COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

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

MONDAY, 31 MARCH 2003

MELBOURNE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Monday, 31 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, Mrs May, Mr Tony Smith 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 9.03 a.m.

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Ageing as part of our inquiry into long-term strategies for ageing. Today we will hear from the Municipal Association of Victoria, Aged Care Assessment Service Victoria, Dr Katharine Betts, the Australian Physiotherapy Association, Kingston City Council, and the Disability Support and Housing Alliance. Local government, allied health professionals, academics and community groups each have an important role to play in formulating and promoting long-term strategies for ageing. The committee anticipates an interesting and productive hearing.

[9.04 a.m.]

EDWARDS, Mr Troy, Senior Policy Adviser, Municipal Association of Victoria

HARGREAVES, Ms Clare Lynette, Senior Adviser, Social Policy, Municipal Association of Victoria

KOOPS, Mr Trevor James, Senior Economist, Municipal Association of Victoria

CHAIR—I welcome the representatives from the Municipal Association of Victoria. 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 Municipal Association of Victoria has made a submission to the inquiry, and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Edwards—Thank you. You have seen our submission and, hopefully, it gives you a picture of the position of Victorian local government in relation particularly to home and community care. You will probably find in your deliberations around the nation that Victorian local government is in quite a different position from that of the other states in that we are a substantial provider of home and community care services and we have been for a long time. It is really a cultural thing that has developed here.

The Victorian Grants Commission estimated that local government was contributing in excess of $90 million per annum to aged and disabled services in Victoria in 2002. Of that figure, around $44 million is contributed by local government to the core HACC services of home care, personal care, respite care, property maintenance, meals, assessment and care management. It is the largest source of specific purpose funding that councils receive. As you are probably aware, it is funded through a fairly complex process involving all three levels of government. One of the particular difficulties in Victoria, given the size of our contribution, is that we are perhaps a silent partner in a tripartite agreement between the Commonwealth and the state and that puts us at a particular disadvantage when it comes to some of the planning and provision. That is an issue that we may touch on later this morning.

Obviously, given the size of local government's contribution—and it is around 37 per cent of all HACC services in Victoria—we are going to be under particular pressure as the demographics of Australia change over time. How we are to meet the demand is the issue that most people think of first and foremost. Perhaps a greater difficulty for local government will be how we pay for it, particularly given that our major source of revenue is property taxation, which certainly does not experience anywhere near the growth of income tax and other forms of taxation, and that is going to be a particular problem as the community ages. The cliché 'asset rich and cash poor' is going to be a particular problem for local government.

Over more recent times the MAV has done quite a substantial amount of work on the position of local government in relation to home and community care. It is unfortunate from our position that local government's share of HACC funding seems to be declining. That is raising a number

of complex issues, particularly when it comes to trying to meet demand—trying to hold the funding for the services at an appropriate level. That is a particular problem.

The only other issue I would raise up front is some of the concerns we have about the growth in what we would see as discretionary elements of aged care, particularly from the state and Commonwealth in areas like the state Linkages program and, federally, CACPs. We might talk about that a bit more but essentially there are efficiency issues there, a lot of confusion and potential competition. It is probably going to be a driver for some major reform in how HACC services are provided. I will leave it there and try to field as many of your questions as I can.

CHAIR—Thank you. You have said that the Commonwealth funding of HACC is increasing and state funding is staying about the same. You said that there is a shortfall for local government. Do you have any suggestions about how to address that?

Mr Edwards—That is a particularly complex issue. One of the complexities is that the agreement between the Commonwealth and the state is based on a matched contribution. The Commonwealth provides around 60 per cent and the state provides around 40 per cent of the funds. In that official process there is what is called a local government imputed contribution. No-one is quite sure of the historical basis for that but it certainly does not reflect anywhere near the full cost that local government is providing. We think it is around $44 million. The last official record shows local government's imputed contribution to be around only $8 million. That is a particular problem when it comes to ensuring that local government's role is recognised in Victoria.

Part of the complexity of that is that the growth in funds from the Commonwealth is certainly keeping pace with the growth in Commonwealth revenue, but it is certainly not doing anything to deal with the growth in demand and certainly the growth in cost. A lot of that cost growth is driven by wages, and it is a particular problem across Commonwealth and state programs in that the CPI is simply one element of what is usually a much larger figure when it comes to the cost drivers for programs. One way to look at that is to start to build inflators for prices that more accurately reflect the demands on local government. Trevor might have some particular quantitative information.

Mr Koops—I think the major issue here is that both Commonwealth and state funding has been increasing, but it is probably a little short of growth in demand. Previously, local governments have been putting in their own contribution. Over time, as unit prices are reimbursed for providing the service, having kept pace with costs, they have drawn back their level of supply. So, while you have the Commonwealth and state putting more in the pot and you expect service provision levels to be increasing—volumes to be increasing—it has not been happening, because local government cannot continue to provide the level of contribution it has done. The total has actually been falling, while a lot of reporting going on at state and Commonwealth level says that HACC services have been increased in Victoria. We do not believe that is the case. Our latest figures show that there has been about a three per cent decline in total service volumes, in spite of around seven per cent being put in by the Commonwealth in terms of growth funding and the escalation factor. So, in spite of the Commonwealth and state putting more money in, there is no growth in the total service volume.

CHAIR—Is that because the costs are increasing, or is it that you are just unable to match it?

Mr Koops—It is both. It is mainly the former, in that the unit costs that councils have paid are well below the minimum service delivery costs, but there are also pressures in terms of whether HACC is a good industry to be working in. For a long time it was not, due to CCT and other pressures. Also, it is hard to get qualified staff in certain areas for higher levels of care—personal care, that sort of thing. So, there are the two factors, but it is mainly cost driven. The price that is being paid to local governments in Victoria at the moment is below the minimum private rate you could provide, and there are greater pressures in the local government sector for wages. You cannot get blood out of a stone. Their response is to draw back on some services, while in other services they do not do that—for example, in the meals area, because it is the most basic of services that someone has to get a meal. So, they will target particular services. It seems to be home care—the basic housekeeping sort of care and, to another degree, respite care—that is being drawn back on at the moment.

Mr ANTHONY SMITH—You mentioned in your submission—and it is something that there has been a bit of media coverage on—the actual funding mechanisms and the complexities of federal funding of state government activities. They decide where it goes. You mentioned some inefficiencies in that, which are reasonably obvious, and there has been a lot of talk about cost shifting. Given that this is a long-term problem if it is not addressed, what would you prefer to see in an ideal world? Would you have direct funding?

Mr Koops—Not necessarily.

Mr ANTHONY SMITH—Let us leave the complexities aside. From where you sit, imagine you could start from scratch.

Mr Koops—I am not quite sure, to tell you the truth. I am not sure about bypassing the state direct funding—I guess the most it would save is a couple of million, in terms of the state administration. It is easy to look at some other areas, for example, the CACPs and Linkages situation, where you have this sort of duplication. Our own figures say that there is at least $10 million a year to be saved there, just on administration. Basically, in particular councils, because of the complexity of the thing, you will have a manager and an administrative arm managing home care—that is, home care, personal care and respite care within HACC—and you will have another manager or coordinator handling Linkages and CACPs. Now, there is no reason that this person, who is the HACC manager, could not manage both but, because of the duplication, you have that inefficiency. That is one area where it is clear.

Mr Edwards—The analogy we often use when talking about the CACPs and Linkages is that it is like going to the football at the MCG. Once you get inside the ground, you are going to see the same game. Essentially, with a lot of the HACC service provision in Victoria, once you actually move through the referral and assessment process, you are going to receive the same service. It is like lining up at the MCG. You might go to one gate and they say, 'No, sorry; not here. Move to the next gate.' They say, 'Those criteria do not apply here; you should try Linkages around at gate 4.' Then they shift someone back there. There are a whole lot of gatekeeping and access issues about essentially accessing the same service.

So from Victoria's point of view, if there were to be some tripartite reform involving the Commonwealth, state and local governments, we would need to move to a system where there would be the provision of a basic service; then, as the requirements were stepped up, more complex types of care would be provided. Essentially, the game plan for local government,

being on the ground, is that there needs to be less competition amongst particular funds, particularly between CACPs and Linkages.

In effect, one of the dangers we see happening, particularly as the Commonwealth moves to provide output style reporting—and I can understand why, because the CACPs program this year is going to provide 500 extra places nationally and those types of things—is that the Commonwealth would obviously like to say, 'We are providing X places.' The trouble is that local government is then funded on a recurrent basis for its core services. We see a particular tension there between the demand to provide Commonwealth programs, where the Commonwealth can clearly say, 'This is what we are delivering,' and the residual Commonwealth funding that is being used to deliver local government services actually being wound back. That places councils in a particularly complex position because at the end of the day they will be the ones administering both programs. People who are getting access through one gate, if you like, will continue to receive quality of service, and those going through another gate will face declining service. So there needs to be that type of streamlining.

Ms Hargreaves—Perhaps I could add to that. I think we attached to our submission a copy of a report we have done to the Myer Foundation. That sets out some of these ideas on national community care reform. Further work has also been done in Victoria since that time, between all the key HACC stakeholders and the state, on the idea of collapsing the current programs and moving them all together. A practical example, as Troy says, is that we would have some councils trying to run 17 brokerage arrangements, either buying or selling the same service backwards and forwards. That has all developed in the last 10 years, since the Linkages program was introduced. As Troy has indicated, we see the fallout on the ground of people trying to manage these complex arrangements when, in the end, the client probably ends up with the same service. Usually, in terms of continuity of care, they would prefer to stay with the same service and have the same care worker coming into their home and not be sent around the variety of doors, as Troy says, to patch together a service.

The proposal for reform is outlined in the report to the Myer Foundation. I am happy to leave the further paper that has been prepared since that time. As we say, in Victoria there is a fairly unusual synchronicity between all the agencies, including those of us who provide the basic HACC services and those providing the packaged programs, that there really does need to be some reform. We would certainly be interested in that in Victoria, quite apart from nationally, given that we have such an interest in trying to make the system work better for members of the community at the end of the day.

Mr Edwards—To go back to your original question about whether we want to see direct funding, what we would like to see is better integration between the three levels. One of the risks I suppose local government faces is—and there is no other way to put it—the political games that may go on between the Commonwealth and the state when it comes to funding. For example, for HACC, if we were to move to a direct relationship with the Commonwealth on a bilateral basis then we would risk losing the unfunded contribution from the state which has been used to relieve a range of pressures on the sector. The reality is that in the last 18 months local government in Victoria has had particular success in accessing more funds from the state, through its unmatched contribution, to actually relieve some of the pressure. I would hate to be in a situation where we would lose that particular access, although a bilateral relationship would have some strengths. In terms of the totality, we would want to maintain an integrated approach but deal with some of the particular pressures. To do that, purchaser-provider type models are

probably the way to go, where you get the three parties to sign off on how you are going to fund it, and at what rate, for a three-year period. Then you return, review it and start again so that you do not get caught through cost shifting over time, because the CPI does not take into account wages growth and other issues.

Mr ANTHONY SMITH—That is interesting. That is why I wanted to get your view as an association. Outside of this hearing, I have certainly heard individual councils advocating direct funding. Obviously, as an association you have to take into account broader issues.

Mr Edwards—On a slightly different tack, being a Victorian member of the federal parliament, you would be aware that we have had substantial local government reform here. We now have local governments of a much greater size and capacity than in other states. However, having said that, I suppose there are still a number of councils here that probably do not have the capacity and resources to handle a direct bilateral relationship. We need to be cognisant of those issues as well.

Ms HALL—If I were to summarise the problems that you see as involving duplication and a crossover, would it be fair to say they involve the competitiveness and the competition that takes place and the barriers that that puts in place? There is also the problem with administration and the bottom line is that it is not a system that works well for the community. Regarding your approach, as a peak body would you like to see a streamlining of services and also a little less competition?

Mr Edwards—Most definitely.

Ms HALL—Is there anything I missed in that summary?

Mr Edwards—One of the points that Trevor brought up is important. Whatever kind of growth seems to be flowing from other levels of government into the service is being used to actually address the unit price cost gap now, rather than providing for growth. So, over a longer period—say, the 40 years of the terms of reference—that is going to be a particular problem. The service is not growing; the funds are being used to simply keep pace with the costs of providing the service now. I guess that is really the headline issue. If we do not address the unit costs now, and then provide for appropriate growth, we are really going to create a massive problem later on.

Ms HALL—So, growth funding.

Ms Hargreaves—The MAV did what was called a HACC status report in 2000, prepared by Dr Anna Howe. Since that time we have really said that the strengthening of the core services of home care—in its various guises—and home nursing is absolutely critical. As you say, what is tending to happen is that small programs for various groups are being funded, which is whittling away the core services. I think even the representatives from some of those organisations—such as the ethnic communities—would be equally concerned if their members could not get the basic services. We have really had to focus on that. The system has just become so complicated, both within HACC and with all the other add-ons. We are just trying to keep focused on keeping the basic system up and running.

Ms HALL—Do you think there needs to be a review of the way HACC services are delivered, and would that review include local government as a partner?

Mr Edwards—The answer to that is an unequivocal yes. Certainly, as alluded to earlier, Victorian local government's level of commitment to HACC is way beyond any of the other state and local government associations, so we would like to see that. In effect, it means that it is particularly difficult for us to seek to have some of these issues addressed nationally, simply because there is not the kind of groundswell in other states to actually get the issue on the agenda. It is just a particular problem we have. Any kind of formal move to do that will provide us with a structure to access.

Ms HALL—Would you like to expand on the issue that was brought up about qualified staff?

Mr Koops—It is common practice to pick up a newspaper—either the local Victorian newspapers or the *Age*—and see that staff are wanted for HACC services to provide home help or personal care. It never ceases; they just cannot get enough staff.

Ms HALL—Are there any initiatives being put in place to address it? If not, what do you think needs to be done?

Ms Hargreaves—There has been work done by the Brotherhood of St Laurence and VHC recently, which you may have heard about, about the situation with home care staff and what is happening in that area. Jointly with the state and other agencies, we are looking at a forward-looking project to see what action can be taken, similar to what has happened in other work force areas such as nursing, to look at the reasons this is occurring and how it can be targeted. We are looking at it with people with HR experience, rather than it just being dealt with in the community services areas, because obviously it is a broader work force issue. As you would be aware, often women are in these sorts of professional and subprofessional areas. We are certainly working hard on creative ideas on that.

Ms HALL—With meals do people come online immediately? Is there any waiting time?

Mr Koops—Generally not for meals as they try to fit meals in—it is the most basic of services; someone has to get a meal—so if they need to pare back something I would suggest that they would look at the other services.

Ms HALL—That goes to the next question. What would be the waiting time for a person to get some home care assistance?

Mr Koops—It varies considerably.

Ms HALL—Give me an idea.

Ms Hargreaves—We have some councils that do not have waiting lists but we have others that I think, from our recent work, obviously would try to move high priority cases in, but other people would have to wait weeks and possibly longer, depending on the priority. So they are very much having to work on those urgent and most in need ones and to move to make sure that

they get some assistance—and if it is not available from the local government they would ensure that another service is able to assist them.

Mr Koops—Rather than do that, they may juggle. If someone has been getting a certain level of care, they may adjust the care hours. They may refine their policy schedule. The standard hours that someone may be getting is three hours of care per week. They may scale that back.

Ms HALL—Is there any group of people that would miss out altogether?

Mr Koops—We have probably got the information but we would have to provide that under advisement. We have survey information on waiting times and on those that do have waiting lists, but we would need to pull that together for you.

Ms HALL—It would be great if you could do that.

Mr Edwards—The report has not been made public yet but we can extract the information from the data and provide it to the committee.

Ms HALL—That would be really good. Are there any problems specific to respite care? Are there waiting periods for people to access respite care? Once again, are there any people missing out or falling through the cracks with respite care?

Mr Koops—I would venture to say yes. Our latest figures show that respite care suffered the largest fall of all the service types. I think it was something like four per cent on the previous year's total volume supplied. It has been mentioned to me by some of the more remote councils, like Yarriambiack. Yarriambiack find it hard to get respite carers. I think that is probably a problem that a lot of the more remote councils face.

Ms CORCORAN—My question goes back to statistics. I think I heard you say earlier that, despite the increase in funding, in fact service delivery is dropping off. I do not think those statistics are in your submission, although I might be wrong. If they are not, are they available?

Mr Koops—They should be in there. For example, for the 2001-02 year on the previous year—

Mr Edwards—This is on page 11 of the submission.

