastructure in rural areas to be enhanced, then we need to put in place programs for those professions which currently are not as well endowed as general practice. This of course raises the issue of Commonwealth versus state responsibilities: who is going to do it? The Rural Health Alliance understand the difficulty, but we are not interested in quarrelling about who should do it, because it is such an important thing to overcome.

Ms HALL—Do you have any examples of a local community that has instigated an initiative either in transport or in attracting professionals to the area? That would be really good for us to hear.

Mr Gregory—In Walgett, in north-west New South Wales, there is a program now which has gone away from trying to attract a fee-for-service general practitioner. As you all know, local authorities around the country are spending a lot of money on providing housing and underwriting incomes and so on. That may be useful, but what they have done in Walgett is to go a different path and to say, 'Let's have a local consortium which includes the local authority to employ a salaried general practitioner.' That is not popular in all quarters, but clearly it illustrates if nothing else that we need to be open-minded about the way we should attract and retain health professionals of all types to country areas.

Ms HALL—There was an article in the *Sydney Morning Herald* this week about the long-term viability of aged care facilities in rural and regional communities. It said that the long-term sustainability of those facilities in smaller communities is very questionable. Would you like to comment on that?

Ms Lipscombe—I have not seen the specific article you refer to, but certainly the comments that came in to the alliance from various organisations and individuals as input to our submission did raise that very question of the sustainability of many aged care facilities. That was partly around the issues of the extra costs and so on involved in meeting the accreditation standards and keeping maintenance up to date and so on. It was also partly related to the need for much better training for the managers of the facilities because they had been faced with, and were increasingly facing, huge demands in terms of changes in the way things were done, accountability requirements and so on. Many of the managers or board members did not have the appropriate training to be able to deal with those issues appropriately and did not really have the foresight, I guess, to think about longer term planning to be able to survive in the changing circumstances. Without having seen the article I certainly say that many of the members and associates of the alliance are raising those sorts of issues, and they are covered briefly in the submission.

Mr Gregory—One of our member bodies in particular, Frontier Services of the Uniting Church in Australia, which are the major provider of aged care places in quite remote areas, are very strong on this matter—I am not sure whether they have made a submission to the inquiry—of remote areas not having the capacity to generate the funds to meet the requirements according to the formula which is currently in place.

Ms CORCORAN—You have talked about support for the elderly in the work force and the wellness approach—keep people working, keep them volunteering—and you have also talked about the risks to wellbeing. I want to turn the conversation to wellbeing rather than age just for a minute. Can you expand on those thoughts?

Mr Gregory—I will just make a comment: it was the main point made on Wednesday—or was it at the conference itself; I cannot remember—by someone who said, 'Whenever we talk about ageing we talk about aged care; for goodness sake, let's change the focus.' I mentioned the IGR in the introductory statement. Clearly we need to have this more front and centre of the public agenda in Australia. This is what we are going to look like in 10, 20, 30 years time. How are we going to maximise quality of life for everybody? Hopefully, the debate is going to become broadened. I do not have any specific suggestions at this time.

Ms Lipscombe—This is a personal view, and I am not sure I speak for the alliance on this point: one of the issues around encouraging people to stay in the work force longer is what that

will do to volunteering and other forms of community service, which many of those older people are currently undertaking. For example, many older people provide child-care services for their grandchildren to enable their sons and daughters to go out to work. There are many older people involved in a huge range of community activities such as Meals on Wheels, University of the Third Age and so on. What will happen if those people are in effect removed from that capacity because they are encouraged to work longer? I am not opposed to encouraging people to work longer but we have to think through the implications of what that does to the useful things that those people are currently doing—unpaid voluntary contributions to the community. In rural areas—I think, but I do not have any evidence to support this—I suspect a lot more of that goes on in terms of communities supporting themselves through voluntary effort of one sort or another. If those people end up for financial or other reasons staying in the work force longer there is going to be a huge problem around community support.

Ms CORCORAN—It has been put to us that perhaps we ought to be encouraging people to stay in the work force, otherwise they are going to become a burden now that there are fewer people at the bottom to support the burgeoning numbers at the top of the age scale. I am trying to explore the idea that contributing does not have to be in the paid work force; it can be in all those things you have just said, which are real contributions. We have to find a way of making that point very clear to ourselves and to the community. That is part of what we are saying.

Mr Gregory—There is a notion that the social fabric of a country area is very much poorer without old people. Without wishing to be pejorative about mining communities, they are not whole communities in a qualitative sense that a place is if it has a mixture of ages and occupations. Clearly we all recognise older people as being a great asset to us in terms of their modelling and caring roles, their wisdom et cetera. If we lose them from rural areas that is yet another way in which rural and remote areas become deficient.

Ms CORCORAN—My last question goes back to aged care again. You have made the point that the present capital funding models approach is just not working. Do you have any alternatives?

Mr Gregory—Yes. We are bold enough to believe that there should be direct, positive discrimination. If we want people to be spread in some sort of equitable and even fashion around the country we have to positively intervene in rural and especially remote areas. That is why I started the opening statement by saying that the fundamental thing about ageing in rural and remote areas is the nature of rural and remote areas for the future. There is little sense in aspiring for people to stay in the paid work force longer in rural areas if there are no jobs. We are passionate about the underpinning need for programs which, through positive discrimination, redistribute resources from the major cities—that is what we advocate. We have more sustainable, viable and vibrant country areas, and that will help the ageing people just as well as everybody else.

Mr HARTSUYKER—On that issue of redistribution, is it the alliance's preference, in providing aged care in regional and rural areas, to have a larger number of smaller facilities spread over very low density areas or to perhaps centralise to a larger regional centre? I ask this because I was involved with a group that was seeking to provide aged care services in an area where the population density was low. But no matter where you tried to locate that facility you could not reduce the travelling time for most people because there was no centre that had a real critical mass. Having said that, would you prefer, given that resources are scarce, to have

services provided for 20 at a larger regional centre or services provided for a much fewer number but in a number of smaller, less efficient facilities?

Mr Gregory—It will vary between the coast and inland. For instance, in your electorate it should be possible, given what we know about the current distribution of population and what we think about the future, to have quite small places with a decent level of service. But there are a couple of things: we are clearly opposed to any suggestions or policies which would lead to a two-tier system. People in rural and even remote areas deserve exactly the same level of service as people anywhere. So we will not compromise on safety and quality. In remote areas, you might have thought from my response to your colleague about regional development that I am a hopeless idealist. One cannot afford to be in larger areas and in more remote areas. It is like, for instance, the analogy of dialysis machines. You cannot have a dialysis machine or a heart transplant facility in every small bush hospital. We have to recognise that. But in coastal areas like yours, the alliance would like to see people having the capacity to stay as near to home as possible through all stages of their lives.

Ms Lipscombe—From my own experience in the bureaucracy, what communities are saying to governments is that they want local solutions to their problems. I do not think it would be appropriate for the alliance to vote one way or the other on that question. Essentially what needs to be done to greater effect is for funders and service providers and communities to get together and to work through what exactly are the needs of that community—what are the various options. Maybe the community itself can come up with something that is completely different and new, as Gordon said earlier. Often it is that coming together of those magic things that do develop innovative solutions that work for that community. They may not work anywhere else. I do not think we are looking for top-down imposed solutions that say, 'If you have got a population density of less than X you must have a centralised place.' I think it really is a matter of local solutions for local problems. If, in that case, there are ways to support people at home—and if that is what people want to do—then every effort should be made to do that.

CHAIR—Thank you very much, and thank you also for your submission which was very comprehensive.

[1.57 p.m.]

AUSTIN, Ms Julie, Policy Analyst, Carers Australia

CHODZIESNER, Mr Ben, Vice President, Carers Australia

GILMORE, Ms Victoria, Federal Professional Officer, Australian Nursing Federation

ILIFFE, Ms Jill, Federal Secretary, Australian Nursing Federation

CHAIR—Good afternoon and welcome. 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.

The Australian Nursing Federation has made a submission, No. 77, to the inquiry and Carers Australia has also made a submission, No 97. Copies of these submissions are available from the committee secretariat. Mr Chodziesner, would you like to make an opening statement on behalf of Carers Australia before I invite members to proceed with questions?

Mr Chodziesner—Thank you very much for inviting us to speak to you today. It is of particular interest to me because my background is not in the care industry; I am essentially an ex-carer. I bring some personal experience to this so you will have to pardon me if I get a little passionate about it.

Carers Australia represents 2.3 million carers who provide unpaid informal care to children and adults who have a disability—mental illness, chronic illness—or who are frail and aged. These carers are usually, but not always, family members and they provide the bulk of the care to the people in need of care. The bulk of the care—somewhere around 70 per cent of care is a figure usually cited—is provided by the informal system of family carers. From the 1998 ABS data it was estimated that there were about 450,000 primary carers. That includes 125,000 providing help to people aged 65 and over who live in the same household, and there are another 76,500 who provide care to a person over 65 who lives elsewhere.

I am sure that in the other submissions the committee has already heard about the demographic trends that have been highlighted for our ageing population, both in the Intergenerational Report and in the National Strategy for an Ageing Australia. I am sure the committee is aware that we can expect a significant increase in the proportion of the population that is over 65 years of age, from around 12 per cent today to 18 per cent by 2021 and up to 25 per cent in 50 years time. We also know that the level of disability tends to increase with age, so we can expect more people to have a disability as a result of this trend in ageing. Hence there are going to be more people requiring care. Even if there is a dramatic increase in formal care—and we are talking about significant increases in funding to provide that—we can still expect that the bulk of the care will be provided by unpaid family carers, as people will prefer to continue to live at home or will need supplementary informal care even when they have moved to residential care. This has been the trend for the past couple of decades.