Ms CORCORAN—Okay. Thank you, I did not see that before. My second question goes back to your comment about being a silent partner. You have probably covered this area since you made that statement. Do you want to add anything to that about the frustration?

Mr Edwards—Yes, it is a particularly difficult process and one of the issues behind it, I think, is just the nature of federal financial relations in Australia. The Commonwealth collects about 75 to 80 per cent of the revenue and the state also collects a substantial sum. They often have the discussions about how it is going to be carved up and who is going to provide it, yet we do not get to the table to have that discussion. That particularly applies in the relationship between the Commonwealth and the state in HACC where, nationally, local government is not a major player in the other states, yet in Victoria it is. I think when the state government has its

discussions with the Commonwealth there are times when both the Commonwealth and the state would like to have local government in the room, but they simply cannot because of the nature of the national agreement on HACC. That is a particular problem that we have.

Roughly around 12 months ago, we established what we call a program partnership with the Victorian state government Department of Human Services HACC people, which we formalised more recently. We have had substantial dialogue with them, including undertaking joint work on issues around HACC, trying to identify some of the key vehicles we could use to actually increase the certainty with which local government provides a service—things like moving to triennial funding and streamlining some of the reporting requirements. They are the small things we can do to tinker around the edges short of actually being a signatory to a tripartite agreement where there was a clear delineation between who is doing what, who is paying for what and how it is going to be provided on the ground and those types of things.

Mrs MAY—As a Queenslander, I am absolutely intrigued by your submission. The way you deliver HACC services on the ground is unique. I wonder about the delivery of those services. You have just touched on the funding level. How do you come to the arrangement of how much funding the local government puts in to the delivery of these services? Obviously, that is a problem when your income stream is limited compared to the state and the Commonwealth. Troy also touched on working with the state and the Commonwealth—obviously there is the state-Commonwealth agreement—and how to identify the services and who is going to take responsibility for those. Your local governments on the ground are delivering the lot, I understand—that is what I glean from the submission. Having the people identified within council to deliver those services must be an enormous project for you as local government. I think some of my local governments just would not be able to do it. Could you expand on that?

Mr Koops—I regard it as working in an environment of stress all the time. They are constantly under pressure to provide. The decision about what level of council contribution they make to services themselves is up to them. It is a cultural one; it depends on how they assess their community's expectation of what is required.

Mrs MAY—If a local government saw a shortfall in a service, is that where they would maybe put some dollars?

Mr Koops—If they are financially able to. You have to understand the context that local government in Victoria is working under at the moment. They face a significant infrastructure gap at the moment on local roads, buildings and those sorts of things. If they elect to put more into aged care, they have a problem.

Mrs MAY—It is like cost shifting.

Mr Koops—It is like shifting the money around. They are not in a position to double-digit increase rates because the electorate would not be able to stand it. It is this constant state of stress in trying to move money to where it can best be utilised and having to deal with two big problems. Probably the two biggest problems in Victorian local government are infrastructure and HACC.

Mrs MAY—In your submission you say that you deliver health and education. You obviously deliver an enormous range of services to your local communities.

Ms Hargreaves—Historically, Victorian local government has been involved in community services since 1917, I think starting with the Maternal and Child Health Service. So we had a prior history of being involved in all the home care services before the HACC program was introduced in 1985. There was a long history, as Troy has said, of councils looking at what the community needs were, particularly postwar, and looking at a variety of very flexible services which, at that stage, were not so constrained by program streams.

Undoubtedly, local government in Victoria is much more involved in human services, so we have a broader history where there is a lot of social planning, aged services planning and so on. We would be very happy to look further at the issues of ageing generally: of positive ageing and all those other aspects. To spend less time focusing on sorting out HACC would be good, because we have a role in looking at the whole stream—the need to work on government housing, home care, residential care but also positive ageing, municipal public health plans and so on, and a different approach to where people are going as they get to retirement.

Mrs MAY—A lot more than rates, roads and rubbish. Could you also expand on those areas of need that you see at grassroots level: where you see an obvious shortfall where councils are having problems meeting the demands of those services financially? What input do you give back to the state? Do you have regular meetings or updates? Are they looking to you for statistics regarding where it is falling off?

Mr Koops—In the statistical area there is always debate about what the cost is. We have done the definitive work in the area; that has basically been said. Also, the Commonwealth had a Productivity Commission report done several years ago. If you look at the costs in that you would know that Victoria is faring badly. There is ongoing communication with the Department of Human Services, but their acceptance of the statistics has to be satisfied within their budgetary constraints. That is the ongoing issue. There is acceptance of the data but there is not the pot to pay for it. When we talked before about growth, it is not just growth funding; it is an acceptance of what it costs. We can talk about growth but, until you get to the point of saying what the cost of the service is to which you can apply the growth, you are never really going to know the full equation.

Mr Edwards—As I said before, that is where we developed a stronger program partnership with the state, where the MAV, representing local government, is involved in some of the high order issues of the day about the planning and where the service is going. Clare might expand on this, but most local governments are locked into a regional process with the DHS in terms of reporting on deliverables and those types of things in particular hot spots. I might also add, just before Clare responds to that, that there are a number of councils that are simply talking about closing off their books. They are saying that their budget cannot sustain the growth in these services and that they are going to have to draw a line and say, 'No more,' because they have challenges on drainage systems, sports ovals and those sorts of things.

Mrs MAY—What would happen if a service was withdrawn, if a line was drawn under it?

Mr Edwards—The short answer is that the politics would be played out. An important issue in local government is that there is a general competence in the governance function. Councils rise and fall on those particular issues as well.

Mr Koops—It is unlikely that the market could fill the gaps, I would think, in the short term. For example, in some of the rural areas there are other non-local government providers but they would not have the wherewithal to pick up that sort of slack straight away.

Mr Edwards—Clare might explain the regional reporting requirements.

Ms Hargreaves—As Troy mentioned, we have an ongoing DHS/MAV—as we call it—HACC primary care working party so we have a structure in place where we are formally looking at these issues with the state. We have a number of councils that sit on that committee from metro and rural Victoria to advise us. Of course, there are a whole range of ways in which we can improve our state, regional and local planning and integrate what we are doing. The problem that we keep running into—and that is why we were very pleased when the Myer Foundation supported us in preparing the report—is that there is only so much that you can solve on the ground by tinkering with arrangements, when they are actually being exacerbated by the structure. That is taking up a lot of people's time and energy. They are being deflected from real work with the community in terms of community planning, creative solutions and where they might go. We are moving to the stage where the state is happy to give local government a bit of a free hand about what creative local arrangements might be. You can only take that so far when so much of people's time is consumed with dealing particularly with the package and Linkages programs, as well as the basic home care. There really is unnecessary duplication in what is occurring at the moment.

Mr Edwards—Since the previous federal election, we have also developed a much more positive relationship with the federal Minister for Ageing, Kevin Andrews. That is a real positive. But he has particular constraints in terms of how far he can go in providing us with some of the kinds of support that we need on the ground, which is where we pick up things from the state department.

Mrs MAY—I think most of us, as federal members of parliament, would say that we work in our electorates, we understand them, we can often identify where those shortfalls are, and I know most of us have probably even said to our minister, 'We would like a little bit of input there as well.' We do see it on the ground and maybe that is a way of working more closely with local councils.

Ms Hargreaves—The veterans' area is a sensitive issue. You are probably aware that the establishment of a parallel veterans' home care program is probably the ultimate example. It is my understanding that federal governments and the ministers wish to make sure that veterans are well serviced. In Victoria the MAV proposed to the Department of Veterans' Affairs that they could have contracted, through the MAV, local government to provide the service that the councils were already providing to those veterans. We also indicated to them that they would probably have great problems with their budget at the end of the day, because we were already aware of the number of people who were transferred to veterans' home care when that parallel stream was set up. The councils have now spent a couple of years dealing with yet another system of parallel administration. At the risk of offending anybody sitting around the table, that would have to be one of the perfect examples of where that waste could have been avoided. Of course, veterans' home care is hitting the wall in terms of its budget, so we are again faced with the issue of the people who cannot get in to that and who are now back on the HACC waiting lists. It is a demonstration, I suppose, of the sorts of things we could avoid.

CHAIR—Do many of your councils have a role in residential aged care facilities?

Mr Edwards—Very few.

Mr Koops—I think there are three major ones.

Ms Hargreaves—Yes, there are a few major ones and some—

Mr Edwards—A couple of larger metros primarily.

Ms Hargreaves—In Whitehorse, and some in the south-eastern region.

Ms CORCORAN—In Kingston.

CHAIR—Does the MAV have a view on the Myer Foundation's recommendation that the funding be separated into capital funding, care funding and the services type funding in facilities?

Mr Edwards—I have not really had a look at it. I do not know whether you have any passing comments on that, Trevor.

Mr Koops—I am not sure how the capital funding process works at the moment, basically because the HACC program is a recurrent funding vehicle.

CHAIR—In terms of your councils, how far ahead do they plan for the needs that they will have to meet for HACC?

Mr Koops—As Clare mentioned before, a number of councils now appoint social planners who are doing demographics and working out what the future prognosis is. Not all of them have that luxury. We are talking about probably a band of the wealthier metropolitan councils being able to buy that expertise, but I would say the majority of them do not have that and they are relying on bits and pieces they can get from published sources and the state government, rather than doing their own work at a neighbourhood level.

CHAIR—Have you or the Victorian state government done forward projections of what you expect the need to be in residential care and community care?

Mr Koops—No. I guess we rely on DHS to do most of the residential care projections and that sort of thing. We have done projections on what we think will be the problems with HACC, but the problem is so serious now. In the next two to five years we will focus on that. Our focus is on trying to get the correct unit cost paid. For example, we were not privy to how Veterans' Affairs arrived at the cost they would pay for an hour of care. We do not know how they arrived at that, but that is still short of the minimum cost of the councils' provision of an hour of service.

Mr Edwards—The state government recently released a discussion paper called *Better Planning and Funds Allocation for Home and Community Care*, which looks at a number of the issues on planning and that type of thing. One of the recommendations we have on that,

particularly when it comes to planning, is to move HACC away from a submission based approach and on to a population needs based model, which will clearly be driven a lot more effectively by demographic change rather than simply a submission based process.

The second one—and I raised it earlier—was to move to triennial funding. Your funding moves out over a longer window and you get direct allocation to invited providers who will provide a panel. That takes local government to the point of having a lot more continuity in terms of their own budgeting about what sort of funds are going to come online to deal with the population drivers there. Other particular planning issues were: to get a one-off allocation of funds into the base cost rather than simply use it for growth to try to address some of the inequities; a move to have more transparent regional and local area plans developed by local government more closely integrated with the planning process and, perhaps most importantly, to move to a point of having joint negotiation with the Commonwealth in terms of multi-year planning and those sorts of things. As we have mentioned several times this morning, it is one thing to have three-year processes with the state but if their funding is still driven on an annual basis by the federal budget we are not really in any better position than we were before. One of the things is to get all the parties agreeing to a process for taking it forward and dealing with some of those issues.

Ms HALL—I will take a different tack, and it is something that you have not mentioned in the submission—looking at the other role of local government, the planning role, as opposed to the type of planning you were just referring to—

Mr Edwards—Land use planning?

Ms HALL—Yes, and ensuring that local government incorporates in that planning process proper in-depth planning that covers infrastructure and provision of basic services like transport and looking at the type of housing that is built and whether it is age appropriate. What initiatives have been taken in that housing area in regard to that planning issue as well?

Mr Edwards—That is an excellent point in terms of the particular challenges facing local government. One of the challenges is to ensure that you have appropriate physical development in the community to deal with an ageing population—and Clare might speak about some of the work we have been doing. We have been involved in a number of areas.

Ms Hargreaves—Absolutely. One of the papers referred to the importance of looking at the home care service and particularly at the housing stock and people ageing in place. That is something the MAV has been involved with over quite a period. We formerly had local government housing programs that we supported. There has been historical involvement of local government in Victoria in elderly persons units and villages and so on. We have got a report in the filing cabinet that was done a number of years ago about the sorts of supports people need to age in place.

I suppose it is a matter of some resources being put in to encourage development in these areas so that, as you say, councils, being at the front line, are more able to assist people with the sorts of arrangements they might make rather than thinking that they have to sell up and move to a facility in a completely different area. This is going to be very expensive for both them and the government and it may not be particularly what they want. So the area of housing is certainly on the agenda for councils. The MAV participates in the ministerial council here in

Victoria but, as you realise already I suppose, the range of roles that local government is trying to tackle means that the emphasis on various areas obviously waxes and wanes to some extent according to where the community is at.

We are also involved in discussions with the Commonwealth department around residential care and the appropriate involvement of local government, if not in provision then certainly in incentives and facilitation around land being available and the possibilities of clustering of services and facilities that you might have. Certainly, broadly, it is on the agenda but it could do with some positive encouragement for local government to play a stronger role.

Mr Edwards—Picking up your point on transport, take the number of local governments along tram route 109 in Melbourne, which runs from Mont Albert, in the east, right through to Port Melbourne. If you know those areas, you would know they are older, established areas. A number of older people in the community often use trams. The old style trams are quite high with a number of heavy steps to get up. The state government and the local governments involved have moved to flatter trams with a much smaller access profile, not only to allow better access for the disabled but also to enable better access for the elderly, because there are actually no steps in the tram itself. You would probably see, in a quick walk down Collins Street, some of the work that has been done by the state government and the City of Melbourne to ensure that you get the same access in the city with raised platforms and those types of things. Some of that work is going on. It is not always as high profile but it will certainly be important at later dates.

Ms HALL—Has the association put together guidelines for builders and developers on appropriate housing? Has a package like that been put together for older people?

Ms Hargreaves—Yes, but, as Troy has alluded to, probably more of the work has gone on in relation to access for people with disabilities and the thresholds that we are at with that, as you mention, in terms of universal design and so on, which then probably drives the potential for older people and those issues to be considered. It is one thing that I think is possibly more done by encouragement and so on at the moment, rather than being perhaps as formal as what you are suggesting in terms of quite how far it has gone. That is certainly another area in terms of the specialised work and disability access that the MAV is involved in directly with the councils as well, as you have mentioned, in looking at those access and participation issues in the whole community. So, as I say, I think anything that is being done in relation to people with disabilities flows on pretty directly to some of the problems that some older people may have as well, but it is something we can certainly check for you.

Mr Koops—I would be surprised if the state government had not developed manuals and things in that area.

Ms HALL—How does that interrelate with local government, which is involved in the approval process? I think it is fairly important that there is a relationship and an interchange of information.

Mr Koops—We will take that on advisement and go back to our specialist building and planning people within the association who can respond to that.

Ms HALL—Thank you. I realise it is outside the scope of the submission that you put to us.

Mr Edwards—That is a good point. As a small association, we have to pick our fights. That is probably one we could get involved in but we do not have the resources and capacity.

CHAIR—Are there any further questions?

Mrs MAY—I was just going to say that in Queensland we have a lot more retirees coming to us. Gold Coast City Council actually has a department within it looking at those ageing issues, given our older population. We seem to be getting the retirees all from the south. They are coming to our sunshine to retire.

Mr Edwards—I would like to take this opportunity to thank the committee for giving us a chance to appear this morning. It is a particular challenge not only to local government but to all levels of government and it will probably need some work.

CHAIR—Thank you very much.

Proceedings suspended from 9.53 a.m. to 10.28 a.m.

HARVEY, Mrs Deborah Jane, Chairperson, Aged Care Assessment Service Victoria and Manager, Kingston Aged Care Assessment Service

HOUGHTON, Ms Penny, Manager, North West Aged Care Assessment Service and Access Unit

O'DONNELL, Ms Gail Michelle, Program Manager, Hume Regional Aged Care Assessment Service

THORN, Mrs Juliet, Manager, Heidelberg Aged Care Assessment Service

CHAIR—I welcome the representatives of Aged Care Assessment Service Victoria to the table. 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. Aged Care Assessment Service has made a submission to the inquiry, and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mrs Harvey—Thank you. ACAS Victoria is a state-wide group of ACAS managers who meet monthly to share information and discuss areas of concern that are emerging in the clinical and operational fields. Today we welcome the opportunity to meet with this committee, and thank you for the invitation to attend. Aged care assessment teams, or services as they are known in Victoria, have a core objective which is to 'comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their needs'. This is taken directly from the ACAT operational guidelines of 2002. Regardless of the state or territory ACAT operates in, this objective remains a constant guiding mission for the program. In undertaking this objective, ACATs are in a core position to observe and participate in the service system for older people and therefore we feel we are well placed to comment on the issues in aged care that exist today.

In viewing the *Hansard* reports that record the submissions made by other organisations over 2003 to this committee, it became apparent that ACATs across Australia have an interface with most of the previous groups interviewed. As an ACAT service we are constantly dealing with consumers, carers, service providers, residential facilities, hospitals, people from ethnic communities, Indigenous communities, veterans, medical practitioners and many other groups in the community.

ACATs service both metropolitan and rural areas and while there are differing issues between city and country there are also some common themes that become apparent through the discussions held at ACAS Victoria. In our submission we have highlighted some of the areas of concern. These can be broadly split into three areas. Firstly, there are the issues relating to residential care, and these include the availability of beds, ageing in place, staffing concerns and the lack of appropriate respite care for community dwelling care recipients. Also, the inconsistency between the ACAT assessment and the residential classification scale, known as the RCS, is an area that causes concern for both ACAT and residential care providers.

Second is the issue of the treatment of older people in the hospital sector. Often a hospital is not an appropriate place to address an older person's issues; however, currently there is little choice of alternative care to address health issues for this group of people. Access to acute beds and then at a later point the move from acute care to permanent residential care is a contentious issue due to the high cost incurred when a person is waiting for residential care in the acute care sector.

Finally, the amount of service provision an older person can access while still living in their local community is a growing area of concern. With rising costs all services are having to rationalise what they can provide. This can be very limiting and as a result some people will enter residential care earlier than perhaps they would have if the service system were able to meet their needs at home. Resourcing is also an issue for ACATs. With rising staff and operational costs, the ability of an ACAT team to meet targets can at times be exceedingly difficult.

In conclusion, ACAS Victoria, representing individual teams across the state, remains highly committed to working with all groups within the community to meet their needs and to further develop close working relationships that enhance the consumers' ability to access appropriate services in a timely manner.

CHAIR—Thank you. In your submission you said there is a disparity between the RCS classification and your own classification. How will you address that? Do you have any proposals for that?

Mrs Harvey—The disparity lies around a fundamental difference between the two things. In an ACAT assessment we are being asked to identify the level of care someone is at. The RCS assessment is around the funding tool for the facility. The two really do not marry up in any way, shape or form, so it causes great conflict. We might think someone is at a low level of care but a facility might think they are higher on the RCS. There are dollars attached to that so there is some friction.

CHAIR—You have also addressed the staffing issue. Have you had an opportunity to make a submission to the joint review that is being done at the moment by Kevin Andrews and Brendan Nelson? They have announced that they will be looking at staffing in aged care up to 2010.

Mrs Harvey—Not at this point.

Ms HALL—I will move on from where Andrew started. There is an across-the-board shortage of staffing, and staffing specifically for your teams throughout the state. What are the specific areas in which you have staffing shortages?

Ms Houghton—I think certain teams have problems with recruiting. I think, particularly, some rural teams have difficulty in recruiting staff that we ideally need—that is, staff who have adequate experience working in both the health and the community sector. But I think we are also referring to the staffing concerns with residential care facilities.

Ms HALL—I was coming to that as well. I just want to concentrate on your teams. Do you have any specific disciplines?

Ms O'Donnell—The rural area needs geriatricians—there is a real shortage. We do not have the support of a geriatrician in our team, so we rely just on the allied health professions. Again, ACATs have allied health professionals and they are in shortage in all areas of health care. Staff are difficult to attract rurally, particularly senior staff who have extensive experience across the sector, in both the acute and community areas. It is a problem. When the city is short of allied health people, the rural areas are even shorter.

Ms HALL—I will go down a level. You were referring to shortages in facilities. Once again, can you go through the areas where you perceive these shortages to be? Registered nurses?

Ms Houghton—I think that generally the facilities have difficulty in recruiting nurses. I think it is not a glamorous area for nurses. Now that the hospital sector realise that they have to offer nurses more, I think we are competing against their recruitment campaigns. So, the residential care sector is competing against the hospital sector.

Ms HALL—Is there a wage disparity?

Ms Houghton—Yes. I think that is another issue.

Ms HALL—Assistants in nursing—are there shortages there, too?

Ms Houghton—Yes, because, again, with personal care attendants the community sector has grown enormously. That sector is competing with the residential care sector. Generally it is a very poorly paid area, so it is hard to recruit people anywhere. I think we are really noticing that. You hear the local councils talking about their difficulty in recruiting, and you know that the facilities are having difficulty, too.

Ms HALL—The other area is the community sector providing the services in the community. You have already identified that there is a shortage. Have you any solutions?

Ms Houghton—There is the obvious one, I think, of more resources in the form of funding.

Ms HALL—What about the training of suitable staff? Have you looked at any training packages?

Mrs Thorn—I think training needs to go right across the board. We need to start with doctors in their tertiary training. They need to understand the special needs of the older person, so that if they are attending an aged care facility, they are able to provide quality care planning. Currently, under their funding, there is no incentive for them to participate in care planning. Allied health professionals, in their training, need to understand better that there is a very big difference between the acute focused allied health professional and the aged care focused person. It is the same with nursing. It is a special person who understands the needs of the older person. That is where a lot of our problems happen in the acute hospital, as well.

CHAIR—For your service, do you have any idea how many clients you would assess in a year?

Ms Houghton—We have targets that we have to meet.

Mrs Harvey—For example, in the Kingston ACAS we would assess 3,000 to 3½ thousand clients in a year.

CHAIR—I see.

Mrs Harvey—That is a mixture of hospital assessments and community based assessments.

CHAIR—In Wangaratta?

Ms O'Donnell—In Wangaratta, we do about 1,300 in the eastern, or Hume, area. Most of ours are done in the community. In fact, there has been a trend towards more community based assessment to ensure that people are actually seen in their normal situation. They are more likely to have community based recommendations if they are in the community sector as opposed to when they are assessed within the hospital situation. ACATs have tended to push towards more community based assessment of the elderly.

CHAIR—Are you able to tailor to the individual client whether they end up in the community or residential area?

Ms O'Donnell—Yes, that is the purpose of an ACAT assessment—to have an individual comprehensive assessment to determine their needs and, of course, their desires as well. The family would also be considered. We find that most people wish to stay in the community. We then have to try and access services for them wherever possible to enable that to happen.

CHAIR—Would you work quite closely with a social worker in doing that?

Ms O'Donnell—We would work with a number of other service providers, depending on what the care plan was actually looking for. As the chair said before, we interact with a number of different service providers in trying to meet the needs of the person we are assessing.

CHAIR—Given that it seems there is some unmet need, waiting lists and so on, do you find it hard to tailor what would be best for a client?

Ms O'Donnell—Yes. You have the care plan you would like in an ideal world, then you might have to compromise with what is available out there. At the moment, for instance, 150 people in our area are waiting for a community aged care package. So while it might be suitable for a lot of people, you know the wait is going to be too long, so you might have to do something in between.

CHAIR—If someone is going to receive community care, how do you decide whether they get HACC or community aged care? Is it basically the same level of service in your community?

Ms O'Donnell—That would be based on needs and what informal support was there, such as the living arrangements of the person. You would also consider what was available—and you have some understanding of what is available. It might be that HACC is only one hour a fortnight and that may not be appropriate for that person. So you need to tap into whatever

services you can find. You actually have to be quite creative sometimes, as a worker, in seeking out things.

Ms HALL—I was going to ask you about respite care, but I will go back to that. I will follow on with something that is a continuation. What sort of waiting list do you have?

Mrs Harvey—At the Kingston ACAS we are operating at the moment probably on anywhere from a five- to eight-week wait for a community assessment. For a hospital assessment, we are meeting our target of a one- to two-day turnaround time.

Ms HALL—Once an assessment is completed, what is the period before a person gets either a placement in a community program or a facility?

Mrs Thorn—In our region it is about two weeks before HACC services can commence and about two years for a community aged care package. We have another problem now with community aged care packages, and it is really making us sit back and think. Once upon a time you had to anticipate where you thought the person might be in 12 months time, given that the approval was for 12 months. Do you put them on the waiting list for a package just in case or do you see that there may be a need in less time than that? We almost run an A and a B list. Everybody starts on one list and then, as the situation deteriorates or the need becomes greater, we will start lobbying and put them on the other list. But there are now issues around full cost recovery if they have gone on to a community aged care package for day centre. Because of the state and Commonwealth differences with the aids and equipment program, the old PADP, they are no longer able to receive assistance through PADP.

Ms HALL—Could you explain that a little more to me? I highlighted PADP in your submission. What is the problem there?

Mrs Thorn—They are no longer eligible to receive aids and appliances through the program.

Ms HALL—Why? What are the criteria these days?

Mrs Thorn—It is because of Commonwealth-state differences and agreements. I think they call it double-dipping. Where I usually have at least a 12-month wait, we can get the early things that one might need. There might be some smaller home modifications: an over-toilet frame, a wheelie walker and continence aids. But once you come onto a package—and if, as in Kingston, there is an eight-week wait for a package—you do not have time, because you can be waiting a good six months for PADP approval of your aids but then you are no longer eligible to receive those aids. So the person has to pay for them. As they age in place in their homes, their needs become greater as well. They might need a bathroom modification or a ramp; they might have ongoing continence problems. So you really start to wonder what are the benefits. Often it is only the case management that is the benefit of the community aged care package. Another issue is that all the providers are really operating slightly differently.

Ms HALL—You have raised some really good points there.

Mrs Harvey—Across metropolitan Melbourne there are different waiting times for a community aged care package, because certainly in my district, in the southern region, we can find a package for someone with relative ease. We assess them and a package is identified as the

required outcome. We can find a package provider fairly easily, but that is primarily due to the huge growth in providers in our district. Now, as those places are being filled up, I anticipate that it will start stretching out a bit more. Certainly, access to the package is not a problem for us, but that creates a problem in terms of the equipment provision. Because we can get them on early, we do not have that lag time to go through the system a different way to get them the equipment they need. So that causes a dilemma for the provider. Because they—either the client or the provider—cannot afford to pay for that themselves, what do you do about equipment? It becomes a big issue to help support people at home.

Ms HALL—With the community aged care packages, do you find that there is a reluctance by some providers to provide services in particular areas?

Ms Houghton—Yes. Something that has been raised with our state-wide group is that some providers might have a designated catchment but they are reluctant to go to the outermost reaches of that catchment because they have issues of having the staff who are able to do that in the time frames that they need to. We can find that a whole geographical catchment is not necessarily covered.

Ms HALL—So do you think that the guidelines need to be reviewed to ensure that there is equity in the delivery of and access to the services?

Ms Houghton—Yes. We think everybody should be able to access them, regardless of where they live.

Ms O'Donnell—Also, there should be some standards of practice around case management and what that means. Because many providers operate differently and their interpretation of the guidelines can be different from another provider's, inconsistencies are practised in the case management service.

Ms HALL—So there should be a benchmark of care?

Ms O'Donnell—Yes, a benchmark of care.

Ms HALL—Or accreditation? Maybe a benchmark of care would be the way to go.

Ms O'Donnell—Because of the huge length of time in rural areas, we have been trying to move away and trying to get people a bit more upstream. The providers have been saying to us that they have been getting people who are far too needy, essentially, and the package cannot support them. So we have rejigged everything to try to catch people more upstream with some basic care to enable them to stay, rather than use the package as crisis management where the needs are very high and it is not sustainable for the package over the longer term. Revisiting why the packages were introduced—to keep people at home rather than prop up crisis management. That is not to say that crisis management is not an issue in itself, but CACPs were not set up to do that.

Ms Houghton—I think that goes back to the waiting times. There is a difference in waiting times across the state, but even for my team in my own catchment there are four local government areas and in two of them we can access HACC services and CACPs fairly quickly—the CACPs are attached to the local government—but in the other two areas the

waiting time for basic home care services is up to eight months. That is what we are looking at as a preventive service to keep somebody going so that they do not deteriorate. Therefore you might be looking at CACPs, because you know you have a chance of getting CACPs quicker than HACC. It is around the wrong way. CACPs should come in when HACC can no longer meet their needs.

Ms HALL—So you are suggesting a streamlining of the services?

Ms Houghton—Yes.

Ms HALL—That is important information for us.

Ms O'Donnell—And trying to get a bit more upstream, with basic HACC earlier and getting in earlier rather than further downstream when people are really in high need.

Ms HALL—So establishment of a continuum of care?

Ms O'Donnell—Yes.

Ms HALL—That is good.

CHAIR—You assess people for the Linkages program, HACC, community aged care packages, residential facilities and ageing in place?

Mrs Harvey—Yes.

CHAIR—So it is everything. It has been put to us that there is unnecessary duplication in some of these programs. Do you see a difference between these programs?

Ms Houghton—There is a difference between the programs. There is a bit of duplication of assessment processes too, and I think that is a concern. Each of those services has its own requirements to meet its occupational health and safety issues. We can go in and do a comprehensive assessment and refer on to them. They will then have to go through an assessment process which has a certain focus that we do not necessarily look at. It also perhaps repeats some of the things we have considered. It is going to take some time before we trust each other's assessments a bit more.

CHAIR—Is it possible with ageing in place that you do have a continuum of care? Isn't that the principle behind ageing in place?

Ms Houghton—The term 'ageing in place' is restricted to residential care but the concept of continuum of care is very important.

Mrs Thorn—So if we were referring from our service to the council for showering assistance, they would go back to the RDNS and have them do a showering assessment and ensure that all the OH&S requirements were met before the council would continue to shower.

Ms HALL—There are some real issues there, aren't there?

Ms O'Donnell—There are issues for the client.

Mrs Thorn—Definitely.

Ms O'Donnell—The client focus, the care approach, seeing different people all the time, asking them similar questions and coming into the home are issues.

Mrs MAY—Being assessed for a certain service and then having someone else coming in asking the same questions for the same service must be very upsetting particularly for the elderly and their families.

Mrs Harvey—It is certainly not uncommon for us to be told by a client or a family member, 'I have already answered this three times. Why do I have to tell you?' People can get particularly distressed by that. It is not every family but we would all have had people commenting to us, 'I saw someone only last week and I answered these questions.'

Mrs MAY—Is that then delaying the service being delivered too while these processes are being redone?

Mrs Thorn—Victoria has primary care partnerships and within our region, for example, we will be using a tool called the SCT, which is a service coordination tool. We will be sending that same referral information to the Royal District Nursing Service or to HACC services so that a lot of that preliminary data is not being asked for again. That facilitates that and then you can build on the referrals that have been made out of your assessment and, hopefully, that will reduce some of that duplication. That has not come in formally yet.

Ms HALL—The information you have given us is important and it should be on the formal record as part of the workings of parliament. Even from the accounting point of view, it seems to me that it would be much more cost effective if things could be streamlined and the duplication were stopped.

Mrs Thorn—Baptist Community Care in their submission referred to having a central network, a continuum of care, and I found that concept quite interesting.

Ms HALL—Respite care was the next thing that I wanted to talk to you about. How easy is it to access? Do you have waiting lists? How easy is it to get somebody into a high-care bed for respite care?

Ms Houghton—In our region it is impossible. The number of respite beds available on the ground today is very limited and to try to get someone into planned respite well down the track is incredibly difficult. For emergency respite it is even worse. There are fewer and fewer beds available and it is something we have grave concern about.

Ms HALL—Does the way those beds are funded have any relationship to the fact that respite care is hard to get?

Ms Houghton—The facilities have indicated that there is not enough incentive for them to offer respite, particularly high care. They have long waiting lists for people to come in

permanently. So, with the turnaround with respite, they need more of a financial incentive to take on that extra load.

Mrs Harvey—Providers also say that the paperwork involved in bringing someone in for respite care for two weeks is enormous, and they are not prepared now to do that.

Mrs Thorn—The facilities are not funded if the bed is not filled. We have about 2,500 respite bed days in the north-east region and we use about 500 of those a year. The only ones that are being fully utilised are being managed through the care and respite centre, where they do a lot of the paperwork and provide extra dollars for settling in and so on, so that extra staff can come in at the times when residents are coming in and going. If the bed is not filled for some reason, the facility does not miss out.

Ms HALL—That is the issue I was hoping to pick up.

Mrs Thorn—The other issue is that a lot of the people going into high care respite are in fact above an RCS3 and the funding does not really match their care requirements.

Ms CORCORAN—I want to go back a step. I have forgotten whether there are 50 high care places or 50 low care places. There is a 50-40-10 distribution—in the home, in low care and in high care. Is that ratio about right or does it need to be rejigged?