We comment in our submission on the changes in the supply of residential care. Our major concern is whether informal care is going to keep pace with the ageing population and whether people are going to be willing and able to fulfil these informal care responsibilities. I will comment on that. The majority of the carers are drawn from the 45 to 64 age group and from the 65 and over group and are mainly women. The age cohort of 45 to 64 is certainly going to increase, in line with the ageing population, but the people in that group have different lifestyles and expectations from earlier generations, so we cannot assume that there are necessarily going to be more carers available. More women than ever before are now in the paid work force. They are delaying having children and are better educated than the older generations. They also may be geographically distant from their families. Families are no longer all in the one location. There are more single person households and sole parents. Retiring from the work force early is not an option for many people these days when there is no opportunity to ever get back into it. So for many, caring is not a choice but it is going to be an enormous strain without access to quality alternative care and support services.

In our submission we have made a number of recommendations to improve the wellbeing of carers and those they care for and to make unpaid care sustainable. These recommendations are based on issues that exist now, and unless they are addressed they are going to become even bigger issues for more people in the future. I would like to run through those recommendations briefly. They are given in much more detail in our submission. First of all, we believe that there needs to be explicit recognition of carers and caring responsibilities in family-workplace health and welfare policies which recognise caring as a normal part of life and not as some sideline private activity. We believe that as a long-term strategy we must develop a national policy for community care and resource it properly to provide the support that is needed in the community by people in need of care and their carers. In the shorter term, we believe that a lot can be done to improve the current suite of assistance packages that are available to those in need of care and their carers. Another issue is work force flexibility, which we believe is critical for carers of a working age and needs to be recognised and implemented in the same way that family policy has addressed the issue of matching the demands of parenting. These policies are now becoming more accepted in the workplace. Similar flexibility ought to apply to the needs of carers.

There are also a number of cost and financial hardship issues that result from caring, both from the loss of income and from the limitations in government income support. These are major issues for carers. This also needs to be addressed to alleviate the strain on people who are currently carers and to encourage future carers to take up and accept their caring roles. That is a very brief overview of a fairly lengthy submission that we have made. Ms Austin and I would be very happy to answer questions that you might have, both on this statement and on the submission.

CHAIR—Thank you. Ms Iliffe, do you wish to make an opening statement before I invite members to proceed with their questions?

Ms Iliffe—Thank you, I would like to make a brief opening statement. The recommendations in the submission from the Australian Nursing Federation cover two main issues, one of which I touched on in evidence earlier this morning. That issue is that, in the future, we will have an increased number of older people in our community and the older people who will require care will themselves be older and have more complex care needs. They will require a work force that can look after them appropriately. There are current difficulties for providers of aged care services in relation to work force, and I will be talking specifically as it relates to nursing, but it

does relate to other work force in the aged care sector as well. My comments relate to the other work force as much as to nursing but because nurses make up 45 per cent of those, my comments relate more specifically to nurses.

First of all, there is the lack of wage parity with nurses working in other sectors. This makes it extremely difficult for aged care providers to recruit and retain nurses. I mentioned earlier that the difference nationally is $123 a week, which is a significant amount when you have competition for a work force which is in short supply as nurses are at the moment. The current funding formula—the indexation formula in aged care—does not compensate for wage increases. I mentioned this morning that for nurses alone their wage increase was one percentage point greater than the average annualised wage increase. The $211 million that the federal government allocated in the last federal budget, which was $50 million each year over four years, has not reduced the wages gap. It is our view that, because there was no specific direction from the government in relation to this money, at the end of the four-year term we will see that that money has really been wasted. The only point in the budget papers for the use of that money was that it is used to close the wages gap, and we have not seen that happen.

Because of the way the provision of care will change in the future with more care being provided in the community, you need a continuum of staff for care across the hospital, the residential and the community sector. You need a commonality of standards, a commonality of assessment processes and a commonality in quality processes such as accreditation. Unfortunately, at the moment, our care in the community has not kept pace with the changes that we have made in residential care and a lot of that is hidden. So we do not have a lot of statistics on the staffing and on the quality, and we do not have any evaluation of the care that is being provided. You will also need changes to the education and training of staff, particularly in the areas of palliative care and dementia care as the needs of the community change.

The other point that we made is that nurses currently are an ageing community; they are a part of the general community and, as they age, they will also contribute to the need for aged care services. Currently, 30 per cent of the nursing work force will be contemplating retirement within the next 10 to 15 years. It is our view that there needs to be some thought given to enhancing the retirement options not just for nurses but for workers generally, specifically women workers, in relation to their health and their income. If I can relate that specifically to nurses: the majority of nurses are women—unfortunately, 90 per cent of our work force are still women; they have reduced income as women generally have reduced income compared with men; women have interrupted employment; and there is a great difficulty, particularly in the aged care sector, for transference of entitlements. There should be some portability of long service leave and superannuation so that income is enhanced for later in life.

There is also a very high injury rate in the aged care sector for nurses as part of the work force because of factors I have already mentioned: reduced work force, a work force that does not have the right skills mix and a sector that is not well funded so they cannot access the technology that would prevent some of the injuries that workers face. They are the main points that we have raised in our submission, which form the basis of our recommendations. Victoria Gilmore and I are happy to answer questions, if the committee have any.

CHAIR—First of all I will ask Ms Iliffe a question. We often hear from the aged care sector that they have a lot of trouble attracting nurses. What sorts of factors underpin that difficulty?

You mentioned earlier today the funding model for aged care as being significant. How are wages set in aged care nursing? Are they award agreements or a mix?

Ms Iliffe—The Australian Nursing Federation puts out a publication called *Nurses' Paycheck*, which explains some of that. I will make that available to the committee. It is put out quarterly and the current one is being printed at the moment, so I will send the current copy to you. It is a mixture. Predominantly, they are enterprise agreements—it is by enterprise bargaining. In New South Wales it is an award arrangement but, predominantly, it is by enterprise bargaining. The argument mounted by providers when they bargain is that there is inadequate funding—that the indexation formula does not give them what they need to be able to match rates. You will notice in the *Paycheck* document that the gap is much smaller in New South Wales than it has been in any of the other sectors. That is a historical fact, because they had awards. Now, with the recent increase in New South Wales, the gap is the same as it is right across the state. That is why I would prefer to provide you with the current copy, because it demonstrates that, obviously, and illustrates my point.

The $211 million allocated in the federal budget was a direct result of lobbying, not just by the Australian Nursing Federation—although, as you can appreciate, we lobbied fairly strongly—but by providers as well, that they needed more money to be able to recruit and retain nurses. We argued that there needed to be some direction; there needed to be a link between the money and the outcomes. We predicted that what has happened would happen—the money has not flowed on to outcomes. But we do support the providers in saying that the indexation formula is inadequate with respect to the way it estimates wage costs.

I think the nurses wage rates demonstrate that we are achieving outcomes higher than the average across all sectors. Nurses make up the most costly staff and the most staff, and they are also likely to be more greatly needed in the future because of the complex care. You have to take that into account. Nurses talk about two things—remuneration is actually the second thing, not the first, although I mentioned it first. The other thing they mention is the inability to be able to provide quality care. Nurses are nurses because they care for people, and they do not like to be in an environment where they cannot provide quality care. They do not get any job satisfaction out of that. With the inability to recruit staff, there is a reduced number of staff. They are working with inappropriate skill mixes. They get very concerned about the quality of care and the fact that they are vulnerable, because they are a registered occupation. If there is an adverse outcome, they are likely to lose their livelihood—their registration. So there is inadequate staffing and they are working in an environment that does not allow them to provide quality care. Those two things and remuneration make it difficult for aged care providers to attract nurses.

Ms HALL—I have some questions for both groups represented here. While we are on nursing, I will keep going with nursing. I notice in your submission and also in your presentation that you spent some time talking about the wages and conditions, and you just spoke a little bit more about it. The first question is: is the gender difference greater in aged care than in nursing, say, in public hospitals? The second question is: looking at super and entitlements such as long service leave and sick leave, is there a different system in the public hospital sector to that in the aged care sector? What kinds of schemes would you like to see in place with super? You referred to similar systems to those for police and teachers et cetera, but I know that a number of state governments have been moving away from the provision of those types of super schemes to those services. Is there a transference of those entitlements between

different areas in health services? I am speaking from a New South Wales perspective because that is the system I know. Are there models that could be used?

Ms Iliffe—I will go to the gender one first. The gender balance in aged care is similar to other sectors apart from the provision of mental health care. We have acute care such as coronary care or emergency care. Acute care, coronary care, intensive care, emergency care and mental health care tend to attract a higher proportion of males. The gender balance in aged care is similar to what you find in a general nursing stream. We would like to attract more men into nursing. We have not been as successful as other occupational groups in doing that.

The providers in aged care are small businesses and there is no commitment or mechanism to transfer entitlements between employers. If you are in a different fund and you want to transfer things such as long service leave entitlements and superannuation, you have no capacity to transfer those entitlements. We are of the view that it would be very easy to do that. Given some of the other things that are happening at the moment with government looking at, for instance, the review of the resident classification scale and taking up issues that have been of concern to the industry as a whole, I am hoping that the government can look at the transportability of entitlements because it would be very simple to do. There are also things that the government could focus on such as workers compensation and occupational health and safety issues. It has been clearly demonstrated from some of the no lift programs that have been implemented in Victoria, South Australia and Queensland that very significant savings can be made if you get some coordinated support for things such as that.

Ms HALL—Can you transfer entitlements within the workplace?