Mrs Thorn—From our perspective, it needs to be rejigged. We have a number of multi-tier facilities, where we have independent living units, low level care and high level care, and they tend to feed in from within their facility. They call it 'ageing in place' within their community. It means that very few people get into the high care beds from within that. We have an ethno-specific facility that has 90 hostel beds and 30 nursing home beds. Fifty-four of the residents in the low care section are actually high care residents. The expectation for the 90 people is that they will all feed in to the 30 beds, and there just are not enough beds. They are fairly demanding residents as well.

Ms CORCORAN—It needs to be pushed along to more high care beds and less—

Mrs Thorn—Very much so.

Ms CORCORAN—What about the 50-40-10 bit? Are there more home care CACPs places than—

Mrs Harvey—I think there is a shift these days. Whereas once someone would have gone into a hostel and had a natural progression through to high level care ultimately, those people are not necessarily going into hostel care at all; they are staying at home. I think there is a need for more community type care, like the package—

Ms CORCORAN—So move the 10 up to 20 or 30 perhaps?

Mrs Harvey—And incorporate some of the edge type packages that provide a higher level of care at home. Plus there is also a need for more high level care because people are bypassing the hostel level and going straight to high level care. There has been a change in focus because

people ultimately want to stay at home until the absolute end, until they have to move on, and that often means high level care at the end of that.

Ms O'Donnell—We are supporting people in the community at a much higher levels of care than we have, and it is what people want, if we can do it.

Ms CORCORAN—Could I go back to an earlier question and the point you raised about the difficulty between the RCS funding model and your own assessment. You explained the difference and where the conflict is. Do you have an idea of what the solution might be?

Mrs Harvey—The conflict often comes in for us at the point where they have been in a low level facility, and now the provider is thinking that they require a higher level of care and they want a reclassification to high level care. On our assessment we say, 'We still think that they require low,' and they say, 'On the RCS we feel that we should be able to claim more.' It is something that, as a group, we have discussed many times. I think that having us come in to make that decision midway through their life in that facility is perhaps not the best way of dealing with it. There should be some process in place to allow the facility to make that judgment based on their funding arrangement, and perhaps we come in at a later point when they can no longer keep that person in that facility and they need moving on to a traditional nursing home. If that money issue were out of the way they could then call on us for a more consultative type approach, when they are just having issues around managing people and want our advice.

Ms O'Donnell—They rightly feel a little bit put out, because they actually manage that person 24 hours a day and we come in for a one-hour assessment and say we disagree with them. It sometimes opens up a conflict because they are seeing this person more often. It is a conflict over money, essentially. We would like to keep the funding issue separate. We would prefer to have our skills used to manage care plans and to look at more restorative options for people, rather than fighting over the funding.

Ms CORCORAN—I want to ask about the concept of ageing in place. I am not talking about ageing in place at home; I am talking about the ageing in place that—without wanting to put it down—is flavour of the month, and that is ageing in place once you are in residential care. In my community there have been conflicting comments: some people think it is really great; others do not think it is so good at all. Do you have any comment to make on the concept?

Ms Houghton—I think the concept is good: to have people stay in one spot for as long as possible. So the basic idea behind it is fine, but you then have to be able to increase the care provided to that person more than what the low care facilities are funded for. It is much better for people not to have to move; and it could be that if they can age in place to a greater extent that what is funded for now, perhaps they will never get to that nursing home stage and they will die in the hostel. That is preferable for them, but it requires the facility to be able to do it.

Mrs Harvey—My concern would be that a lot of people age in place to a certain point, which would be when the staff can no longer manage that person because of very high care needs—two-person transfer case, doubly incontinent—and at that point they will often say to families: 'We can't look after your mother or father. You'll need to move them to a nursing home.' That happens at a very difficult time for the individual: they are very frail in health and all of a sudden they have to uproot themselves from the place where they have lived for a number of

years and move on. So whilst ageing in place as a principle is good, because it does not carry through from admission to death it means there is still a move for some people at a later date, which is very disruptive at a critical time in their life. We are seeing the growth of facilities being built now with a mixture of high and low beds so that they can manage to age people all the way through the spectrum, but that is just starting to emerge as new buildings are being built.

Ms CORCORAN—Some of the providers in my electorate are making the comment that the residents do not like ageing in place, that they do not want to be in there with all these old people. Is that an attitude that you have picked up at all?

Mrs Harvey—It is not something that has been said to me. But I could imagine that fitter, more active people with fewer care needs may well dislike being grouped with others who are incredibly frail and may perhaps feel that they are in the wrong place.

Ms CORCORAN—Or with those with dementia?

Mrs Harvey—Yes.

Ms O'Donnell—It would depend on the facility and how they manage ageing in place. We are finding an enormous variation among facilities as to how they do it. Some do it much better than others; others do not even try to do it. In rural areas it is a good concept because people can stay in the community where they have lived all their lives and not have to move to a high care facility a long way away, where their family members cannot visit them because there is no transport. It has appeal in rural areas and there seems to be a bit more uptake of it there. But it is problematic when people have increased needs and the staff do not have the skills to manage them.

Mrs Harvey—There are also some issues around security of tenure that emerge when someone who is ageing in place in a facility goes into acute care because of an episode of ill health and the facility uses that time to make the decision that they do not want to have them back, that it is time for them to move on. That seems to be fairly commonplace. We see that when we are doing the assessments at the hospital end. People have been ageing in place and all of a sudden they are not wanted back. I know Residential Care Rights have had plenty of involvement with that. It is an issue that acute care often precipitates the transition to a nursing home.

Ms Houghton—ACAS are often asked to be involved in that dispute point, when the facility does not really want them back because they have a duty of care issue, the hospital wants to get them out and the family do not want them to move. Often we get called in at that point to try and help sort it out.

Mrs Thorn—Could I add that a lot of it in fact goes back to the planning around the time that we do the high-care assessment. We encourage families and the facilities that they are living in at that time by saying, 'You are not really there for life.' A lot goes back to the resident's agreement, what they have signed in the beginning and what their security of tenure is. At that time, the family needs to start looking at nursing homes and start waitlisting at nursing homes. If they are lucky, they won't ever need it and the facility can always say, 'It's okay. We are

managing your mother okay at the minute.' Alternatively, if a vacancy does come up and they are not managing, then that preparatory work has been done.

Once upon a time as ACASs, we facilitated a lot of direct admissions into nursing homes. We are finding now that when we do the ageing in place assessments, we do not really know what is happening out there. If the facility is tardy or the family is tardy, we are not a case management service but we do need to keep in there until that next stage is really mapped out for them so that they can then sit back, hopefully, and the person can stay on there. If it is not organised or planned, then you have the crisis where they turn up in the public hospitals and so on.

Mrs Harvey—There would be some facilities that would take a dim view of us actually going down that path with the family and recommending that they start forward planning. They would find that quite affronting in terms of their ability to manage that person. It is a very fine line that you walk.

Mrs MAY—In your submission you made a comment about the accreditation system for nursing homes; you felt that it was just another documentation procedure, and it was not actually delivering the high care that we were looking for. Would you like to make a comment on that?

Ms Houghton—I think that was around the time of the first accreditation process for facilities. It was an enormous exercise for those facilities to get all their paperwork up to scratch. That is a good thing because that is a process of being accountable, but I think it really was at the cost of direct care time of the residents. It was an issue and it is an ongoing issue now too. Generally, the facilities find the amount of accountability with paperwork so onerous that it really is limiting direct hands on care time.

Mrs MAY—On the other side, would you see accreditation as bringing some of these nursing homes up to standard, particularly in the care that they deliver? I think we have all seen proof of that out there. Some of my nursing homes have said to me that the initial accreditation process was onerous. It was a huge burden. It took a lot of time and a lot of hours. Now that they have done it the first time, if they have their three-year accreditation, they know on an ongoing basis what is expected next time. Wouldn't you see that as being supportive of the industry which gives them a big tick if they get that?

Ms Houghton—I think you are right that it will get better, inasmuch as it is an ongoing process and it will not be such a huge effort next time. Generally, even day to day, they are feeling that what is required for keeping up to scratch with the accreditation process is an onerous paperwork exercise.

Mrs MAY—I want to ask you about your relationship in Victoria. We heard from the local government association this morning about their role in delivering services in aged care—something which is very foreign to me because in Queensland it just does not happen. I wondered about your relationship with local government in identifying where service needs are falling down or where there are shortages. Do you work closely with them? Do you have any input at that level?

Ms O'Donnell—In the rural sector, we actually have quite close links with local government. We work closely on an individual client basis, but we also review the service system together

and highlight areas of need. We do have strong ties with them. They, like us, are suffering from not having enough HACC dollars to actually deliver on the services that we would like. My sense, rurally, is that some of the local governments are thinking seriously about whether HACC is their core business because of the amount of money they are having to use to support the work.

I think the HACC system is extremely stretched. A lot of that has to do with the fact that a lot of money has gone to subacute and also into moving people quickly from hospital out into the community without dollars being transferred into the community sector to support that work. HACC has been asked to now prevent hospital admission through their work. We used to simply have inappropriate residential care admission but we are now being asked to prevent acute admission without any extra dollars. Our brief has grown and the dollars that are being saved in the acute sector are not being transferred into the community sector to support that work.

Mrs Harvey—In terms of the relationship between ACAS and local government, we would all have fairly active involvement in local government circles in relation to talking about the issues on the ground. Often local government comes to us about issues or we may go to them. For every ACAS in the state, I can say that we would have very good interface with them. However, there are issues which we cannot do much to help with. As Gail said, it all comes down to a funding issue. I have good working relationships with local government in my area.

Ms Houghton—And they are critical players in the service system. People pay their rates and they expect something from their local council. It is a connection that makes sense to the older client group.

Mrs MAY—We have just touched on funding again and that issue has been raised this morning. In your submission you talk about clients receiving a lower level of care. This all comes back to funding dollars. We heard this morning that the state can put a dollar value on a service and local government can put a different dollar value on that service. Do you feel that the funding is not keeping up with the cost of the services that are being delivered into the community?

Mrs Harvey—It is a feeling.

Mrs MAY—So that is definitely the problem?

Mrs Harvey—Yes.

Mrs MAY—So it is the cost of the service delivery—

Ms O'Donnell—And the demand. There is increasing demand for services and there is the cost of those services. There are two issues.

Mrs MAY—Thank you.

Ms HALL—In your submission you talk about placement agencies. I am not familiar with them in my area. Could you tell me a bit more about them?

Mrs Harvey—There has been a growth of private groups in Victoria which are there to help facilitate other institutions or individuals in the placement process once a level of care has been determined. For example, you may have a family with a mother who needs nursing home care and they will contract to a private placement person, for which you pay a fee, to help them find the appropriate accommodation for their elderly care recipient. Likewise, hospitals will sometimes employ placement officers to help facilitate the movement outwards from hospital to an appropriate nursing home facility and the fees for that can vary from $500 to $1,000 per placement. There are certainly a number of these agencies around.

Ms HALL—I can understand hospitals employing someone to do it because that can be streamlining between the hospital and the facility.

Mrs Thorn—Some of our hospital patients have extremely complex medical needs, for example, tracheostomies and so on. We had one lady who had a multitude of problems, including obesity, and the hospital social work staff had been unable to place her over a period of time. As an experiment, the hospital employed a placement agency to see whether they were able to do any better and they were not; they still could not come up with a place. The facilities just were not interested in the people with really complex care needs.

Ms HALL—That is a bit of a worry if that is an indication of the future. There will be agencies out there that will not facilitate a quicker placement and they will not be able to get people with more difficult problems into facilities, but they will be charging families for that. Do they still take a fee if they do not find a placement?

Mrs Harvey—Basically.

Ms HALL—That is something we need to look at.

Mrs Harvey—There are some other issues around that. When the institution is employing this type of person, their parameter around it is to find a place—end of story. So there have been instances where someone may have been placed in Williamstown but they live in Black Rock and their elderly carer cannot get to the facility to look after their partner. They only measure success by placement, not necessarily by a placement in a geographic area that is appropriate for the family. When the family are in control of it, they can put more parameters around it in terms of location and size and what they are looking for, but it is a huge growth area.

Ms Houghton—I think there is a market for this sort of service because we have busy families and they want someone else to do some of the legwork and perhaps give them a shortlist. We are concerned that people see a facility before they actually put their name down on the waiting list. There have been examples where they have said okay to something they have not actually seen and when the offer comes they turn it down because that is the first time they actually walk through the door and have a look at it, so there is that concern. As I was saying, I think there is a market for it, but it is a deregulated system at the moment and I think there needs to be a lot of care because people are very vulnerable at that point.

CHAIR—I think you are saying there is nothing wrong with placement agencies per se; it is just that they should operate by some sort of code of conduct.

Ms Houghton—And also by some knowledge base too. They need to know enough about the aged care world so that they know what the client care needs are or work with us to do that.

Ms HALL—So there needs to be accreditation and some guidelines put in place and some control of placement agencies—do you agree with that?

Mrs Harvey—From a social point of view I have a problem with it because my observation over the years has been that families need to work through a variety of issues when they are looking at permanent residential care for someone that they have been caring for. They need a lot of counselling and support through that process. By bypassing a system I think that some families never get a chance to work through those complex issues, and when that person is in placement that is when the conflicts start occurring.

Mr ANTHONY SMITH—So they only postpone the problems.

Mrs Harvey—Yes. There is a place to be dealing with that grief and loss and moving on issues, and sometimes I think in a private placement in a way it gets bypassed. I do not think that is healthy.

Ms O'Donnell—I think the point Deb is making is that it becomes a business transaction. Care of the elderly is not about business transactions, so we need to be very careful about those types of situations.

Mr ANTHONY SMITH—In a general sense you have raised a number of issues, but ours is a long-term inquiry, and I think we all agree that with an ageing population some of these are inevitable. I am wondering, from your standpoint and in a general sense, whether you think anyone overseas does it or certain aspects of it better. Most democratic countries are facing the sorts of challenges we are talking about. Are you aware of any of those, whether they are in the UK, Europe or the US? Although there is a number of challenges to overcome, a lot of the feedback I still get in the general area is that we are doing it better than other countries. I am wondering whether you have a view on that.

Ms O'Donnell—My response to that would be from my reading, which is that those countries that actually take on a social policy approach to ageing have a far broader approach to it and they seem to be able to come up with more innovative and more satisfactory answers to the situation.

Mr ANTHONY SMITH—Which countries would they be?

Ms O'Donnell—Some of the European countries take an approach as to housing. If we are going to move towards more community care options, then it is not just about services; it is also about housing and communities that are appropriate for ageing people, ones that allow people to age within their community, and access not just to their own home but to community services and community buildings. It is about that broader social look at how we want people to age and where people want to be, and it is not just confined to residential care. So I would be hoping that we would look at and have some sort of statement in the social policy area that matches the needs of the aged. It is not just about health and ageing; it is about all the other parts of it too.

Mr ANTHONY SMITH—This inquiry, as you know, is to look to the next 40 years. I am particularly interested. You work in the area. Everyone picks up anecdotes and views, but perhaps there is something particular that you have come across that you think is done better overseas or, for that matter, the things that we do well.

Mrs Harvey—In my experience, people generally come to Australia to see how well we do it. Certainly, Southern Health in the Kingston Centre has an export program with Japan. They are always very interested in how we are conducting our aged care here, and they take some of those ideas back to their country and certainly try and implement them. I think that the social stuff is probably the critical factor, but we are on the right track. We have some really wonderful programs in the community, but they just are not as sustainable as we would perhaps like them to be.

Mr ANTHONY SMITH—It is interesting that people from other countries are coming here and seeing us as somewhat of a role model in certain areas.

Ms Houghton—We have had the same experience of overseas delegates coming to see how we are doing it and being impressed by a lot of the things that fit together with our aged care system. But I think there is always value in looking at any other models overseas.

Mr ANTHONY SMITH—Yes.

Ms Houghton—I think that is the way that we can improve on what we have been doing. I support what Gail was saying about a social approach. Perhaps it would take it away from the health focus that sometimes, I think, dictates things.

Ms HALL—I still have two questions to ask. One is that you mentioned the treatment of older people in hospitals. I would like you to expand a bit on that. In doing so, discuss how the process between hospital to referral to facilities or an appropriate community program works. Also, I would like you to talk just a little bit about the stereotyping of older people in hospitals and the general treatment, per se.