Ms Iliffe—Yes, you can transfer the entitlement. You often cannot transfer the monetary value, but you can transfer the entitlement so you do not actually have to start again. You get the years you have been with that employer and you carry that entitlement across, but you do not necessarily get the monetary value. As far as superannuation is concerned, it would also be beneficial to look at the fact that we are wanting to enhance people's retirement, we are wanting to enhance their capacity to care for themselves and not be a burden on public funds when they are out of the work force. I think there needs to be some focus on what we can do to promote things that will enhance their ability to care for themselves and to pay for their own care as they age. A superannuation scheme for the aged care sector in which you can transfer your benefits would be very beneficial.

Ms HALL—Are most people working within the aged care sector involved in the HESTA scheme?

Ms Iliffe—Predominantly, yes. Because that allows them to do that, it is one of the things that we promote to look after the interests of our members.

Ms HALL—What are the nursing profession's thoughts on RCS and the changes that need to be made?

Ms Iliffe—We have two. It is really important for us that demonstrating the need for funding is not the driver of the need for care. Those two things should be separate. The care that a person needs should be the driver, not what you have to say so that you get the funding dollars. It is really important that we see those two things separated. I think that the current review of

the RCS has done that. It is also our view that you should be able to reduce the number of questions and get the same funding outcomes now that we have had the RCS for a while. It should be possible to do that statistically.

The other point is, as I said this morning, that you cannot go the other way and just wipe out documentation altogether. Documentation is really important. It protects the nurse, because we work shiftwork and we are the 24-hour carer. It protects the clients because if there is an adverse outcome, you can track where things have gone wrong. It means that you have better quality care because if someone comes on a shift after another person or if an outsider such as a GP or a physiotherapist comes in, they can see what care has been provided. You have to have some documentation. But the documentation that you do only to justify the funding you are receiving, which has no other useful purpose, has to be looked at to try and reduce it as much as possible. It drives nurses mad when they are sitting there filling out forms when they know that people need care. We are used to documenting, we know that we have to document and we want to document, but we do not want to be doing only documentation when we want to be caring for people.

Ms HALL—Do you think that the current RCS rewards sickness as opposed to wellness?

Ms Iliffe—You need to fund for the care that is required. The current RCS was based on trying to reward wellness. The complex care required for frail people takes time. People who are frail do not want to be dragged out of bed and rushed off to the toilet or rushed into the shower. They deserve a bit of time being spent—instead of putting them in a wheelchair and rushing them down the corridor, to actually take time. If they can walk down the corridor, that is enhancing their care as well. But the focus in the current RCS is not on the frail aged; it is not on people who are frail—those who require two people, for example, to assist with their care, so that they do not get skin tears. The RCS does not reward that—it does not recognise that. In the drive to promote wellness, we have left off a group of people, in the same way that it has not really looked at people who require palliative care or respite care. It is positive in one way, but we have to now look at the deficiencies in it. Generally speaking, the RCS was a positive attempt to address deficiencies in the previous tool, but I think we now have some deficiencies in the RCS that need to be addressed as well to make it a better tool.

Ms HALL—I will ask two questions of the carers. I noticed in your submission that you identify respite care as being an area where there needs to be improvement. Did you touch on that in your presentation as well? Could you tell us what the issues are with respite care and how you would like to see the government address the issues?

Mr Chodziesner—I will touch on that broadly and then perhaps get Ms Austin to fill in some of the gaps as well. Respite is one of the key issues for most carers. It is about giving the carer a break from caring duties. There are a number of concerns. One is just a general quantitative one. There are insufficient respite places. If we are talking about the simplest form of respite, which is residential respite, somebody can go into some sort of residential facility for a couple of weeks and give the carer a break. There are insufficient quality places available to cover the demand.

To some extent it cuts into the previous discussion on RCS as well, because the reward for providing respite is, in fact, inadequate. The nursing homes that provide it do so more out of community spirit than out of any economic incentive—it is quite the reverse. That means that

respite is often only available in facilities that you would not normally put anybody into—you would not want to. So the experience of respite is very often poor. People try it only once and then do not do it again, and then suffer from the consequences of not being able to access quality respite. That is one issue, probably in the simplest area, where you just provide a place for somebody which is hopefully going to be fulfilling in terms of the care recipient and which allows the care giver to have a break and feel that the person they are looking after is still going to be looked after properly.

The other area is in the home. Respite in the home can consist, in lots of places around Australia, of absolutely nothing. It can consist of a waiting list onto which you go and you might or might not get some service. In other places it represents 1½ hours a fortnight during which your local council will provide somebody to come down and do something around the house while you maybe go out and get the shopping. Again, it is an availability issue. There are just not enough respite hours available for the home and the various packages that address that are invariably insufficient. That has been my personal experience and there is lots of evidence on this.

The third aspect of respite is that it is largely inflexible. In other words, you have a choice between somebody coming to the home perhaps for a very limited time or you can put whomever you are looking after into residential care and there is very little in between. Day care, for example, is quite sparse. There are facilities in many places that provide day care in a central location so that you can leave somebody there for a few hours maybe once or twice a week, and that is good. They can normally only cope up to a certain level of care recipient capability. My personal experience with my wife, who had dementia, is that she was thrown out of the day care system because she was too much trouble for them. At the time when the load on me was increasing and I needed more help, the help that was available could not cope. It is a system that can cope only with very limited slabs of people.

Then there are the issues about weekend and overnight respite. It is very scarce and also hard to organise. The concept around respite that we are striving for is to get some level of continuity which means some innovative respite solutions which will allow people to have contact with service providers at various levels in the home, in day care, maybe overnight, maybe on weekends, and maybe ultimately lead them at the end of it all to residential care when you cannot look after them in the community any more. That is a concept which the current system does not really address very fully yet.

Ms Austin—To add to that answer, the data shows that there are places available but because of the flexibility issue they are largely not being taken up. It seems to be very much a supply driven situation rather than a demand driven situation. You might get two hours here on such and such a date but that is not when you need respite to fit in with the rest of your circumstances. If we are talking about trying to enhance the wellbeing of carers and giving them a normal life it needs to be turned around so it is demand driven rather than supply driven to give them that flexibility.

Ms Iliffe—There was a very interesting article a few days ago about respite. I am not sure whether the committee has heard about this. There is a pilot that is being trialed for a scheme similar to family day care for children. There is family day care where children go to somebody's home. The carer is licensed and they can care for up to four children in their own home. There is a pilot going on where people are taking older people into their homes in a

similar model and caring for one or two older people. They are licensed to do so. That is all I know about it, but I was wanting to explore it more. It seems a very innovative way to provide respite for longer periods for older people.

CHAIR—We will chase that up.

Ms CORCORAN—That is interesting. That program exists in my electorate, along those very lines. It is excellent because it provides a little bit more personal care to some of the clients who do not necessarily fit into a bigger day care facility, and friendships develop. The issue always is finding the carers but it is a very good program indeed.

Ms Iliffe—There is also an incentive because the carer gets remunerated for providing the care, so it has benefits and people are still in the community.

Ms HALL—My last question goes to the recognition of the role of carers. Picking up on some of the details of your submission, could you identify the resources that you see need to be put into this area? Are you looking at some sort of uniform accredited program being available in communities throughout Australia to provide educational support to carers? You also talk about financial and personal support. You might like to talk a little bit more about those issues.

Ms Austin—You have got a bundle of issues.

Mr Chodziesner—That is quite a number of issues. You might like to pick up on education first, Julie.

Ms HALL—And in all conscience I will ask one more question.

Ms Austin—You started off with the recognition of caring. We see that as a separate and discrete area of policy that needs to be addressed, and we are happy to talk about that. On the education side of it, that is a bundle of services to enhance the support provided to carers. It can include any range of things from somebody who suddenly finds themselves a carer—what do they need to do to manage the situation best—as well as networking and counselling opportunities and all those sorts of things that go with it. Some of those services exist already to varying degrees. But one of the issues is how that sits with all the other support services out there and how accessible they are to carers. Some of them are run through the carers associations in the states. But we know too that the majority of carers are not using the services that exist there and we have to find out the reasons why as well. We have to identify a lot of those hidden carers and make the support services available to them when they need them.

Mr HARTSUYKER—On the issue of access to respite, I understand that in my electorate I have an officer who basically performs the function of a respite broker, putting needs and available respite together. Is that something that does not exist around the rest of the country?

Mr Chodziesner—That operates in many places through the Commonwealth carer respite centres. So there are programs which formalise the availability of respite. However, they are only as good as the number of respite beds—if we can call them that—available in the area and acceptable to carers.

Mr HARTSUYKER—That brings me to another question. Carers are probably amongst the most selfless people in the whole community. Certainly in my electorate we have carers from six to 86 caring for others. Is there perhaps a reluctance by some carers to seek respite, or are they failing to take advantage of the services that are available because of an inability to hand their patient over to another professional carer, if you like?

Mr Chodziesner—There is a great difficulty in that for many carers. The prime concern is for the recipient of the care. They want to make sure that they are going to be looked after as well—and wherever they go, if it happens to be respite outside the home—as they are at home. Many care recipients have a great reluctance to leave the home and to be looked after by strangers, and that is just a fact of life. It has been like that for a long time and I shared that when I was a carer. I needed a lot of persuasion to take up respite care.

There are ways of overcoming that by providing some continuum. For instance, if you have somebody who is helping you in the home, an external carer, use them to also provide some help when somebody goes into residential care. I was able to utilise that, so it provided a bridge. As far as my wife was concerned she still saw a familiar face; she was not suddenly exposed to strangers. It is also good if you can use respite care on a number of occasions so that you are going back to something familiar. In spite of all that, many care recipients are very reluctant to leave the home. That applies in particular to men, who seem to have more difficulty in not having their wives to look after them than is the case in the reverse situation. I hate to make gender specific comments, but it is my experience that that is the way it works.

Ms Austin—That is a big issue in culturally diverse backgrounds too, where traditionally one person has been designated the carer in a family. That is their role and it is taboo to look for assistance outside the home. We uncovered that issue when we did an exercise in palliative care, and it is one that we have not grappled with or tried to attack yet, but it certainly exists out there in the community. Something that comes up anecdotally all the time is that people will try respite care, but for some reason or another they have a bad experience or it is too inflexible for them and they never try it again. One anecdote came up yesterday about a gentleman who liked to have a drink every day. There is nothing abnormal about that, but he was not allowed to do that in respite care; it just was not on. Minor things like that can really upset the balance.

Mr Chodziesner—I would like to add one short, final comment on that. One of the roles of carer support groups, which we encourage because it is a great way for carers to share their experience, is to encourage carers to try respite care before they go into a crisis situation. Very often people utilise respite only when the carer has fallen down and broken a leg and somebody needs to take care of whoever they were looking after. That is the worst time to do it, because you finish up in a place where you did not want to go in the first place. To avoid getting into crises we say that to best look after the person you are looking after, you need to look after yourself as well. One of the ways of doing it is to avail yourself of respite care before you absolutely have to. If you plan this, you can do it much more effectively than if you are doing it in an emergency.

Ms CORCORAN—I have a question for the carers association about workplace opportunities. But before I ask it, I am not clear, Julie, about whether or not you finished your answer to Jill's question earlier about training.

Ms HALL—There were quite a few things I do not think I got answers to.

Ms Austin—I think I have finished. I think the main part of your question was on education services, but you started off talking about recognition. I was trying to unbundle it a little.

Ms HALL—Financial support was part of it as well.

Ms Austin—Maybe I can work through it sequentially.

Mr Chodziesner—Do you want to talk about financial support? I want to make one comment on financial support. When we have phone-ins from carers, which we do from time to time, the issue that gets most attention is financial hardship. Many carers say the only way they are going to be relieved of their burden is when they die, because they are in very poor financial shape. We get some heart-rending tales, so anecdotally we could give you lots of information.

Ms Austin—That is particularly the case for people who have been lifelong carers.

Mr Chodziesner—Yes. There are many people who have never had an opportunity to do anything else. They are usually in multiple care situations where one person is looking after a number of different people for different reasons. It is almost as though they have chosen this as their vocation, but it is not really what they want to be doing. Did you want to add something else on financial issues?

Ms Austin—This is the subject of another submission we are doing on poverty at the moment, but it also ties in to the welfare reform agenda. We are making the case very strongly there that carers need extra support and recognition for the unpaid service they are providing to the community and the economic contribution they are making. One of the immediate things that could be done to alleviate the situation somewhat is to increase the carers allowance dramatically. At the moment it is $87.70 a fortnight. It provides some recognition of these people as carers, but it really does not cover the costs of their caring or give them any compensation in any way.

Mr Chodziesner—I used to always remember the amount of the carers allowance because it was not quite enough to cover the cost of my wife's incontinence pads. That was it, gone, every week.

Ms CORCORAN—My question is about workplace or working opportunities. I would like your comments on what carers need during the period when they are providing care if there is a time when they do not provide care full time. I would also like to know what happens to carers when the person they are caring for does not need their care anymore because they have died or are in residential care somewhere. What are the workplace needs of carers?

Ms Austin—First and foremost, some flexibility and recognition that this person is a carer and therefore has other demands on their time. If employers can provide time off to care, the ability to work from home, job sharing—all those alternative ways of working that we now have but spread much further through the work force than what we are seeing at present—these would go a long way in assisting people and relieving them of a lot of the stress that goes with trying to juggle caring and working. The data shows that many carers are in the work force. When you become a primary carer, your ability to work and be a primary carer diminishes significantly. The majority of primary carers either are not in the work force or are working part

time. It is the only way they can manage. All that ties back into the argument about income and trying to look after the wellbeing of the carer too.

Ms CORCORAN—The second part of the question is: what are their experiences when they perhaps get back into the work force or maybe even go into the work force for the first time?

Ms Austin—We are asking that programs such as the Transition to Work program cater for carers as well. It does to some degree now but you have to be out of the work force for two years before you can use it to get back into the work force. It depends on what your skill or competence level is as to whether that is of any use or not, or what the transition process will be for you. This program is quite well received but it has that two-year framework around it. The other issue is that for young carers—and we have identified quite a number of them in the community; we did a whole report on them—to get the carers payment, you cannot work or undertake education and training for more than 20 hours per week. For quite a lot of the people in this situation, where they are caring mostly for a mother with mental health illness—although that is not always the case but it seems to be a fairly predominant example—you have to ask what their prospects are in the long term and what assistance can be given to them to further their own career prospects and wellbeing into the future. That 20-hour restriction is quite a significant one for people in that situation. They will all be labouring the point in the welfare reform work.

CHAIR—Thank you very much for your submission and for your evidence today.

Proceedings suspended from 2.42 p.m. to 2.57 p.m.

GERSHEVITCH, Mr Conrad Peter, National Coordinator, Federation of Ethnic Communities Councils of Australia

MALAK, Mr Abd, Chair, Federation of Ethnic Communities Councils of Australia

VOLOSCHENKO, Mr Serge, Executive Member, Federation of Ethnic Communities Councils of Australia

CHAIR—Welcome. 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. Thank you for your submission. Who will be making the opening statement?

Mr Gershevitch—Serge Voloschenko will. We do not have a formal spokesperson yet on the issue of ageing and aged care services, but I think Mr Voloschenko would be the closest the organisation has to an expert in that field.

CHAIR—Mr Voloschenko, would you like to make an opening statement before I invite members to proceed with questions?

Mr Voloschenko—In addition to our submission and those made previously over the years—not so much in addition to those particular submissions—we would also like to make the point that we are aware that the committee is involved in examining ageing issues rather than the issue of aged care alone.

CHAIR—Correct.

Mr Voloschenko—Many of our submissions also related to aged care, per se. Ageing is a growing area of concern, not only to us but to the whole nation, in the years to come. I also feel that ageing is a positive way of addressing the future—in other words, 'ageing' is a positive definition, rather than 'aged care'. Maybe it is not crystal ball gazing, but in that way we would like to extrapolate something that is commonly used now. In terms of the whole nation, people in that sector—for better or worse, say, migrants—particularly people from non-English-speaking backgrounds, have different cultural backgrounds and linguistic backgrounds. This is where we are at the moment.

CHAIR—Thank you very much. Firstly, you are quite right: ageing is much broader than purely aged care. What additional challenges face people of non-English-speaking backgrounds as they age?

Mr Voloschenko—In terms of loss of English language, even though they might have been fairly fluent at one stage, as they age very often they will lose that proficiency. Also, the different types of dissemination of information may not be on par with some of the mainstream—and I use that word rather judiciously, I suppose—at the moment. I suggest that all services—and I do not mean services in terms of physical services but in terms of information available to them—be able to empower them to make decisions. Very often, some of the government sponsored programs exclude some of the people who have been here for a

long time. It might not be available to them in the same way that schemes are provided to people who are newcomers, because they have been here for less than six years, and so on. There are situations where they might have been too busy or whatever—they were not available for the English language. However, having said that, they also need to be provided with services that are culturally appropriate. They are, after all, Australian citizens and they obviously need to be provided with the best care we can afford.

Mr Malak—There are a couple of things from a health point of view. A large percentage of the people at that age are single, very isolated and have no support. About one-third of people over 65 in Australia come from non-English-speaking backgrounds—they are overseas born. Let me talk about two examples. The first one is about torture and trauma and the second one is about suicide. When we analyse suicide in Australia over the last 25 years, a report done by Steele and Macdonald in Sydney identifies that the suicide rate of overseas born males, 75 years and older, is 56.6 per cent higher than for males in the average community. For women of the same age, over 75 years, the suicide rate is 177 per cent higher than in the general community. Suicide in ethic communities is a big problem for all people, not just young people. The report and reference is in our submission.

The second one is torture and trauma. A large number of older people went through the Second World War, the Holocaust or other bad experiences. For instance, in Sydney there is a 24-hour line run by the transcultural health centre. They started to get calls from people concerned about the war. Some people think they will be put in camps where no food will be available if the war starts. Even though it is not real and it is not going to happen, the history of experiences that they had a long time ago means that for them it is real and creating a lot of pressure for them.

Mr Gershevitch—There are two other things that have been touched on briefly in the submission. One is that, in some communities, as people age and begin to die off, there is a loss of peer support and those who are left behind feel more isolated. That is more likely to lead to the kinds of psychosocial problems that Mr Malak was talking about. There is also the issue of cultural separation, which is a fairly technical issue. There is that idea of expatriate culture: that communities come to Australia and they bring their home culture with them and nurture it. They conceive of the culture they came from, but often there is a separation in that that culture has evolved. For instance, in Crete the culture has evolved enormously over 50 years. But when those people from Crete, who are now in their 70s, think about what Cretan culture is like now, their visualisation is of what it was like in the 1950s—but it is not that any more; it has gone. That kind of dissonance between cultural realities creates those sorts of problems as well. I think we should refer the committee to our draft policies because some of those issues are discussed in more detail in our arts, culture and heritage policy, which is still in the draft stage at the moment.

CHAIR—Thank you, Conrad. I will ask Ms Hall to ask some questions because she has to leave to catch a plane soon.