Mrs Harvey—I think that older people, like any group in the community, get unwell and need to go to hospital, whether that is through fractures or a medical episode of ill health. But, once that is over, hospital is certainly not the place for them to be, primarily because the care that they require is not geared for an acute sector. Hospitals are where people are sick and they stay in bed or they just sit by the bed—there is no extended therapy once that acute episode is over. People become a little bit more deconditioned and, therefore, their chances of perhaps returning to their prior place of residence are reduced and often permanent care becomes the outcome. Also, there are problems with the stereotyping of what they call ‘bed blockers’. It is a common linguistic thing in hospitals to say ‘that person is blocking a bed that someone else could have’. There is a lack of interim care, when residential care is the choice, to move them out of the acute sector to some place that is more conducive to a normal lifestyle while they wait.

Ms HALL—Is there a need for some sort of transition placement?

Mrs Harvey—Yes.

Ms HALL—Is there anything like that anywhere in Victoria?

Ms Houghton—I think that there is. The Innovative Pool Scheme is happening at the moment. It will be interesting to see how that works and how well people are chosen for that process. There is no point in treating it like a parking lot. People have to be able to access adequate ongoing therapies so that they do not, as Deborah was saying, get deconditioned—so that they are not needing a higher level of care than perhaps they should be.

Mrs Harvey—Once upon a time there was a thing called 'convalescence care'. People would leave the acute sector and go to a bit of convalescence care and then go home. The convalescence care concept has well and truly disappeared, so there is nowhere for people to go just for that little bit of extra improvement time before discharge. I think that is what is lacking for older people—that convalescence type of care, helping them return to their pre-existing place of residence.

CHAIR—In Victoria, do you have any step-down facilities?

Mrs Harvey—There are interim care facilities, but they are primarily for permanent care. There is no step-down facility for someone who perhaps just needs a bit of a brush-up but not rehab. Rehab is just that little bit of extra intervention to help them get back home.

Mrs Thorn—The state government is currently funding three different models of interim care. One is the hospital based interim care model, which we have at the Austin and Repatriation Medical Centre. The second one is a residential care facility based model, where you purchase some unfunded beds and there is funding for hospital demand management projects. The third model is a community based one where if a family want to give it a go because they are not sure their mum really needs to go to residential care, but they are not sure of the demands, they are supported through that. Those models seem to be working quite well, but it is that transition. For some people there will be an improvement and they will be able to return home and manage okay for a bit longer with community resources. You might be advocating priority for them for a community aged care package or sometimes HACC services can sustain them adequately. But those three models are operating.

Ms HALL—This inquiry is looking to the future. What do you think should be in place? Can you put four or five points before us on what you think government should be doing to address the issue of ageing and the needs of people as they are getting older?

Mrs Thorn—I know I am going to be one of them! I would really like to be able to stay at home and I am prepared to pay for or contribute to the cost of my care to stay at home. To me, it is really important to be able to stay at home. We know that in 40 years time the incidence of dementia will be 3½ times what it is now but our population will have increased by 40 per cent. So if I am the carer and my husband has dementia I would really like the necessary carer support. One of the hardest things, and the things that can break down, is that carer burden, whether it is for the necessary medications, the in-home respite, the residential respite, all those services that will support me in caring for him—or him for me—in the future.

Ms HALL—What about equity for people who cannot afford to pay?

Mrs Harvey—Yes, I would like to see a higher amount of Commonwealth funding to the programs to make them more sustainable. There are going to be people in our community who can afford to pay, but there is also a high proportion who cannot afford to pay high costs to bring in services for their care recipients. That will continue to be the case, I am sure. So we need to be looking at what we provide and making it cost effective, but at the same time not be in the position we are in today where services are being reduced in order to make the budgets balance. The financial arrangements in place need to be working better so that a local government service can provide the appropriate home care or a CACPS provider can provide the required services, so that any program out there can meet the demand. That obviously involves a fairly big shift in policy in terms of how much of the gross domestic product comes to aged care. But if we are serious about what we need in the next 40 years, resourcing is a fairly big part of that.

Ms O'Donnell—I have one wish I would like to make—if this is the wish list?

Ms HALL—Yes, this is the wish list.

Ms O'Donnell—My wish is that we have more flexible options. Elderly people do not just sit in little squares, but that is the way we like to think and to fund—and it does not work. We need to have more flexible options so that people can have small bursts of rehab and then go back into the community and there is some continuum of care. We have to realise that acute care plays an important part in the life of an elderly person—they do need to have admissions—but it is not the end of the world when they go in. We have a sense now that once they get in there it is difficult to get them out and back into the community. We do need to see where we all fit and to try not to have these silos of funding. If we have flexibility we can actually be more efficient. We are not particularly efficient in some areas now. That would be my wish.

Ms Houghton—I would like to see more cooperation between levels of government, particularly state and federal. Regardless of political persuasion, it is a common problem that they have to grapple with together rather than having a bit of buck-passing between the two, which makes it very difficult for services like ours that are trying to be answerable to both. Finally, ACASs really need to be resourced adequately to be able to meet all these things that we are trying to grapple with.

Ms HALL—Excellent. Thank you.

CHAIR—Thank you all very much for appearing before the committee.

Proceedings suspended from 11.29 a.m. to 11.37 a.m.

BETTS, Dr Katharine Jane (Private Capacity)

CHAIR—Welcome. I remind you that the evidence that you give at the public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and it could amount to a contempt of the parliament. Dr Betts has made a submission to the inquiry, and copies are available from the committee secretariat. Do you have any comment to make on the capacity in which you appear?

Dr Betts—I am appearing in a private capacity because, while I am employed by Swinburne University of Technology and my submission is as a result of the research that I do as part of my duties there, I have not been instructed by Swinburne to appear.

CHAIR—Thank you. Would you like to make an opening statement before I invite members to proceed with questions?

Dr Betts—By all means. I would like to draw on the main points of the written paper that I sent you before Christmas. There are three main headings, the first of which is my claim that normal demographic ageing is inevitable and has some benefits. By 'normal demographic ageing' I mean the kind of population structure that you get with a total fertility rate that is somewhere between 1.85 and 2.1. It is inevitable because the only ways of avoiding it are either unacceptable or impossible. We could avoid it by going back to the medieval demographic regime in which people bore large numbers of children, large numbers of whom died in infancy and early adulthood. That gives you a youthful population structure. I do not think there would be any support for our returning to that. Indeed, we have spent a lot of time and effort trying to avoid that structure, particularly when it comes to early mortality.

The other way of avoiding an older age structure is to keep going with the kind of structure we had in, say, 1900, when we had high fertility and lower death rates. We could do that for a while, assuming that we could boost fertility, but it would lead to exponential population growth. While opinions vary about what the ultimate population of Australia might be, I think we all agree that it cannot go on growing forever, so at some stage we would have to stop. The humane way to stop is by reducing fertility but then we would be back with the age structure that we face now. That is what I mean when I say that the normal ageing of the population is inevitable and it has benefits. After all, who wants to go back to the situation where a woman might bear 20 children and raise only two of them to adulthood? There does not seem to be much point in trying to achieve that.

It is also beneficial because it means that, in a sense, we swap childish dependence for elderly dependence. If you think of the population pyramid of Australia, we have children and we have older people, and what happens with normal demographic ageing is that we have proportionately fewer children and proportionately more elderly people. I think it is fairly obvious that a 65-year-old is usually a more productive and self-maintaining member of the community than a five-year-old. However sweet the five-year-old may be, they are still a lot of work and effort before they can be self-maintaining and make a contribution to the wider society.

Normal ageing, of course, presents challenges but change always does. However, economic research suggests that we will have the financial means to cope with it. In that regard, I am referring to an article by Guest and McDonald, which came out late last year. I do not think it is in my written paper. We will have the financial means to cope with it and we should also have the social resources to cope with it, if only in the form of the paid and unpaid labour of the older people themselves. Those of you, which I guess is most of us who have elderly parents, will know that with any good luck there are informal social networks of elderly people's friends that offer a lot of support above and beyond what family provide. Then there are also more institutional arrangements like the University of the Third Age, and a wonderful little group I have discovered in Tasmania called Senior Link, which is run by older people and exists to help older people get on the Internet. I have been bemused to watch my 85-year-old mother master the email and so forth so she can write to her grandchildren who are scattered all over the place. So there are the informal social networks and the slightly more formal stuff like the U3A and organisations like Senior Link. That is point 1: that normal ageing is inevitable and has some benefits.

I would like to talk very briefly now about social factors and dependency. I think a lot of the writing about the ageing of the population has this assumption that you turn 65 and you are flat on your back in a nursing home somewhere requiring around-the-clock care. If you have my written paper in front of you, figure 4 on page 10 has a diagram of the population as it was in 1995. I prepared this for a class some time ago. The bit that snakes up the centre of the pyramid shows those deemed needing help with self-care. Those are the people that the Australian Bureau of Statistics surveys say are severely handicapped—that is, they cannot do things like washing, dressing or feeding themselves without someone to help them. The ABS omits children under the age of five, but I think if we are trying to look at the overall burden on society of actually having to provide hands-on care to other people, it is very silly to leave out the infants from age zero to four.

That graph shows that there is a serious increase in the need for some other human being to help with the daily tasks of washing, feeding and dressing once people turn 65. There are also an awful lot of people over the age of 65 who are not in that category and there are a surprisingly large number of people between the ages of five and 64 who are. Indeed, adding them all up in 1995, the numbers between five and 64 and 65-plus who needed help with self-care were about equal. Obviously, as the population ages that balance is going to change. But when we think of dependent people who need a carer they are not all old people by any means. The graph shows that it is only at the very early ages of zero to five that your biological age is automatically connected with needing someone to take care of you. But that does not mean to say that everybody else who is not in this central category of needing help with self-care is making an independent contribution to the welfare of others.

That graph is fairly crude, but to summarise you could say that there are two major social institutions that create dependency. One is education and the other is the labour market. I think the fact that we now have a far wider proportion of people staying on in the formal education system does mean that the old demographic rule of thumb that said the work force consisted of people aged 15 to 64 is obsolete. With a lot of people in their late teens and early 20s, if they are in the work force they are only in the work force part time and they are dependent on parents or Austudy or their own labours to put themselves through higher education. I often think of Watkin Tench in the 18th century. Watkin Tench had a distinguished naval career in his late teens and at the age of 21 he was the commander of one of the ships of the First Fleet. My

students at the age of 21 are splendid young people but I cannot see them commanding a sailing ship coming out from England to Australia. So we have reconstructed the way in which we think of youth and of the kinds of things that we can expect of young people. That is appropriate because the kind of economy that we are preparing them for is very different from that of the late 18th century. Education is one of the institutions that is creating dependency. I think this is a good thing and that there should be more of it. We should make sure that it also scoops up people who are over the age of 25 and people who have perhaps been caring for elderly parents or children so that they can be brought onto this fast track to decent jobs in the modern economy.

Let us look at the labour market. Those bits that are coloured black are the unemployed. These are unemployed according to the ABS way of defining it. There are also a lot of people over 15 and under the age of 65 in the white bits. These are people who are not in the labour force. Lots of those in the 20- to 45-year-old bracket would be caring for children but I think that when we look at the 45- to 55-year-olds there is a lot of wasted potential. This kind of dependency, which is constructed by labour markets in various forms, is something that we should be trying to reduce. That was what I meant in my paper when I said that a lot of the dependency that we are looking at is not dictated by the age structure but is the result of our social arrangements and therefore is something that we can alter if we want.

The third point that I emphasised is the need to avoid hyperageing. I have made a rather crude distinction between normal ageing, which is an age structure produced by a total fertility rate between 1.85 and 2.81, and hyperageing, which is an age structure produced by total fertility rate of 1.6 or lower. As you would know, a number of countries are already a lot lower than 1.6. Indeed, within three generations a population that starts with a total fertility rate of one—and Japan and Italy are getting pretty close to that—will be reduced to one-eighth of its starting size and it will be into exponential decline, and there will not be much you can do about it at all. The way to avoid the hyperageing produced by this sort of age structure is not to bring in massive numbers of migrants. We may want to bring in migrants for a lot of other reasons, but it is a very poor and crude and costly way of trying to offset the ageing of the population. The way to try to ensure that we are on the path to normal ageing, which is affordable and has a lot of good aspects, and that we avoid hyperageing is to boost family size. That is easier said than done but that is the way to go.

I believe you have already heard from Professor Peter McDonald, and I will skip quickly over the bits that he has probably said: that we should support families, that a way of doing this is to make it easier for women and men to combine paid work with child rearing and that we need to provide accessible, high-quality child care for those who want it. I have no doubt that this is expensive but, compared with the infrastructure costs of adding an extra 10 million or 15 million or 20 million people via a mass immigration program, I suspect it is the less expensive option.

Secondly—and this may not be something that Peter has emphasised; I have not seen it in his written work—the current costs of providing family-friendly workplaces fall disproportionately on employers. They have to cope with staff who are absent on maternity leave plus the costs of training and the loss of continuity that this involves. We know that a lot of mothers would like relatively secure part-time work. That, too, has human resources costs that the employer would have to bear. We want employers to not discriminate against young or pregnant women, as we know that they in fact do—there is anecdotal evidence. A young friend of mine who is about to

produce her first child has been told by her boss that if she is back at work full time within five months it is okay; if she has a second child it is the end of her career. It probably is not legal for him to say that but he is feeling that he is going to lose a skilled worker and he has to find somebody else to fill her place. If she is going to be on-again off-again over a five-year period, why should he bear those costs? Rather than saying, 'What a sexist monster,' we have to look at it from his point of view. If we do not take seriously the costs that firms bear when they are trying to provide a family-friendly workplace, as we would like them to, they are, on the sly and on the side, going to be less than friendly towards young parents.

Another point is that we need to look at the high cost of housing. I do not know of any research, and it does not look obvious from current demographic evidence but we could be looking at perverse effects whereby high immigration drives up the cost of housing in the major cities, which makes it harder for young people to get established. It is not obvious because the total fertility rate is high in Sydney, where we know lots of migrants go and it is lower in a town like Adelaide, where we know they do not go. There are the confounding factors of more economic growth and more jobs in the one place, and more migrants perhaps from areas where it is normal to have large families and so forth. So it might be a topic that is worth teasing out by doing a fairly sophisticated piece of research that would control for those extraneous variables. The cost of housing is something worth looking at.

There is also the cost of HECS. I am completely across the argument that says that a young person who gets a university degree reaps some personal advantages from this and it is only fair that they should pay. However, we also have a situation where people stay at university later: they start at 18, maybe 19, and they stay longer because they have to; a simple pass degree is usually not going to be enough. They can emerge with quite a substantial debt before they have even started. I do not know of an easy fix for this, but we have in our social policies some things that have a perverse effect on the capacity of young people to start families. There is also the problem—and again there is no easy fix—that jobs, within a globalised economy, are now less secure than they were. Economic globalisation has brought many benefits, but a secure job for life is not one of them. As we all know, if you are downsized you cannot downsize the family. The family is a commitment for 20 or 30 years. If you do not have the job security that my parents had then it is riskier to take that leap.

Another deeper problem, and this draws more from the work of Bob Birrell and Virginia Rapson at Monash University, is produced by contemporary labour markets. It is not just that we need to support parents having children; we need to support couples. The work of Birrell and Rapson has shown that there is a body of low-skilled men who either cannot afford to marry or, if they do form families, cannot afford to keep the families, and these families break up. If the man is not making much of a contribution, separation, divorce and the one-parent family ensues. Again, that is not easy to fix but it is a problem that has not had as much attention as maternity leave and family-friendly workplaces. It is fine to have those structures in place to support couples who have already formed, have made a commitment to each other and want to have children, but what about this swathe of men who, in the past, would have had factory or low-skilled jobs of some kind that would have enabled them to pay a mortgage, buy a car and support a few children? Those sorts of jobs are not there anymore; a whole swathe of men are on really low incomes or are not in the work force at all. It is a problem of partnering, which is what this work at Monash University is looking at.

CHAIR—Thank you very much. You said that if the fertility rate was to fall to 1.6, we will see hyperageing. From memory, that was the demographic projection from the Intergenerational Report which I think said it would fall from 1.75 to 1.73, to 1.6. Even if it is 1.6, it would still be one of the higher fertility rates in the OECD. I understand that France has had some success in raising its fertility rate, but I understand that it has raised it only to 1.6 or thereabouts.

Dr Betts—I am not sure. I mean, 1.6 is bad, but it is not as bad as 1.3. The lesson from the France-Sweden sorts of comparisons is that a very small increase in the total fertility rate takes you a long way. I have a table which shows that if you compare 1.85 with 1.75 and 1.6, you get a very marked change. You do not need to change the total fertility rate a lot to make a very big difference. You also do not have to do some mammoth change in public attitudes. You sometimes hear people say that with the growth of education for women and the employment of women, you are never going to turn back the clock and make them want to have children. Survey data shows that, on average, most young men and women want, on average, two children. The problem is that our social arrangements make it too hard for them to achieve that goal. We are not looking at a massive attitudinal change. We are just looking at something that would make it a bit easier for them to have the number of children they say they would like to have.

Mr ANTHONY SMITH—The interesting thing about your submission is that you would characterise a lot of the commentary and debate as a bit simplistic in each area—

Dr Betts—Yes.

Mr ANTHONY SMITH—particularly with regard to the capacity of people over 65. That is an interesting point. Do you think there has been a change in attitudes over recent months since the debate kicked off? You made the point in your opening remarks that there is an assumption that once people reach the age of 65, overnight they go from being highly productive to being totally unproductive. The flip side in your submission is that level of dependency in younger age groups.

Dr Betts—Yes.

Mr ANTHONY SMITH—I had not heard the figures you quoted from 1995 which showed that those under 65 were roughly equal. That is quite important. What lessons can we learn from that for public policy so that we are not always overreaching?

Dr Betts—We are still talking about ageing as a dreadful problem. I imagine that as the electorate gets older people will become a bit more canny about this and will stop saying that old age is a problem. Old people hear that and they take it on board and they feel that they are useless and old. I told my 85-year-old mother that I was going to talk to you people and she said, 'Why are they wasting time on old crocks like us?' She is a very useful and active person. She is not sick and she supports a range of friends who are sick and she makes phone calls and drives here and there with hot meals and so on. That sort of work is not part of any organisation or association; it involves old people taking care of old people and the tremendous flowering of the University of the Third Age. Those are things that we could talk about more. These are not hobby things to keep the old dears happy while they wait for decline. It is just as useful as housewives in their 30s taking up a hobby or learning a language. I do not know how you persuade the media that these are interesting, exciting and newsworthy stories, but there is a lot

going on out there amongst older people. Obviously we clearly need to focus on the nursing home population and the people who need support in homes, but not at the expense of stigmatising all people over 65, or even all people over 80, as hopeless crocks.

Mr ANTHONY SMITH—It is interesting, because there are still many policy settings or assumptions that ignore that fact, aren't there? People still have a concept of working full time up until a certain age and then cutting off altogether.

Dr Betts—Yes.

Mr ANTHONY SMITH—We know from some people—it is so common that it is almost a cliche—that after six months or so they are out doing something else. Do you think we should encourage a trend of going from full time to part time as well?

Dr Betts—I think that would be really sensible. You see from that graph that there is a smidgin of people over the age of 65 who are still employed. But if you could see the people who are working as volunteers in the sorts of roles in which they are bringing their expertise—like an older family friend of ours, who is retired but who works on the board of a nursing home and puts in a lot of his management skills, allowing them to be used freely—I think that we could do a better graph than that, one which showed that kind of thing and this use of older people's skills. I am sure it is happening now, and the ABS time use study is probably the place to go to document it. All volunteer work is useful, but some of it is quite highly skilled, depending on the sorts of skills that people bring to it. For example, the people who teach in the University of the Third Age are usually retired teachers of some kind or another.

Ms CORCORAN—I want to first of all thank you for bringing us back down to ground again. We tend to hear on this committee lots of problems associated with those few people who end up in nursing homes, whereas the bulk of the population never actually gets there and in fact does enjoy healthy long life. I have two questions for you and they are quite different. The first one is that it seems to me that we need to promote a picture of old age as being a healthy, useful time in our lives, and we do not particularly do that very well. So I would be interested in your comments on how we should be doing that, how we change the perceptions in society and how we actually take advantage of older people and their skills, which can sometimes just go to waste. The second question is quite different. Right at the end of your presentation you talked about the problems associated with young men not having very well paid jobs and how that prevents them from having families. I am interested in why. Is that a problem just for men or is it a problem for women as well? Or is it just where the research happened to go?

Dr Betts—This is not my own research. This is done by Bob Birrell and his various colleagues in the Centre for Population and Urban Research at Monash. It is a problem for young women too, and it is especially a problem in regional areas of Australia. I think their work focused on regional Victoria, where there are few decent jobs for young men and for women. There is a pattern of family breakdown which follows very much the income level of the man. If you think these things all work on romance and love, it is a bit of a downer to have a look at these tables. Whether it is formal marriage or a de facto partnership, it is much more likely to last if the man has a reasonable income and much more likely to break up if he has a low income. You do get a problem with young women in regional Victoria who do not have access to decent jobs, are maybe not equipped for higher ed or do not have access to higher ed. Having a child outside of marriage is an honourable occupation, and it is really quite high in

regional Victoria. If you wanted, I could send you particulars of that research after I get back to my office.

Ms HALL—I would like a copy of that.

Dr Betts—Sure.

Ms CORCORAN—Thank you for that. My first question is: how do we promote and get much better at recognising and using their skills?

Dr Betts—I am only guessing, but the media chase bad news. So the old lady who dies alone and is found a few years later, which was an awful story, is news.

Ms CORCORAN—My colleagues may not be aware of that. They are not from Victoria.

Dr Betts—But an old lady who is keeping her family and friends organised and is leading an active and useful life is scarcely news. Maybe the media people, press secretaries and so forth could think of ways to get more favourable stories into the media. Maybe we could have 'old person of the year' awards. I do not know whether that would go down particularly well.

CHAIR—We have had the community International Year of Older Persons, which had a lot of recognition. There were a variety of awards. Slim Dusty, in fact, got the main award—I digress—and there were about 40 older persons who were recognised at a big dinner.

Dr Betts—Probably in a big city like Melbourne this is not so much of an issue. But I come from Hobart and when my father died and my mother was on her own, she tried very hard to get involved in a variety of volunteer work. She did not want to do things like Meals on Wheels. She wanted to join Amnesty or something like that, but she found that they were not particularly welcoming. This can be a problem with a volunteer group in a small place—it gets cliquey, you like being with your own crowd. There is always a tension between trying to keep the esprit de corps of the existing members and trying to be open to new members. But that might be something that could be worked on from a policy point of view: a group of volunteers could get brownie points if they recruit older people. While it is great to know that you are supporting your family and friends, it is also good to have an honoured role in a more formal organisation. I know that a friend of mine who runs a nursing home was about to disband the network of volunteers which supports the nursing home because they were so cliquey and would not accept anybody else into it. She thought that they were not really playing a useful role in trying to integrate her home into the broader community. This is a social problem, which is perfectly easy to understand—we would all rather hang out with our friends and not welcome in new people—but if we are aware that it is a problem, perhaps the way in which organisations like that are funded could be tweaked so that they get brownie points for being open to new members, especially older members.

Mrs MAY—You were talking about policies to support fertility. In fact, you have said that most young people would like to have one or two children, that they identify as mum, dad and two kids. What sort of policies does government need to look at to encourage that fertility level? You went on to say that it is not a case of them not wanting children; it is a case of life being too difficult because of the pressures of life, career and that sort of thing. Could you expand on that

and maybe touch on the social policy that you think government could look at in encouraging young people to have families?

Dr Betts—I have been following with some interest the debate about paid maternity leave. As a professional woman who knows professional young people, I naturally support that. But I know that the research is showing that that would perhaps meet the needs of about 20 per cent of potential mothers but the rest have a more adaptive attitude towards work and they do not see work as the main focus of their lives. The Prime Minister is probably on to something with his message that he is going to try to support permanent, secure, part-time work, because that would meet the needs of a broader swathe of potential mothers. But, again, I hark back to this business that the costs of making this happen must not fall on the people who hire the potential workers because, whatever we may say about the rules, I know from talking to the young people whom I teach or have taught that these sorts of obstacles crop up.

It is reasonable that an employer does not want to have to shoulder all of these costs. He is reluctant to employ someone who is three weeks pregnant—he would rather employ a man. He is even reluctant to take in someone on a six-month contract who is a few months pregnant, but he thinks with any luck the six-month contract might evolve into something more once he has tried the person out. Somehow or other things have to be structured so that the person making the choices about who to hire and who not to hire does not wear disproportionate costs from hiring people who might have children or who have children now.

I am sure that you are aware that with this wonderful idea of job sharing where we have two people doing the one job, it is silly to claim that there are not any on-costs in that. You have two people to train; you have two people to keep up to date with how the workplace is moving; you have two people that HR has to take care of. That all costs something. I have watched it work. People say, 'You can't get a secretary for love or money.' I say, 'How about a part-time one or how about two part-time ones?' They say, 'It's too hard.' It should not be too hard. I am not saying that that is cheap but the alternative is not very good.

Mrs MAY—What about young people themselves accepting responsibility, whether it is at school age or when they first leave school, for maybe contributing financially to make provision for the time when they may be off work having a family? You have been talking about the employer and I agree with you that we cannot put that financial burden wholly and solely on an employer. How about some of this responsibility coming back to individuals taking charge of their own lives and taking responsibility for having that time out of the work force?

Dr Betts—The young people whom I see are tertiary students in higher ed. They are working extraordinarily hard. As you know, the span of people whom we take into higher ed has expanded. Most of them come from families where they are the first people to go to university. Most of them do not get youth allowance.

Mrs MAY—It is income tested.

Dr Betts—Yes. Their parents have to be dirt poor for them to get it. To support themselves they are doing part-time jobs in supermarkets and so forth. They are working really very hard just to stay afloat at university. To be expecting them to put extra money into a pool for—

Mrs MAY—Maybe that would not happen until their career started—I am thinking aloud here—but there has to be some responsibility taken by the individual because business cannot take on the burden of that cost.

Dr Betts—I do not think they should; I think that is a bad way to go.

Mrs MAY—Exactly, but I am wondering how we shift that cost. Where does it go?

Ms HALL—Are you suggesting something similar to a HECS type approach?

Dr Betts—Inasmuch as they are saving up for houses and so forth and saving up for marriage, they are making those sorts of commitments already. It is just that the relative cost of housing compared to average incomes has gone up enormously. There is a very big hurdle for them to jump. When I got my first degree, I could walk straight into a job. I am an arts graduate and thought, 'Great, I can have a job.' Now they probably have to get something else beyond that first degree. They are going to be about 24 or 25 before they are looking at their first serious job, and they have that HECS debt. I am only talking about that 20 per cent who are going through the higher ed system; there is the other 80 per cent whom I do not see in my working life.

For the ones who are not going through the university system there is the situation where the low skilled but reasonably secure, moderately well-paid jobs that would have financed the three-bedroom brick veneer in the suburbs, the house and the children are not there anymore. I would be nervous about something that put even more financial burdens on the 18-, 19- and 20-year-olds because they are really doing it a lot tougher than I did it when I was their age.

Mrs MAY—Maybe government has to continue down the path of providing those extra child-care places or providing tax incentives for families through the tax system.

Dr Betts—Yes.

Mrs MAY—Maybe that is the path we have to continue to go down so that we see our fertility rate increase. I have a daughter who is nearly 33 and career is very important to her.

Dr Betts—Of course it is.

Mrs MAY—Taking time off to have a family has been planned that much better. It would have to fit in after so many years or so much study, and then you wonder if the biological clock has gone and there will be no children. I take on board what you say, though. It is an interesting area to get involved in, for our young people and for the impact that that is having on our population growth. You have touched on a lot of things, like housing, HECS debt, study and workplace, so it has been very interesting listening to you this morning.

Dr Betts—Thank you.

Ms HALL—I would like to join everyone else and say that I found your submission really challenging and it raised a number of very interesting issues. We have focused a lot on the deficits of ageing rather than looking at the positive aspects of it. I think that in the future that is

going to be a challenge for us as a community. Rather than seeing it as something that is going to increase costs, we should be writing in some of those factors that you mentioned about voluntary components and the contributions that older people make at that level. I do not want to go over things that other people have asked. You mentioned the issue of research. Could you give us an idea of the direction that you feel future research needs to go in?

Dr Betts—I think we need to do more research on the various types of potential families. I do not know whether you know about Catherine Hakim's work. She is British but she has published in Australia in *People and Place*, which is a journal I am involved with. Her survey work leads her to say that British young women can be divided into more or less three groups. There is the 20 per cent who are career focused and who are never going to have lots of children—one, maybe two, if you are lucky. Then there is the 20 per cent who are home focused but not interested in working. They will probably have three children. Then there is the big swath in between of about 60 per cent whom she calls 'adaptive'. They are women who want to have children—the focus of their lives is indeed family and children—but they want part-time work, partly for interest, partly so that they mix in the wider world and partly to help make a contribution to the family budget. But work is an extra for them; it is the home that is the focus.

The problem with meetings like this is that we come from the 20 per cent who are career focused, our children are career focused and the people whom our children know are career focused, so we tend to have the career bias. We need to perhaps know more about what the adaptive women, who make up the bulk of potential mothers, need and want. Is maternity leave going to be a real help to them or is it just going to be a luxury where they will take the money but it will not really help? What about something like special payments for the third child or child care that you can use from time to time, not on a round-the-clock basis but when you really want a break or you want to go and work in your part-time job? What about that sort of flexible child care? Knowing young people who are now moving into the family formation stage, on the one hand I read that we are putting all this money into child care, but on the other hand I know a lot of people who cannot find child care that they think is of a suitable quality. Child care is very expensive to provide. It is silly to be providing it for every child—and that is not what every parent wants—but there should be flexible child care of high quality.

What we can learn from the research is that in countries like Germany and Switzerland it is seen as a matter of deliberate policy to make it virtually impossible for women to combine paid work and child rearing. It is structured so that the preschool comes out at such and such a time, and the primary school kids come home for lunch, and the high school children do not get out at the same time as the primary school children. Germans and Swiss people think this is done on purpose to make it hard, the thinking being that if they are not let into the work force they will stay home and have lots of children. It does not work like that. If you force them to choose, they will choose the work force. We have to avoid forcing people to choose: 'You either stay at home full time and have children, which is what we want you to do; if you insist on working we are going to make it jolly hard for you to combine the two roles, and that will teach you and you will stay home and have four children and we will all be pleased.' In Germany they are not doing that. I do not know what the total fertility rate is there, but it is fairly pathetic—about 1.4.

Ms HALL—The research that I have read shows that those countries that adopt those kinds of policies are the ones that have the declining birthrate, and the birthrates are declining faster there than they are anywhere else.

Dr Betts—The watchword is that we have to be flexible. We have to know more about what young potential parents want, and we have to be flexible. That might not be particularly expensive. As I say, I am in favour of the maternity leave option but if we can find a better way of spending that potential money, let us do it.

Ms HALL—The other thing I was particularly interested in in your paper was the issue of the people who are over the age of 65 and between 15 and 25 who are identified as needing the same level of care. The other issue that has not been picked up so much is those people who are unemployed and out of the work force, who possibly have similar kinds of issues to do with the labour market and the way all this is impacting on ageing and the fertility rate, and the consequential issues.

Dr Betts—We have probably knocked it off over the last five years, but for the last 25 years we have had a kind of perverse sort of policy where we have been trying to nudge people out of the work force, persuading them to take early retirement. Indeed, you are getting this conflicting message. Ten years ago it was, 'You're taking up a slot in the labour market that a deserving young person ought to have so you should take an early retirement package and leave.' Yet, at the same time, you would hear people saying, 'We have this ageing of the population; how are we ever going to support them all?' We need to be clearer about what we want to do about early retirement. As you know, far more people today take early retirement than was the case 30 years ago, so we need to look at the kinds of policies that have supported or nudged people into taking early retirement. In lots of cases it is, 'Either you take the early retirement package and maintain your self-respect or we are going to sack you.' On the other hand, there are superannuation schemes—not the one I am in—which scarcely make it worth your while to stay at work after the age of 55.

Ms HALL—There is another issue that you have not touched on—Tony referred to it a little—and that is the transition from full-time employment—something like the Japanese model where there is a gradual decline in the number of hours you work, the type of work you are doing and maybe even the status of the work you are doing but still a provision within the societal structure where people can work and have paid employment at a different level.

Dr Betts—That is another avenue where reasonably secure part-time work is a useful solution to the suite of problems that people may have: it is helpful for young parents and it is helpful for older people who may find the full-on working week a bit too much and would be happy to scale back. There are not very many workplaces that have that kind of arrangement.

Ms HALL—There needs to be a turnaround in the way employers and we as a community look at employment—perhaps part time at the end as well as for the young people, who are doing it for obvious reasons.