Ms HALL—I will only have time to ask one question. It relates to evidence we received from DIMIA last time we were in Canberra. It was that within the general parameters of aged care—services and facilities, respite programs, community based programs for people as they get older, the fact that English can still be a problem—understanding the concepts, policies and plethora of issues that surround them is sometimes a little bit too much for the older person. It

was suggested to the committee that under these circumstances the older person from a non-English speaking background needs to rely on their family. Do you think there should be more resources and support services et cetera for that person to be able to operate independently within the community? Or do you think they should have to rely on the family?

Mr Malak—I will respond to that with these words: all of us, when we become old, would prefer to stay in our own homes. It is probably good to put on the record the community packages that are helping people to stay at home. HACC is very successful and we really appreciate it. It is a very good program which is able to provide some nursing support, some community support, some shopping and gardening and practical help to keep people at home. It is good for the people who continue to be healthy, it saves a lot of taxpayer money that would be spent on nursing homes and people have a much better lifestyle at home. There is a lot of evidence that they become less sick than on average. This program is great. It provides more support for the community and the family to be able to do it. It is vitally important to strongly support it and it is probably cost effective. It means there is a better quality of life for the older person. I think Serge runs a nursing home.

Mr Voloschenko—Yes, we run a couple of nursing homes. I will support that statement because we are equally appreciative of the trend to be able to provide care or to at least support care—what used to be called domiciliary nursing is now called care at home—with appropriate support from the medical and associated health services as well as other types of services as required. However, there are sometimes breaks in that. Very often those breaks happen when we are unable to provide services because of isolation. That can be a problem, too. We have found that it is not always best that people be provided for at home. Sometimes they become more isolated—the reverse happens. Another thing is that we live in a world where changing commitments in terms of their children and other relatives—

Ms HALL—Excuse me, I am going to have to read the rest of your answer in the *Hansard*—and I promise you I will. I am very interested in what everyone has to say on this. I might miss my plane if I do not leave.

Mr Voloschenko—We appreciate that; thank you very much. I will try not to repeat anything or state the obvious. The increase in government support and government direction is appreciated, as long as we are aware that residential or other types of care or services should not be neglected. I am not saying that they are; I am saying that they should not be under-emphasised.

CHAIR—If we are looking 40 years down the track, how do you expect the mix of people who are from culturally and linguistically distinct backgrounds to change?

Mr Voloschenko—Without repeating the crystal ball gazing, we do not know some of the things that will happen. But in terms of talking about it today, some of the changes or issues will be represented. If I digress a little, we are talking about people living beyond not only three score and 10, and four score and 10, but five score and 10. I have been bombarded by people saying that we are going to be cloning organs and doing all sorts of things so that people will live forever. This is perhaps not within the scope of this committee. I know you were asking me the serious question of how I see it. Some of those issues will not be the same, but they will be similar in that we will still be ageing. We need to assume, as a community at large, that people will live beyond the age that they do now. We need to look at how the same problems—that

people still need to be empowered, that they still need a safe environment, health services, financial security and so on—can be faced, which is a very large task. For people who are less proficient or are unable to access the information, we need to be able to improve the information flow so that they will be able to be informed, form opinions and network within their communities. That is something we will be facing 20, 30 or 40 years in the future. Maybe there will be a different mix of issues in some ways, but I would suggest, from all the evidence I see so far—and I know that 40 years from now is a long time—that we need to prepare gradually.

A lot of people are asking me questions and they very often come up with the problems of how they are going to survive financially if they live to 120. They say, 'I don't know if I can survive financially if I live to 80-plus.' This is a very real problem. People are saying: 'That's all right; we will look after it. Don't you worry about that.' The thing is, we need to look at it now and look at how we can recognise that the intergenerational gap is widening. This will perhaps be more severe for people from different cultural backgrounds, because the intergenerational gap will be even wider, so we need to look at resources now to solve that problem—although it is not a problem and we should not treat it as a problem; we should treat it as a positive situation. It is a target and we need to meet that target. We need to aim to do better, rather than isolating aged people as if they were a problem. They are not a problem. They do not have diseases, they are just ageing. They are not disabled, and by that I mean they have been able to walk, run or whatever. It is a natural process. We should not be penalising people for ageing, but rather emphasising what they can do.

Mr Malak—You talk about health as one example. As Serge was saying, in 40 years health will be significantly different. If you read some of the health planning for the next 40 to 50 years, especially keeping in mind the developments of the last 10 years, some of them say very clearly that they expect that nobody will die from any disease like cancer. Cancer will be treated like the flu in 20, 30 or probably 50 years. However, the biggest challenge that will face us will be people living longer and the issue of depression. Mental health will become the biggest challenge facing the world. I am not sure that we are ready to deal with the issue of depression, isolation, loneliness and people living longer without any support. That is the No. 1 issue.

The second issue is that the migrant community in 40 years will have two significant, distinct groups. One of them will be newer refugees and newer migrants coming to the country, like me, who will come with the issues of culture which we have been talking about. The second group, which we call second or third generation migrants, are people who were born here and have grown up here. I personally see them as being probably the suffering generation because they are expected to provide support for their families, and they have done that, but when they get old their kids are not going to do that for them. The community treats them as part of the mainstream because they speak the language and have grown up here. However, they still have some issues of culture and environment which will affect them.

CHAIR—Thank you very much.

Mr Gershevitch—There is an issue which we have not really touched on yet perhaps as much as we should have, although I think there were some references in our submission, and that is work force training or work force development. I know there are very rigorous competency standards in the area, particularly for HACC workers, but from what I hear there are still issues from time to time, particularly in rural Australia. For instance, meals are not

culturally appropriate and some of the HACC work force may not be quite as sensitive as perhaps they should be in dealing with clients. In 40 years time we will have even more pluralism and even more of a mix in our society than we have at present. An argument that we are trying to promote in the transcultural mental health field as well as in the multicultural health field is that if you change attitudes or at least skill up the medical work force, the social workers or the whole allied professional work force to be more sensitive to the needs of culturally and linguistically diverse community clients it will have a positive flow-on effect for the community. It is really training people to be sensitised to the individual, and I think that is very important.

The issue in addressing this pluralism is how are we going to do it and do we actually have the resources to do it? I would say that one way of doing it effectively is through information technology. In 35 or 40 years time that capacity is going to be vast. It is vast now, but it is going to be significantly greater because the use of IT is growing exponentially. I think improved computer literacy is something to aim for with an ageing population, because it is an area where—this is a generalisation—by and large older people do not engage with new technology. We have to make sure that the baby boomers who are not really using technology well start to use it better. That provides very cost-effective ways for the government to get messages out. So I would build on what already exists with the Government Online Strategy. That has been a very good initiative, but I think we need to do more of it. I think the interface between the community, the government, academic institutions and service providers needs to work better so that the flow and availability of information in community languages in ways that are accessible to communities is established in an optimal way.

Ms CORCORAN—Conrad, it might have been you who talked about the high suicide rate.

Mr Gershevitch—No, it was Abd.

Ms CORCORAN—Sorry, Abd. Some of the figures you gave us were, on the face of it, very alarming.

Mr Malak—They are horrific.

Ms CORCORAN—Yes, exactly. I want to explore that a little for a minute. I am not sure whether people commit suicide just because they are depressed or whether there is an element of self-imposed euthanasia in the people who commit suicide and who are very sick. Is there an element of that sometimes for some cultures?

Mr Malak—It is probably a lot of that. I am happy to send this report to the committee.

Ms CORCORAN—That would be useful, I think.

Mr Malak—Though we have not discussed it, if you analyse it it would probably include very sick people trying to find a way out. There are probably lonely and depressed people. There are probably people frightened of the future, with no family or no connections, who are scared. There are probably a hundred different reasons, but definitely people were sick and seeking a way out was one part of it.

Ms CORCORAN—My other question is quite different. You talked about the value of aged care being culture specific, if you like. In my electorate I have a couple of nursing homes, one in particular called Dutch Care which has created a little Holland in the facility. I have observed my mother-in-law who lost all of her English as she got older and reverted to her native language. How important do you think an aged care facility is that is very much based on a particular country or nationality?

Mr Malak—It is vitally important. The reality is that when we become old we sometimes lose the second language and our confidence. We lose our ability to survive. We become frightened of everything and we really need to see something which gives us some security, something which reminds us of the old days—a nice tree or a nice statue or something. It is vitally important.

I can make my own observation. When I go and visit some of the nursing homes and I visit somebody from one language group who is lonely, I can see how depressed he is, how he is sitting in the corner. When you go to one of the language based nursing homes, or what we call a cluster program which was funded by the community a couple of years ago, they have five or six people from a Greek community. It means that you have five or six from that group in the cluster. It allows the priest to come and visit them and food can be taken to them. It means that they can have some sort of Greek environment. There was an evaluation of this work which was very useful to the ministry, because it shows it provides some sort of richer diversity and fun and all of them can go to the church and all of that. It is vitally important. The most dreadful place you can see is where a person cannot speak the language, cannot eat the food, is unhealthy and sits in the corner in a nursing home. It is strange.

Ms CORCORAN—My final question for the moment is getting away from dealing with the problems of ageing people but dealing with the delights of ageing, I suppose. It seems to me that there is a lot of point in getting more proactive in how we use the skills and the resources that older people have. Do you see anything that we should be doing? We have to put a recommendation into parliament at the end of the inquiry. Is there anything you would like to see us recommend along those lines?

Mr Malak—I think you hit a very important point. Many of these people never used their professional skills. They came and they left their skills somewhere and worked in some manual jobs. If we give opportunities for people to become very effective leaders, teachers and tradespeople, there are a wealth of skills if we are able to utilise them. The whole community benefits from this, but there are benefits for the old people themselves because they would feel they could contribute. It is a vitally important point.

Ms CORCORAN—Do you have any ideas about how we can go about doing that?