Dr Betts—There is an enormous distinction between part time and casual. One of the sad pregnant stories I have been hearing is about a fairly highly trained girl leaving to have her first baby, wanting to come back part time and being told by her employer, 'I could not possibly have you part time but I will have you back on a casual basis.' Casual is useless for a young mother trying to arrange child care and so on. I understand that casual is just brilliant from the employer's point of view because he has the person when he wants her and not when he does not want her. But it is not good from a social point of view. We need to take the costs that the employer bears seriously instead of saying that there is one more sexist monster out there. There

is one more person trying to make a quid in a highly competitive marketplace. If we put more burdens on them they are going to be even snakier about hiring people who might need extra support.

CHAIR—Australia seems to have a lower work force participation rate compared with other comparable countries in that 55-year-old to 64- year-old group, and you touched on some of the reasons. What reasons do you see for why we have a lower work force participation?

Dr Betts—If we just think firstly of men, I think we have the early retirement syndrome that I have referred to. We have also got the growing numbers on disability benefits. If you look at page 11, table 4, in both 1996 and 2001, about 20 per cent of men aged 55 to 64 were on disability support. That is just a rough reading of the graph but there are not 20 per cent of men aged 55 to 64 who come up on the graph as severely handicapped.

The article that I drew that table from claimed that this was quite legal. In regional areas where there is very high unemployment the Family and Community Services people put people on the disability benefit rather than on Newstart and Jobsearch because there are not any appropriate jobs. These are low skilled men. The kind of industries they were working in have vanished and it is really terribly unkind to put them onto Newstart because they would be pestered to apply for jobs and so forth. If there were any grounds on which you could say they had battled migraines, or whatever else it was, that would justify the disability support and, well, that was the way of it. I know that at the political level there has been some move to try to do something about this, but I think we are left with the social problem that there are people who live in areas where there are no appropriate jobs. What do we do about it? In the meantime as a humane society we want them to be able to stay alive, eat, be fit and feed their families.

Historically we have had a low work force participation rate of women compared with Europe, and that is interesting. I think we should be looking at the older age group. At the younger ages where they have family responsibilities, perhaps we do not. We need to know more about that and what kinds of barriers to training and travel there are. We are finding that with the really rapid population growth that Australia has experienced compared with Europe, we are getting suburbs and areas that are being built up in relatively remote areas. I have just been proofing an article for the journal that I edit and it compares Cranbourne in Melbourne with the Sunshine Coast in Queensland. They are both areas you can look at as sort of overflow areas. If you are on a low income but you have a family and you can maybe afford a house, Cranbourne in Melbourne is the place to go. From there you cannot commute to a job in the centre of Melbourne but you can commute to jobs in the mid-range south-eastern suburbs. The rate of employment for adult men there is not bad. What is worrying about Cranbourne is that the schools are not performing well: children are not staying at school and they are not going on to higher education or TAFE so there is probably going to be a problem there later.

More worrying is the Sunshine Coast. The image is that that is where retired people go to retire in the sun. However, there are a lot of working age families with children and young people moving there. They cannot commute into Brisbane for work. The only work they can get is people servicing work and house building work that is happening because this is a growing area. If you are a housewife on the Sunshine Coast married to a low-skilled worker who might have a job, your chances of finding a job might be really poor. We need to think of some of the perverse effects of a relatively rapid population growth. Are we pricing young people out of the housing market? Are we pushing them into areas where they are removed from reasonable jobs,

and especially affecting women who cannot travel as far as men? We have to bear in mind that all this stuff is interconnected.

CHAIR—What social factors contribute to dependency among the aged?

Dr Betts—Dependency in the sense of not getting paid work in that not many people want to hire somebody aged over 65. They may not want paid work if they can survive without it. However, there are stereotypes about older workers. We do not want to be too pious about this. In many cases, an older worker might not be appropriate. The workplace culture is all young people who throw beanbags at each other, play loud music and that is the way the workplace functions. Having a granny in there might really change the ambience. We need to be sensible about it, but there are stereotypes about the slowness of older workers. A colleague of mine at Swinburne, Louise Rowland, who may have made a submission to this inquiry—I have not asked her if she has—has done a lot of work on the stereotypes that employers imagine about older workers. They may be a little slower to pick up something new, but the flip side is that they are loyal and dependable. They do not take sickies because they have hangovers. The older worker could be marketed. If you have an employer with a mindset that he wants a youthful graduate, and that he had better not have a woman because she might get pregnant, he is really limiting the pool of people he can recruit.

CHAIR—Thank you for your submission, for your presentation and for your answers to questions.

Proceedings suspended from 12.32 p.m. to 1.30 p.m.

MALONE, Mr David John, Chief Executive Officer, Australian Physiotherapy Association

NALL, Ms Catherine Marjorie, Vice President, Australian Physiotherapy Association

CHAIR—I welcome representatives of the Australian Physiotherapy Association to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. Therefore, I 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 Physiotherapy Association has made a submission to the inquiry and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Malone—Thank you for the opportunity to appear here today. To elaborate on who we are, I am not only the CEO, I am also a registered physiotherapist. Cathy, our national Vice President, is also the director of physiotherapy services at the Austin hospital and is an associate clinical dean at the University of Melbourne. The APA is an organisation that represents 10,000 physiotherapists in Australia. A lot of those physiotherapists have a strong interest in issues on ageing. We also have a specialist subgroup within the APA of members who are particularly passionate about this area. A lot of work has gone into our submission and we are glad to have the opportunity to come along today and answer questions about it.

I would like to highlight a few things that are in the submission. The first point is the issue of a focus on preventative health care for older Australians. We are aware that the PBS and high-tech interventions are likely to increase in cost as a percentage of the total over time. There are a lot of drivers for health care costs going up. We have tried to highlight in our submission our belief that there is an alternative, particularly in the areas of musculoskeletal and arthritic conditions, to drug interventions in some cases and other high-tech interventions. There is now a considerable amount of evidence available that exercise interventions for those types of conditions can be very effective.

The work of Dr Leonie Segal at the Health Economics Unit at Monash University is something that we are aware of. We have not seen her work published yet because it has not been made available, but at a presentation last year at the arthritis summit, Dr Segal talked about some of the early findings from her work and we are looking forward to the opportunity to see that published paper. Our understanding from her presentation is that there is likely to be a high degree of cost-effectiveness from exercise intervention for elderly people with arthritic and musculoskeletal conditions as opposed to drug interventions. We would also draw your attention to the fact that there is a large amount of evidence based on physiotherapy interventions that, particularly for older people with complex conditions or who have certain pathologies, exercise programs when delivered under the care of a physiotherapist can be very effective. This is particularly so compared with perhaps older fit people who do not have pathologies or complex conditions who can manage sometimes without that expert degree of care.

We have tried to elaborate, in our submission, on the concept of exercise programs being prescribed by the doctor as an alternative to drug prescriptions. The association brings with it the value of having a lot of members who have an interest in this area. We have a good framework and an independent research body within the organisation—the physiotherapy

research foundation—and we would really relish the opportunity to develop a program that could be prescribed by the general practitioner, just like the general practitioner might currently prescribe a drug intervention for these people, to keep them active for longer, more mobile, more engaged in society and fitter. They would consequently be a lesser burden on the health system. Hopefully we might answer some questions about that.

The other point which I wanted to highlight as part of the opening statement was some concerns that the Australian Physiotherapy Association has in respect of the RCS. We made a separate submission to Minister Andrews in August 2002, which is in the material which we distributed and which you will have a copy of. It is the yellow paper in that file. I can summarise it. In a nutshell, the concern that we had is that we know that more and more people are being squeezed into aged care facilities. With a decrease in acute care services, people are entering aged care facilities earlier than they might have in the past. Without enough of a focus on physiotherapy intervention in aged care facilities, people become more dependent, they become more of a burden on their carers, they are more likely to have subsequent falls and more likely to have further complications of their conditions, and they are less likely to leave the facility and more likely to be a burden on their carers and a burden on the health care system.

It concerns us that, after the physiotherapists who work in these facilities complete their paperwork, we have calculated that they literally have five minutes per resident per week. There are 600 physios working in Australia's aged care facilities. There is a significant work force problem there. There is a significant work force problem in physiotherapy generally, which we have also highlighted in our submission. But its relevance to aged care facilities is very relevant to this inquiry and its scope. In a nutshell, you have 600 physios trying to look after all the residents of Australia's 3,000-odd aged care facilities, and they have problems with the degree of paperwork tying them up and keeping them away from their patients. The association has a strong commitment to proper quality assurance and note-taking and so on; we have procedures and policies in place for that. But when it gets to the point where paperwork is actually pulling people away from patient contact time and you end up with literally five minutes of physio per resident per week, we do not think that is in the best interests of the system. We would like to see some programs and policies put in place to address that and to make physiotherapy more readily accessible to people in these situations.

CHAIR—In your submission, you did address the issue of preventative measures to reduce the risk of falls or injuries following falls. What sort of program would you like to see, or what sorts of ideas do you have there?

Ms Nall—Essentially, the work that helps prevent falls is strength programs and balance programs. There is a range of evidence already to show that these can impact on the rate of falls. There is very good expertise within the physiotherapy profession in that regard. An example is the program which we run at our organisation, which is funded by DVA, because, as you probably know, in Victoria it is funded on a fee-for-service basis with no capping, so we have much more flexibility to develop programs for DVA clients than for any other kind of client. This is an outpatient program. Patients come once a week. They participate in a class—we have a low-level one and a high-level one—depending on the sorts of needs that they have. They undertake a range of strength training and balance activities. For some of these people, it is the only time they come out of their house for the whole week. We are doing the evaluation at the moment, but what we strongly believe is that this is preventing falls, preventing hospitalisation

and preventing depression and all those social things as well, because the socialisation aspect of it is also important.

CHAIR—How would you target a program like that?

Ms Nall—There is a range of different ways to target it. I think you would identify people who have actually been hospitalised as the result of a fall; obviously they are a key group. Also, you could look at a group that have been identified by the growing number of community care providers, who might think that perhaps this is happening at home—also the GP and other people who are in contact with people on a day to day basis, such as HACC services or whatever—and then try and have some way that they could feed into such a program earlier rather than later. The referrals that we have for our DVA patients come from everywhere and we strongly encourage a pretty open door policy to it. Sometimes it is word of mouth from other clients who know that they have that problem, but a lot of the referrals are from GPs.

Ms HALL—Thank you very much. That is another excellent submission that we have before us. We were talking a little bit a moment ago about exercise and fall prevention. In your submission you talked about community programs and the need for community programs to be strengthened. I was particularly taken by your idea for an exercise and wellness plan for retirement, just as people have a financial plan for retirement. Basically, if you do not have the wellness then the retirement is not going to be much fun, is it? Would you like to tell us a little about that, please—what you envisage with that?

Mr Malone—I think you have summarised it pretty nicely. I think a lot of people get to retirement age or their elderly years and they have no concept of what is required to keep them active and mobile for longer. Where we see the expertise of physiotherapists being particularly valuable, as I said in the opening gambit, is that people who have pathologies of some sort or complex conditions will quite often start a program and develop symptoms from actually exercising. When it is being destructive and a motivation for them to stop and give it all away, physiotherapists can add a lot of value. They can look at modifying the exercises, treating the pathology, directing the person in the right direction to get treatment or doing it themselves. That is very different from someone who is in the lucky group, if you like, that can exercise, have a good idea, get on with it, and do not have any problems.

These people often have complex conditions. They have other overlying conditions that will influence what sort of exercise they can do. That is an area where physios have a lot of skills in assessing and modifying those sorts of programs. The concept of a screening examination before someone embarks on a program or the tailoring of a program for somebody who is in the group I just talked about are the sorts of things we think could be blended into a plan—much like a financial planner does a financial plan, which is why we use that analogy. The key is that they are individually tailored, so it is not a recipe based approach to exercise. I think that is where exercise with the elderly goes wrong. It is okay to have aerobics videos, handouts and all the other things that might work with a fit, healthy, younger population, but those sorts of resources do not work well with elderly people, particularly elderly people with complex conditions.

Ms Nall—It does not necessarily need to be the physio who is doing all of that work. The model we use—going back to home base again for a minute—is that our physio assistants are human movement graduates, but they work with the physio. The physio modifies the exercise

prescription as required, based on any pathology that might pre-exist or might arise, and reviews and directs the program overall, which makes for a very cost-effective intervention. The other thing that we need to look at is the growing evidence that is emerging for the role of exercise—things like cardiac failure, which is the largest reason for hospitalisation in the over-65s. There is a growing body of evidence to say that, if you can start exercising that group early, you can stop the cardiac failure perhaps progressing either as fast or as far as it would have. There are many other similar examples.

Ms HALL—In your submission you also spent time on work force issues. You looked at training, the impact that universities have had and the need to adequately fund hospitals for placements. Adding a little local flavour to that, I know that every hospital in my area—I come from New South Wales—always has a physio position that needs filling, and I am sure it is the same for each of us here. Do we also need to encourage more physios to be trained?

Ms Nall—Absolutely.

Mr Malone—It is a huge issue for us. Our board of directors have made it their top priority at the moment. It is the No. 1 issue that our members bring up all the time. I went to a meeting of the heads of schools of the Australian physio programs just this week out of Newcastle, and it is high on their agenda. It is an issue the profession is very concerned about. It is very hard to find a physio to come and work for you full stop.

CHAIR—What determines the numbers entering physiotherapy schools?

Ms Nall—At the moment, the numbers are largely places the universities make available. To some extent there are other constraints which include how to provide clinical education to undergraduate students and to postgraduate students too. It is a little bit of a catch-22; it has to go in a step-wise process. The funding that comes through for an individual student per year in physiotherapy is even less than what comes through for a science student. Given that our students have to hit the ground running—we do not have an intern year; they are registered at the completion of their course—we have to make sure that people are safe before they are let loose on the public. A lot of one-on-one intervention is required. For example, physio gets about two-thirds of the funding that medicine gets, yet medicine has an intern year, as you know, and that is where new graduates really start to learn procedures; whereas ours have all had to learn their procedures. This means that in many ways there should be an equal allocation of funding to ensure that you have that intensity of supervision while they are undergraduates.

Ms HALL—How does funding relate to occupational therapy?

Ms Nall—It is the same.

Ms HALL—They have similar issues.

Ms Nall—Yes, they have.

Mr Malone—Clinical placements are a big issue—as big if not bigger. The heads of schools are looking to the APA to be an advocate for them to try and find more funding for clinical placements. It is a huge problem. With cuts in funding to public hospital physiotherapy

departments, it gets harder and harder for the hospital department to subsidise this training cost, if you like.

Ms Nall—Not only that but unfilled positions put more pressure on other people to do the work. Also, the nature of acute hospital work and rehab work is such that the throughput is higher, the pressures are greater and the accountability is greater. All of these things just take time away from people; therefore, there is less time to spend with students as well.

Ms HALL—I know. I used to work in a rehab facility, and we used to recruit physiotherapists from overseas. That was the easiest way.

Mr Malone—That is another issue. The overseas entry regulatory body is called AECOP. They have changed their policy a little in the last couple of years. They used to have a grouping system where if you came from a school of physio in a certain country—essentially, the UK, Ireland and a couple of other countries—you could come in without sitting an exam. They now have a process in place where the grouping system has been done away with and you have to sit an exam to come in. That slows the process down, and it makes it less likely for a backpacker or the locum type group of work force people to come in.

One of the big problems is that the standard of physiotherapy is very high in Australia relative to overseas trained physios and that the main concern of the registration boards, which contribute to that process of overseas examination, is obviously protection of the public and maintenance of the standards that are here in Australia. So it has become hard to get overseas physios to come in and do three- to six-month locums, which used to provide a very useful relief work force particularly for our rural hospitals and some of our major teaching hospitals in the cities as well. So that has been made a bit harder.

Ms HALL—How is public liability impacting? Maybe I am a little bit off the line here.

Mr Malone—Professional indemnity insurance?

Ms HALL—I meant special indemnity, sorry.