Mr Malak—I come from the Coptic community, the Coptic church, a Christian group from Egypt. The church utilises all the people by teaching people the Coptic language and teaching them the traditions. Some of the people have specific art skills in the traditional drawing and they teach the young people how to maintain this art. The things can happen either within the Dutch nursing home or within the local church or the local synagogue or the local club where people come together. They need to identify what skills the people have and what is needed in the community.

I work with health personnel and we are getting a lot of monitoring and self support, for well, aged people to go and visit people in hospital, to talk to them and spend time with them, or to go and visit them at home when they get out of hospital. I am talking about people between 60 and 70 who can provide a lot of social welfare, community support and back-up. They do that very well. There is no limit; they can do everything because they have the skills—it is just how to identify them and give them enough support.

Mr Voloschenko—I would like to expand on that. Obviously there is no real answer that can be done just like that, because we all talk about training and so on, but what is the training for? I would like to digress a bit on volunteering. Many organisations that are community based, especially ones from different cultural backgrounds—different migrant communities, if you like—have fairly strong communities and community centres. Some of them are a bit challenged now in terms of the whole volunteering concept. Even the practical associations and clubs cannot exist anymore because of things like public liability insurance, which has knocked a lot of things on the head. In other words, it is not just bits and pieces, it is very often the whole of what the community is going through.

You will find that some of those networks are challenged in their support for those people, and not just in the area of gainful employment—because I feel that everything is gainful—but also in supporting activity and participation in our society, which we call citizenship. Some communities break down because of those wider challenges. There are also the challenges thrown at them by regulations and legal aspects. Structures are being challenged. This happens to all communities, but those communities provided support for some of their members and could have continued to support them, because they need reassurance, safety and a feeling of connectedness, which is important to them. People could then have gained from that and contributed. Often, some of them are contributing by raising their grandchildren and great-grandchildren, and there are many positive aspects to that. But that might be isolating them because, while they are doing that and doing a good job, they are being isolated from participating in a larger network. I guess we also have to look at redefining work again. I know we have redefined work many times, but very often we come back to an economic situation where, if somebody does not produce anything that can be sold, exchanged or bartered—

Ms CORCORAN—Or does not get paid.

Mr Voloschenko—then it is not work. We have probably defined many times that mothers do unpaid work and we have accepted that. But that is probably not so for those people who are forced to retire somewhat earlier than the age of 60. That is a very crucial time. If people are forced to retire between 50 and 60, they start to lose all kinds of contact. I am not only talking about males but also females. It is great that women have caught up, and that is great. They are participating more but they are also being retrenched, just like their male counterparts.

Mr Malak—I will briefly mention the age of retirement. We strongly support the abolition of the age of retirement in the Commonwealth being 65 years of age. I think in some states there is no limit on the retirement age, but the Commonwealth still has 65 and I would like that to be abolished. There is another issue regarding income security, especially with what has happened with the superannuation market going down. The people in that group have a lot of pressure and concerns, and we are looking for community and government involvement in securing people's incomes and superannuation, which is vitally important. We talk about people being vulnerable and worrying and sometimes making disastrously wrong decisions by taking money from their

accounts and putting it somewhere else. Fear is pushing them to do that. We are looking for more support to be able to help them to make the right decisions and to protect their money in the first place.

Mr HARTSUYKER—Is there a reluctance among some ethnic groups to access the existing aged services?

Mr Malak—Yes and no. There is a reluctance to go into a nursing home. I know of one case and it is about a friend of mine. She took her father to a nursing home and she would visit him. He would be sitting in the corner, nobody would talk to him and there was food over his body. When that sort of thing happens, they are reluctant about going into a home and they get very angry about it. However, I think it depends on the quality of the nursing home. If there are quality services at the home and they are properly supported, usually they do as much as possible to provide better communication and better support to the person. If the family is local, usually the family can visit and provide a lot of support. So it is to do with the quality of the nursing home and the quality of the support. I think the quality is vitally important.

CHAIR—Thank you. As there are no further questions, thank you very much for your submission and also for your appearance before the committee this afternoon.

Mr Malak—Thank you for having us.

Mr Gershevitch—I have a copy of our draft policy, so I can leave it as a further exhibit. It deals with the issue of intergenerational cultural transmission and those sorts of matters.

CHAIR—Thank you.

[3.33 p.m.]

GREENWOOD, Mr Stephen, Executive Director, Pharmacy Guild of Australia

PHILLIPS, Ms Wendy, Director, Strategic Policy, Pharmacy Guild of Australia

WHITE, Mr Patrick, Committee member, ACT Branch, Pharmacy Guild of Australia

CHAIR—Welcome. This is in fact the second time that we have spoken to the Pharmacy Guild on this issue. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. Therefore, any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The Pharmacy Guild has made a submission, No. 75, to the inquiry and copies are available from the committee secretariat. Mr Greenwood, would you like to make an opening statement before I invite members to ask questions?

Mr Greenwood—Yes. Thank you for the opportunity for the Pharmacy Guild of Australia to give evidence at today's public hearing into long-term strategies to address the ageing of the Australian population. The guild represents the majority of 5,000 community pharmacy proprietors in Australia. As an organisation, we are committed to ensuring the value and accessibility of quality community pharmacy and to maintaining community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicine management and a wide range of related medication, health and preventative services.

The guild supports the recommendation of the Myer report in 2002 that there should be a substantial reform and an expansion of community based care to enable older people to live in their own homes for as long as possible and to delay entry into acute and residential care facilities. We believe a community pharmacy is well placed to assist in providing an expanded range of community based services. The guild is recognised by government as a key stakeholder in the emerging directions of the health care system and in 2005 will negotiate its fourth guild-government agreement for the next five years.

The Pharmacy Guild of Australia is committed to forging strong alliances with organisations in the aged care sector and works on establishing and maintaining solid relationships with organisations such as the Council on the Ageing and the Association of Independent Retirees. Recently, we have been admitted as the 23rd member of the National Aged Care Alliance. The guild has demonstrated its commitment to ensuring older Australians receive professional, quality health care and advice by implementing a joint community-business partnership project with the Council on the Ageing, titled Being in Control: Older People and their Medicines. This was a very successful national peer education project which aimed to educate and inform older people of ways to best manage their medication and to empower them to take a more active role in their medication management. Community pharmacists link with peer educators in the community to support and promote the project, its aims and objectives.

With an increasing proportion of the population in Australia already aged 60 years and over, the alarming levels of medication related problems—and polypharmacy is a crucial factor—

resulting in death, hospital and residential aged care facility admission, and poor health outcomes, the guild believes that community pharmacy is ideally placed to extend its role in assisting government to implement policies through a range of expanded professional pharmacy services.

It is estimated that on average a person goes into a community pharmacy 14 times a year. Community pharmacies provide an accessible, nationwide professional primary health care service to all Australians—in particular, to older Australians who, due to their greater medication needs, rely on this quality service, dedication of care, advice and counselling from a pharmacist, who is a highly qualified health care professional. Older Australians rely upon this system that allows them to walk in off the street and consult a pharmacist about a whole range of products, treatments and medicines in order to achieve better health care outcomes.

The valuable relationships between community pharmacists and their patients, particularly older patients, cannot be measured in dollar terms. They are often built up over generations and contribute substantially to improved health outcomes. Many older people take multiple medications and need personal supervision and assistance to ensure that they achieve the best possible health outcomes from their medications. Pharmacists are able to help by monitoring compliance and by providing advice on possible adverse drug reactions, thus reducing hospitalisation and GP visits. Older Australians view their pharmacists as a primary source of advice on the use and effects of all medication and see the pharmacist's role in prescription medication consultations as reinforcement of the information provided by doctors.

Given the sheer volume of customer visits and pharmaceutical sales through community pharmacies in Australia, the community pharmacy is a primary setting where opportunistic interventions occur, particularly with older people. The pharmacist plays a crucial role in the early detection, possible prevention, education, counselling and referral of people at risk of or developing a chronic condition, such as diabetes, asthma, incontinence, arthritis, falls, osteoporosis, hypertension and mental health, and is well placed to assess if an older person requires a referral to a GP or emergency service.

In the rural area, of the 5,000 community pharmacies throughout Australia, approximately 1,300 are located outside the metropolitan area. Community pharmacies not only provide the most accessible health services in regional Australia but also, in many cases, are often the only readily available health service provider. In these cases, the relationship between the pharmacist and the older Australian is an important factor in ensuring the quality use of medications and the patient's continuing wellness. Before the rural pharmacy package commenced in May 2000, there were at least five pharmacy closures in six months in rural areas. Since the rural package, there has only been one closure of a rural pharmacy and, indeed, the number of rural pharmacies has actually increased by six.

Underpinning this primary health care and counselling service to pharmacy clients is the Quality Care Pharmacy Program. This is a program incorporating professional and customer service standards designed to provide better customer service, to improve health care outcomes and to demonstrate the public benefit of community pharmacy. The program is based on business and professional standards aimed at achieving world's best practice in the delivery of community pharmacy goods and services. Community pharmacists provide not only quality care to our older Australians but also assist in health care savings; for example, the health care system in Australia as well as consumers are starting to benefit greatly from the introduction of

Domiciliary Medication Management Review services, DMMR; Home Medicines Review, a collaborative initiative implemented between GPs and pharmacists in October 2001; and Residential Medicine Management Review services, RMMR, which was introduced earlier in 1995. Evidence has shown that such services lead to improved patient compliance, reduced inappropriate medication use, fewer preventable adverse drug effects and interaction, reduced hospitalisation, reduced GP visitation and a better quality of life for the Australian community.

The release of the government's Intergenerational Report has been the trigger for the formation of a national health care alliance, which the guild was instrumental in establishing with other major health and consumer related organisations. The guild has publicly taken the position that the Intergenerational Report with its extrapolation of the costs of the Pharmaceutical Benefits Scheme 40 years into the future is overstated and paints a very one-sided picture. It sees the PBS only as a cost centre, rather than as a value centre and the cost savings produced as a result. The guild is concerned by the limited perspective of the Intergenerational Report whereby parts of the health and social support system are considered in isolation, and believe it could result in cuts being made without taking into account their impacts in other parts of the health system. The guild and the national health care alliance are anxious to work in consultation with the government to develop health policies which are not only economically viable but which ensure that those most in need in the community, such as the elderly, continue to receive accessible, high-quality health services. Community pharmacy is a key stakeholder in maintaining the provision of these services.

Mr Chairman, there are a number of pamphlets in your folders. Ms Phillips will take you through those.

Ms Phillips—There are not very many there but I want to bring them to your attention. The project that Stephen referred to that the guild did in conjunction with the Council on the Ageing produced this pamphlet, *Medications … take control ... Ask your pharmacist*. We find this a very valuable brochure. It is the old story that a person, perhaps particularly an elderly person, often forgets the questions that they ought to ask. Pharmacists often make the statement that it is difficult to know how far you can go with a person in giving information—they may not want to receive it—and it makes that whole dialogue so much easier if the person initiates it by asking the pharmacist questions.

The other sheets there are fact sheets. The one on the value of professional pharmacy services talks about the statistics related to hospital admissions and so on due to medication misadventure, polypharmacy and people getting muddled with the medicines that they take. There is another one on the Home Medicines Review, HMR, which has been referred to. There is a third one which refers to dose administration aids and these are shown on a page behind that—the Webster type pack system you are probably all familiar with. We feel these aids are very useful particularly for elderly people so that they do not get muddled with the medicines they are taking, particularly where they are taking several medications. We feel that these kinds of dose administration aids have a real place in the community, to enable a person to stay living longer at home and not be confused about their medicines, where there is a carer involved and in residential care. For a long time we have discussed with the government the value of requiring pharmacists to be paid to make sure that this packaging is used. At the moment it is very discretionary, according to what the nursing home or facility wants. We would like to see these dose administration aids being compulsory as part of the accreditation requirements for

residential facilities. They are quite labour intensive to provide so it is difficult if there is no payment to do that sort of packaging.

The only other one is what we call a medication manager. Often the very simple things are the most effective things. We have found that these are quite useful for people to keep their pension card, their scripts, and so on—to have everything in the one place, particularly if they are travelling and find that they have gone on a holiday without their script. Often these simple things can lead to quite difficult and problematic situations.

CHAIR—Thank you very much for that and also for your submission and the subsequent exhibits. I will ask you firstly about the Home Medicines Review. I know it has only been going for 18 months, but are you getting any feedback from your members about how it is working—its efficacy and that sort of thing?

Mr White—There are a number of issues with the HMRs. The guild and all pharmacists would applaud HMRs. It is a fantastic step ahead. There are some issues with it, though. In theory it is fantastic, but in practicality it really needs to be driven. One of the issues that we are finding as pharmacists is that the doctors are not as proactive as we would like them to be. That is not so much a criticism of the doctors but rather a recognition that they have time constraints as well. How they are to be driven in the future to get the most appropriate people assessed with HMRs is probably the issue.

One trial that is going on here in Canberra—just to let you know—is where the pharmacist speaks to the doctor's surgery and they decide between the two of them that the pharmacist would do a review of their patient's medication history, pick out the most appropriate people and refer them to the doctor for review, and then between them they would decide whether it is appropriate or not. The pharmacist would then drive that from the point of view of making the contact et cetera. One of the issues we have with bulk-billing surgeries is that some of the surgeries have indicated that they do not wish to wait for their remuneration and would like the patient to pay the $120 up front and then claim the $100, or whatever it is, back from Medicare. That, in its own right, has been a disincentive for a number of people.

Ms CORCORAN—I was not aware of this until about 12 months ago. I did not realise it is a fairly recent innovation. I am keen to promote it in my area because I think it is a very useful thing. Someone earlier today talked about it a little bit, too, and made a comment that I was a bit interested in hearing. I have forgotten their exact words, so correct me if I make a mistake, but I think it went along the lines of them being disappointed that a lot of this review happens in the pharmacy rather than in the home. I had not realised that the review was actually designed to take place in the home. The point that came out of that was that, had it taken place at home, perhaps people who have a cupboard full of medicines might have been picked up earlier in the piece rather than later. To me that raises issues of intrusion and all sorts of things. Do you want to comment on that?

Mr White—The issue is that HMRs are supposed to be done in the home. There are exceptions. I cannot list the exceptions off the top of my head now but, for example, it might be that, from a religious point of view, it would not be seen as being appropriate that a male pharmacist, for argument's sake, would visit a person in the home or, in a rural case, it may be that the travelling time and the distance is too onerous and, therefore, it could not be done from

a practical point of view. In those special circumstances—there are about seven or eight—the interview, because there are a number of different stages, would then be done in the pharmacy.

Outside those cases, the interview is supposed to be done in the home. So you can be looking at things like the ability of the person to comply. For example, if they have arthritis, can they actually open the bottle to take the medication? Have they been hoarding medications where the doctor has taken them off them but they have still kept them in storage? Have they got memory problems so they are not quite sure, if they wake up during the night, whether they have taken their sleeper—and therefore take another one? There are a number of different issues and they all come into that HMR interview process and assessment in the home.

The process is then reviewed. The review is either done in the pharmacy by an accredited and trained pharmacist or, because there are a number of pharmacists going through this accreditation at this point in time, there are external assessors who can actually do that review. Then that comes back to the pharmacy and the pharmacist takes that up with the doctor. But the actual interview should be done in the home unless there are exceptional circumstances.

Ms CORCORAN—There are two questions coming out of that. I will have to check the *Hansard* but I think the person who was giving evidence earlier suggested that something like 90 per cent of these reviews are taking place in the pharmacy. Does that ring true to you? Is that your experience?

Mr White—I cannot give you any statistics except to say that pharmacists are supposed to do those interviews in the home.

Ms Phillips—I think the HIC did undertake a small survey but it was based on a very small number so it is not statistically reliable. It was nothing like 90 per cent but it was a higher number than we were happy with. I think it might have been around 40 per cent. As I say, it was a very small sample. This was something we were both going to follow up on. But Patrick is right: there are exceptional circumstances. Another one obviously is security itself. If it is a difficult situation for the pharmacist to go into they may not want to go into the home. Where possible we are advocating that it should be done in the home for all the reasons you are saying and the reasons Patrick has mentioned.

Mr White—I would like to qualify that if I could. When you actually look at the interview process and the travelling time, to do the actual review there is no fixed accredited IT package to make sure there is consistency of reporting, and that is one of the biggest issues. If reviews are being done by different pharmacists and they are going back to a particular surgery, there should be consistency there so that the doctors can feel it is a system they can work with. When you look at the travelling time and the interview time, the review by specialists at this point in time is taking approximately two hours. When you look at the remuneration for the pharmacists at the normal rates it equates to about three hours. So the people who are getting into HMRs at this point in time and are doing them properly—and I will stress 'properly'—are actually losing money. But pharmacists are prepared to do that on the basis that they see this as a very valuable tool for helping with people's health, be it aged care—and it does not only have to be aged care; there are a number of different people who fall into this category—or something else.

Ms CORCORAN—How is it funded?

Mr White—It is funded by a remuneration back, which is $140. If you are in the situation, for argument's sake, where you have to travel 10 or 20 kilometres, you then have to sit down with someone, get them into a good frame of mind to do an interview—and that may very well entail having to go through the tea and cakes exercise, as a number of my pharmacists have reported back to me—and then get the information that you require, go away, do the review, relate back to their doctor et cetera, there is a lot of time spent there and $140 does not go very far.

Mr Greenwood—It can be quite time consuming and quite a significant number of people prefer to have it done in the pharmacy. But it is preferable if it is done in the home. That will not always be the case. I think the Commonwealth has acknowledged that.

CHAIR—I want to ask you about the Pharmaceutical Benefits Scheme, and I have read your comments very carefully. Does the Pharmacy Guild accept that extrapolating current changes will lead to a five-times increase in the PBS over the next 40 years?

Mr Greenwood—We accept that there will be an increase in the PBS if the current criteria under which the PBS is operating continues into the future, but we do not think that will be the case. We think that, in economic terms, the Intergenerational Report has a number of major flaws. I could provide to the committee some work that was done for us by Access Economics, which may be of interest to you.

CHAIR—We would be happy to accept that.

Mr Greenwood—Essentially, we think that the Intergenerational Report does not take into account the increasing wealth of the Australian economy. We believe that to extrapolate the PBS costs out over a 40-year period would actually lead to the PBS costing more than the GDP, which is clearly an absurdity. Nevertheless, we do acknowledge that there is a major problem in terms of managing health care costs. Through the national health care alliance, we have established a symposium, which will be held later in the year, which will bring together a number of experts in the field, mainly representing the providers, to examine these issues and to look at ways in which we might usefully comment as a sector on the means by which Commonwealth programs are funded and implemented so that we can all contribute to using the funds that are available in a more effective way. At this stage, that process is only in the planning stages.

CHAIR—I think I understand your position which is that the increase in the PBS may be offset in other areas, so it is not necessarily a bad thing. Does the Pharmacy Guild have any suggestions about how the PBS can be more efficiently managed?

Mr Greenwood—Yes, we do and we have put a number of suggestions to the Treasury in various budget submissions as to how that might be achieved. We think there are great savings in the system if the network of community pharmacies is used in an effective way because of the fact that no new infrastructure is needed to set up government programs. There are trained health professionals there, the pharmacists are well able to coordinate care in a number of areas and usually have very good relations with the local medical practitioners.

We think that there is a real opportunity for some major savings to be made, but we do need the Commonwealth Department of Health and Ageing to sit down with us and go through how

that might be achieved. At the end of the day, we think it is about the means by which the programs are implemented and funded. I think we all agree on what the ends ought to be in terms of reducing the incidence of diabetes, asthma, improving Aboriginal health or whatever it might be, but it is about the way in which these programs are funded and the way in which the community pharmacy can contribute to a better use of health care funding. That is where we see the debate and that is where this symposium will, I think, lead us. That in turn ought to lead us to be able to engage in a much more effective way with the policy makers in Health and Ageing, Treasury and Finance as to the way in which funding is programmed and the way in which our own five-year agreements are constructed.

Ms Phillips—Something like medication reviews is a real step in the right direction. It is still very much in its infancy as an initiative, both in residential care and now particularly in the community. But if doctors and pharmacists can work together and have better communication with the patient—to have a more ongoing and continuous review of medicines a person is taking—ultimately that is likely to lead to a reduction in the number of medications that that person takes. So that has been one very good initiative and one which needs to have a lot more put into it and to be developed further.

Another thing is for the trend generally to be towards preventative health. That relies on a lot more education of people. Pharmacy is very well placed to assist in that whole process so that, rather than people having an attitude that you wait until you get sick and then you take medicine, people start to look much more at their whole lifestyle to prevent illness occurring in the first place. Obviously, a huge case in point at the moment is the problem of obesity in children in Australia, which means that we are not doing very good preventative work at all because that is going to lead to all sorts of medical problems for those children as they grow older. That is the area that we ought to be focusing on, and perhaps not just looking at ways to cut existing costs.

CHAIR—This may be a question for the HIC, but have you found that requiring the Medicare card to be presented has revealed whether there was any free-riding by people who were not eligible to be on the PBS?

Mr Greenwood—I will let Mr White answer that in terms of his experience within his own pharmacy. I think the procedures that have been put in place have reduced the incidence of abuse of the provisions, but I do not have any qualification of that. Often in these things you can never know how many people might have been caught by the system because once people realise those provisions are in place they do not necessarily risk flouting the arrangements. It is difficult to tell just what the numbers might be, but certainly the government itself projected savings of, I think, $20 million. We found that somewhat on the high side. Only time will tell whether or not that is the case. Patrick, what have you noticed in your pharmacy?

Mr White—Certainly one of the initial issues was that, although people were turning up with their correct Medicare card, it was being rejected. That seems to have died down. People are very aware of it now so there are a lot more instances of them coming in and producing their Medicare card and their health care card at the same time. Also, the use of technology means that it is remaining in the system and is being checked. A lot of pharmacies are now moving towards using computers at the point of presentation—in other words, there is a receptionist as such who takes all the clerical data and checks on the computer, rather than taking the

information and then finding at the back end of dispensing that there is an issue, which causes some problems from the point of view of the person who wants to get their medication.

There are still problems of people not turning up with Medicare cards who require acute medication. It does not happen so much with people with chronic conditions because it is an ongoing exercise, but when someone turns up with a child without a Medicare card—they have a Medicare card but they do not necessarily have it with them when they are looking for an antibiotic et cetera—it does cause some angst from time to time. But certainly it has become a lot more acceptable now. I do not see any major issues in the future.

Ms CORCORAN—How do you see the role of pharmacists in dealing with people who are getting older? Also, I want to ask a specific question about what I call 'dosetts'. You do not call them that.

Mr White—Compliance packs.

Ms CORCORAN—My own family experience has been that the pharmacist has been able to look after them for a relative in residential care. But it seems to me that they are so useful that there must be thousands of people out there in the community who would find them useful. They are obviously time consuming to put together. But, firstly, do you agree with me that many people would find them useful? Secondly, if that is the case, is there a need for them to be funded or made available in a way that does not mean that chemists are tied up for the rest of the year filling them for no reward?

Mr White—Compliance packages are a great innovation, and there are various different types of compliance packaging now. Some are suited only to aged care facilities and others are suited to aged care facilities and the general community. They are only a tool, though, and that is one thing that really needs to be recognised. They are not a problem-solving panacea. Yes, certainly there is a need to finance them, because they are expensive to produce, both in terms of the raw materials and the pharmacist's time. If you are in a situation, for argument's sake, where compliance packaging for a week is costing you as much as your medication, if you are on a health care card, that is sometimes a disincentive. It is difficult sometimes to convince the people who most need it that they really should be having it and need to take it. I would love to see more doctors take a more proactive role, because they really are at the cutting edge with their patients and they really know and should be able to tell whether patients require compliance packages. Sometimes when they are suggested by a pharmacist, the response is: 'I will check with my doctor.' So a double-pronged attack from the pharmacist and the doctor is a good way to go.

Secondly, though, I see an issue with aged care and compliance packaging. A number of different types of packaging can be used in aged care. But now we are seeing more and more that, because of budgetary constraints or issues, aged care facilities are going to compliance packaging to allow non-registered nurses, as in enrolled nurses and carers, to actually give out the medication. Therefore, they are not necessarily going for the best system to suit the residents but the best system to meet their financial needs. That is an issue that really needs to be addressed. I believe it is a real issue.

CHAIR—Stephen, you mentioned in your opening remarks initiatives relating to rural pharmacies or the closure of some pharmacies in rural areas. Are there any initiatives to attract

to pharmacy courses more students from a rural background? Is that happening in many of the courses?

Mr Greenwood—Yes, there are initiatives. A number of measures are part of the current third community pharmacy agreement. There is an undergraduate scholarship scheme. Perhaps I could just go through some of those issues.

CHAIR—Certainly.

Mr Greenwood—There is a rural pharmacy package, which was part of the five-year agreement, which consists of the rural pharmacy maintenance allowance and the start-up allowance. That is to encourage pharmacies to start up in areas where there is no pharmacy. There is a succession allowance. There is also an emergency locum service and the Rural and Remote Pharmacy Infrastructure Grants Scheme, as well as continuing pharmacy education and professional development allowance schemes. There is the undergraduate scholarship scheme, which I mentioned, which is currently providing 29 scholarship holders with an additional 12 scholarships to be awarded in March 2003. There is also the Aboriginal and Torres Strait Islander Undergraduate Scholarship Scheme. A rural pharmacy course has been established at Charles Sturt University, at Wagga, which is coordinating a lot of these initiatives in the rural pharmacy area.

There is also the Rural and Remote Internship Scholarship Scheme and funding for the provision of pharmacy academics at university departments of rural health. In addition, we also fund a number of initiatives in this area through our Quality Care Pharmacy Program. We put out newsletters and rural pharmacy promotion materials to pharmacists who operate in that area. There is a lot going on in that area, and the guild has been able to work together with the government to improve those services. A number of these measures were modelled on some of the provisions that applied to doctors, but we find it has been working very well indeed.

CHAIR—Does it also encompass measures that relate to when someone has graduated and they do further training in a rural area or to things that will make it attractive to practise in a rural area?

Mr Greenwood—We are certainly trying to encourage people to practise in rural areas, especially students who come from those areas. That is what is happening through Charles Sturt and there is also work going on in Mount Isa and in a number of other locations. But I would have to say that the number of graduates needed in pharmacy is far beyond that currently being funded by tertiary grants that are made available to the universities.

We have just undertaken a major work force study. Perhaps I could leave you this briefing note, which covers the issue of the surge in demand for pharmacists. It derives from *The study of the demand and supply of pharmacists, 2000-10*, which was funded through the third pharmacy agreement research and development grants program and was undertaken by Health Care Intelligence Pty Ltd. It found that not only is the pharmacy work force ageing but the proportion of females in the pharmacy work force has steadily grown to approximate the number of males and that there is likely to be a significant restructuring of the work force in the next 10 years as older pharmacists retire and are replaced by younger female pharmacists.

The point of all this is that there is going to be a much higher demand for pharmacists in the years to come and that, unless the universities are able to produce more graduates and unless we can attract pharmacists to stay in community pharmacy and not pursue other careers, there will be a shortage. The main way you can attract pharmacists to stay in community pharmacy is to enhance their role and use the knowledge they gain over four years of study, especially in the clinical area, to provide an enhanced range of services in cooperation with other providers in the area in which they work.

CHAIR—A number of submissions to this inquiry have raised the issue of specialist pharmacists in the area of gerontological pharmacy. Does the guild have a policy on that? Do you believe there is a need for that and is there scope for people to specialise within pharmacy in such an area?

Mr White—There are already a number of specialty areas within pharmacy: asthma, diabetes and so on. Rather than isolating a practice to aged care or gerontology, I would like to see it as another module within an improved structure of pharmacy. I will go back to something Wendy said earlier on: in this submission it was indicated that the average number of visits to a pharmacy is 14 per year. That is a lot higher than the average number of visits to a doctor.

We need to focus on wellness. Most people, particularly males, visit their doctor on the basis of illness, and then when they are pushed, rather than wellness. When we look at the projected cost of the drugs associated with lifestyle issues, such as cholesterol, obesity et cetera, we are going to have problems with the cost of the PBS over a period of time. If we have that exposure to the population, surely we can play a role in educating the population. Those specialty practices you are talking about would become more of an incentive for pharmacists to really get involved. I think that is where we should be.

CHAIR—Thank you very much for your evidence this afternoon and for your submission. I thank all of the witnesses who have appeared before the committee today.

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

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 4.16 p.m.