Mr Malone—The premiums for physios have gone up markedly in the last couple of years, as they have for everybody else in the health sector. Physios can still get professional indemnity insurance, which is one good thing. It has probably not had a marked impact on our established full-time work force. But we have a large proportion of our work force that is female and we have a large proportion of the physio work force that is part time. A lot of the females who are part time also work in sectors, such as aged care, where the pay is very poor. Most people are usually surprised to hear what physios earn in these public facilities. Say you are a part-time physio working two or three days a week and your pay is fairly low to begin with. The PI premiums do not distinguish between things: you are still a risk if you work two days a week versus full time, and that is where the issue has had the most bite. I have had phone calls from people who work three days a week in an aged care facility. Their before tax pay might be under $40,000, sometimes even under $30,000 particularly if they are working two days a week, and their premiums are $1,500 and they have to pay for that in after tax dollars. I know it is a tax deduction but a lot of them are saying, 'This is the last straw. I might as well not work at all.' So I think it is biting there, but we do not have the same problems that some of the medical specialities have.

Ms HALL—The other thing that you spent a bit of time on and that I found very interesting was the cost shifting issue. You were talking about how the Commonwealth-state relationships were impacting. Would you like to expand on that a little bit more for me, please?

Mr Malone—One of the frustrations that the association has is that physiotherapy services often fall between the cracks of state and federally funded programs. The Commonwealth Department of Health and Ageing would say that physiotherapy is a state responsibility, yet at the same time the Commonwealth has programs, like the enhanced primary care program and the More Allied Health Services Program, which in principle are terrific ideas that we support and which are trying to deliver a multidisciplinary service to people who have conditions that have been shown to respond well to multidisciplinary care. Yet how well do those programs work on the ground when you cannot find a physio because there is no state funding for physios and there are huge work force problems that do not seem to be necessarily getting a lot of attention from either federal or state governments? That gets a bit tricky.

CHAIR—How has this shortage come about? Has it always been the position of the APA that there has been a shortage of physios?

Ms Nall—It has never been as bad as it is at the moment. What has really contributed to that has been the change in the AECOP rules, which we have already talked about. We have a small strategy to help address that which we can talk about; that is starting to look a little bit better than it was. Also there is the fact that people are realising that the population is ageing and physios are important. That has soaked up a lot of physios. There is just the fact of all of the substitution diversion programs for acute hospitalisation—in Victoria theirs is called HARP—and the hospital demand management strategy, all of which are starting to employ physios. Finally, some of the EBAs are starting to recognise the need for annual leave cover and those sorts of things. Just in my own institution that has soaked up another three EFT, and that is across the board.

Mr Malone—One of the things with the work force is that there is a real problem with good data. We have information from a number of sources that the APA uses and collates to develop our material. The only study that is contemporary that we tend to rely on a lot is the Australian Institute of Health and Welfare study of 1998. But that was not a particularly good study in that the department disowned a lot of that material just before it was due to be published because there were problems with their data collection processes. So what we ended up with was not a particularly substantial document, and that is five years old anyway. We rely a lot on information that we gather through our networks and our frameworks. We have a lot of members who, like Catherine, are directors of hospital departments. We represent 80 per cent of the work force, we have good networks and good committees, so we get a lot of information. We have been quite keen to lobby the federal health minister to fund a national work force study into physiotherapy. That is one of our big things. If I can take this opportunity to put in a plug, we would love to see that funded.

CHAIR—Kevin Andrews and Brendan Nelson announced a study, which is looking at work force issues in the aged care sector up to 2010. Have you had any input into that?

Mr Malone—We have been verbally invited, not formally yet, to put a representative onto that committee, which we appreciate and are looking forward to. The Australian Health Workforce Officials Committee let us know that they were considering funding a major national

work force study into at least one allied health group. We put a submission to them, which is in your files—it is the blue paper. That was only fairly recently—we did it in January this year. It is our understanding that in doing their next budget cycle, this committee are looking to fund an allied health profession, and we would really like it to be the physiotherapy profession. We are letting anyone we can know about it.

Ms Nall—We have tough competition. The competition is radiation therapists and pharmacists, both of which also have huge work force issues.

Mr Malone—Our argument would be if you look at the need for a focus on non-pharmaceutical interventions and if you look at the relative size of the three professions, we think it should be physiotherapy that gets funded.

Ms Nall—Either that or they decide to fund three, which would be a much better outcome.

Ms HALL—And OT as well.

Ms Nall—Yes.

CHAIR—In your submission on page 7, you mention the particular problems of rural and remote communities need to be addressed. That is in the context of community programs. Have you got any proposals on how to address the problems of adequate physiotherapy services?

Mr Malone—To be frank, the degree of work force shortages hits us so hard at the moment across rural and metro, our policy development and other efforts have been directed to increasing the work force body. It is probably true to say that we have not done an enormous amount of work on looking at ways in which the work force can be distributed—rural, remote and outer metro sorts of issues—although we do have a rural subcommittee of the APA. They have been very active in the development of rural scholarships for allied health, which we think is a good step in the right direction. We applauded that scheme when it came out. Our members have had a fair bit to do with the development of those programs. So we have thought about those sorts of things. But when you have public hospitals in the metropolitan areas and private practices all across the country screaming out for staff, you tend to focus a little more on the bigger picture of increasing the work force before you focus too much on the distribution issues.

Ms CORCORAN—I think you said there are 600 physios across 3,000 facilities. I assume that there are more in the city than in the regional and rural areas?

Ms Nall—We do not have the data, but I would assume so.

Ms CORCORAN—And you talk about the paperwork occupying a large amount of your time. I am not too sure whether you are saying that the paperwork is necessary but there is not enough time to fill it in or whether the paperwork is over the top. What follows from that is the question: do you need more time to complete the paperwork? Can the paperwork be done by somebody else or more cheaply than by a physio? There is obviously a combination of issues there. I do not have a feel for which way we should be going.

Ms Nall—First, a lot of the paperwork is repetitive. If there were some good software solutions for the paperwork instead of having to write out plans, and the details could be edited through the software, that could be a solution. A coordinated response to that would be good. From the point of view of accountability, some paperwork is obviously very important. It is critical in terms of nursing homes getting their funding for the various levels of residents. However, that funding does not necessarily need to be spent on physiotherapy; it could be spent on anything once the person has been classified. That is another issue. I am sorry, what was the other part of your question?

Ms CORCORAN—It was whether the paperwork needs to be done by a physio. Your software solution partly answered that. My simplistic question is: are we paying too much for the paperwork to be filled out? Is it a matter of allocating more physio time or of bringing in a half-trained physio?

Ms Nall—That is probably part of it, but even if that requirement were decreased by some efficiencies that could be worked out, the amount of physio time is still very small and the dollars are not sufficient to support a career structure. For many physios, it is not an area that they choose to go into because there is no career structure and the remuneration is poor. Physios are more likely to go into an area where a nursing home is grouped with another aged care facility so they are part of a wider team. It is a very isolated existence for a physio. Obviously the physio interacts in the multidisciplinary team, but in terms of peer support, unless they get that through our special groups such as the gerontology group, it is not there. It is not like a division of GPs which gets huge support from its peers through a network.

Mr Malone—On the issue of paperwork, physios have a duty of care and are responsible professionals who need to document their notes and, like doctors, they would not be happy for someone else to be completing their paperwork. Our members would have the same concerns about that type of issue. In addition, when we talk to our members about this, we get a strong sense that a lot of them feel that they are in the facility to fill in the paperwork which allows the facility to keep its funding going rather than filling in the paperwork for the purpose of helping them deliver the best care possible to their patients.

Ms CORCORAN—We have heard that comment from all sorts of different groups of people. What does AECOP stand for?

Ms Nall—The Australian Examining Committee for Overseas Physiotherapists.

Ms CORCORAN—I guess it is a bit contradictory. You made the point that they have set the bar a bit higher because of Australia's high standards. I could argue—as I guess you would—that that is a good thing, but that has caused a lack of locums or casual physios coming in. Without threatening the profession, is there room for—and I do not know what the term would be—an associate physio, someone who does not quite meet the requirements, but who could come in and do some of the lesser technical work?

Ms Nall—We do have physiotherapy assistants or aides whom we use quite constructively—

Ms CORCORAN—I didn't know that.

Ms Nall—to try to find cost-effective solutions. However, on the other hand, the Australian public has an expectation of what a physio will achieve so you do not want to go backwards.

Ms CORCORAN—That is the conflict in my mind.

Ms Nall—Part of that response came about because the UK cut back the physiotherapy course from four years to three years. The solution we have put up to AECOP which depends upon the registration boards implementing, because many of them have that capacity within their existing legislation, is for us to bring in these backpacker physiotherapists, put them in an organisation where we can ensure adequate supervision at all times, take only people who have already had one year of experience overseas, so that that is the equivalent of the four-year course in Australia, and then they can come here and work in exactly the same way that they did before.

Mr Malone—These are registered physios from overseas.

Ms Nall—We think that that is going to provide a solution. We have just had some agreement about that in the last couple of days.

Mr Malone—AECOP would argue that they have not lifted the bar; they just cannot be sure that those people meet the current line, because their programs have dwindled a bit and, as Cathy said, some of them have been cut back a year and there has been a bit of an explosion in the number of programs. They have found it very hard to keep tabs on these graduates from all these different courses, so they have said that everyone has to sit the exam now. They have not put the bar any higher; they are just saying, 'We can't get around an exam for everybody now.' That slows down the intake.

Ms Nall—They also had EEO issues, because they were originally Commonwealth countries and now they have to be even-handed across every country.

Ms CORCORAN—I can see a lot of reasons why they would want to do that. My final question—I do not know whether it is a question or a statement—is about lifelong exercise. You talk about the value of exercise for older people. To my way of thinking, you do not start exercising when you turn 65; you have either done it all your life or you haven't. It occurs to me, from watching TV ads and watching people being encouraged to exercise, that if you are lazy like me you are not going to go out and exercise, but if you can exercise on the way to work or walk to the shops or something that is one way of doing it. I wonder whether there is a role for this committee to make recommendations to encourage people to exercise 'as they go'. I noticed that a few of our colleagues are wearing little meters on their belts that say how many steps they have taken today. There is the concept of being able to exercise as you go about your normal business and finding ways of doing that.

Ms Nall—That is fine, but obviously some types of exercise are more valuable than others.

Ms CORCORAN—I am not talking about replacing it.

Ms Nall—Exercise that puts up your pulse rate to a certain level is more valuable than just walking around the house, for instance. Strength training, which is where you lift weights or

whatever more than you normally would, is more valuable than lifting a light weight very repetitively, for instance.

Ms CORCORAN—Walking to post a letter is probably better than sitting there waiting for someone else to do it for you.

Mr Malone—You are talking about motivation to exercise. The big issue is the demotivating events that occur. If somebody is elderly and they start exercising and then their OA knee flares up or they start and another part of their complex condition flares up, they are very unlikely to have another crack at it without expert advice along the way. As distinct from general fitness trainers and the fitness training industry, physiotherapists play a very important role because that tailoring of programs for people with complex conditions and people with existing pathologies is very important. We are probably more worried about those people who commence and have a negative early experience because they have an inappropriate program that was based on a recipe approach that they got from a video or from a handout. Sometimes general practitioners will give people handouts or exercise programs. As we said in our submission, like you have the PBS system, you might have an EBS system so that the doctor can write a referral and somebody in this risk group is properly assessed. Then they can get onto an exercise program and stay on it without a negative event that turns them off exercise for life.

Ms CORCORAN—If we lived in the ideal world, when you turned 40 or whatever could you wander along to Dr Southcott or to you and get that done?

Mr Malone—I think so. We have highlighted that.

Ms Nall—We would love the opportunity to have some support to develop a pilot program like that which we could then trial and evaluate as a way of getting the ball rolling.

Ms HALL—Before I go back to the question I was in the middle of asking you all that time ago, you just mentioned bringing in overseas physios and putting them in a supervisory role. I think that is a great idea. It may be a way of circumventing the need for that formal assessment and exam if they pass the competency test whilst in that formal situation. Then they could move on. Is that what you are looking at?

Ms Nall—Yes, something like that. We also envisage doing a reference check. If I have a physio who has been working at Guy's or Kings in London, or somewhere like that, that I know is very comparable to our hospital, I only need to ring the head of their department and ask—

Ms HALL—'What are they like?'

Ms Nall—Then we make sure that we supervise them and get a feel for what their work is like. That gives us access to a registered physio that we would not have otherwise.

Ms HALL—Back to the cost shifting question that we were in the middle of.

CHAIR—Pardon me, Jill. What registration issues do they have if it is from a Commonwealth country?

Mr Malone—We have put a proposal to AECOP, who only on Saturday endorsed it in principle, where they would be able to come in if they satisfy certain criteria, which include things like a reference check—they have to be registered in a country with similar training, and so on. The recommendation that has been endorsed by the umbrella body of the registration boards is that they be given a form of limited registration, which applies at a set site, under supervision, for a set period. Now we have to go out and lobby each individual state and territory registration board to try and bring that in. Some will be keener on it than others.

Ms HALL—Back to the cost shifting exercise, if we could. You have addressed the part looking at the different physio treatments in public hospitals, and the doctors and the drugs. The other issue that you raise, which I think is quite interesting, is looking at the Commonwealth-state health agreements. Would you like to expand on that a little bit, please?

Ms Nall—I guess the key issue with those agreements is that it transfers a certain amount of funding to the states to undertake a range of activities, but those activities are quite broad. There is nothing in there that says that a certain component of this funding should be specifically directed towards physiotherapy intervention.

Ms HALL—So it is written into the agreement that that is the way it should be?

Mr Malone—Our experience, talking to our members who run large teaching hospitals and physiotherapy departments, is that, when a funding squeeze comes on, the cut to the physiotherapy and other allied health departments is often disproportionate to the cut across the board as hospitals strive to maintain their surgical services and other what they would call 'core medical services', I suppose. The position of the APA is that, when you look at the contribution physiotherapists make in all these different areas, particularly the fact that it is relatively cost effective compared to high tech and pharmaceutical interventions, physiotherapy should be considered a core medical service within these agreements, with some onus of responsibility attached to the funding to make sure that hospital boards do not disproportionately cut that to give other services gain. Allied health is not particularly well represented, I do not think.

Ms Nall—No. Around the executive tables generally, because the numbers are just not quite big enough.

Ms HALL—Just for my information, every hospital in Victoria has its own board. Is that the way it works here?

Ms Nall—Yes—every health service, not every hospital. A health service may have, typically, three hospitals as part of its health service.

Ms HALL—That is the same as New South Wales then.

Ms CORCORAN—There has been a change.

Ms Nall—It used to be each hospital, but now it is clustered.

Ms HALL—It is very similar to New South Wales. The other issue you raised in relation to the Commonwealth-state funding issue is the lack of transparency and accountability, and the duplication that arises. Would you like to expand on that for me please? Give me examples.

Ms Nall—I guess it is where you have similar services being funded by the Commonwealth or by the state. It is a question of going to the Commonwealth and saying, 'We need more of this,' and them saying, 'That's the state's responsibility.' If you go to the state and say, 'We need more physiotherapy for this particular group,' they might say, 'No, that's the Commonwealth's responsibility.' As David mentioned before, physio really falls between the cracks in many ways. Cost shifting is used as an excuse to try and not have to fund something.

Mr Malone—If we go to the Commonwealth and say that their enhanced primary care program is a good program by design, but that we can see that, while health assessments have taken off really well, case conferences and care planning are perhaps lagging behind a little bit, and we tell them that we think part of the reason is that there are not the physiotherapy and other allied health services on the ground to contribute to those programs, the standard answer—without wanting to sound rude about it—is, 'That's a state responsibility.' Our branch network within the APA will talk to state health ministers, and often the reply back will be, 'Go and talk to the Commonwealth, EPC is their program.' It gets a bit frustrating from our perspective on the ground.

Ms HALL—Are you saying that there needs to be greater coordination going across levels of government where perhaps there is joint responsibility, and not the passing of the buck from one to the other?

Mr Malone—Pretty much.

Ms HALL—You talked about physio in aged care facilities. The other issue is occupational health and safety in those facilities and the contribution that physio could make to that. Would you like to expand on that?

Ms Nall—The aged care facilities rely enormously on the physios to actually help them, particularly in manual handling, to actually teach the nursing staff the best occupational health and safety approach to handle each individual resident. Often the physios are the ones who know how to use all the various equipment, or what the capacity of each individual resident is to, for instance, do a standing transfer versus a hoist transfer, or whatever. That is a very important component of the role as well. Nursing staff and other carers rely very much on that support yet, again, it takes away from the amount of time that the physio has to spend with the individual residents.

Ms HALL—The other thing I was getting at there was exercise programs within aged care facilities. Would it be beneficial if you had an exercise program that went across the staff and the residents, where you were increasing the fitness level of both of them at the same time?

Ms Nall—Absolutely. The aged care work force is ageing, as you probably know, and therefore are more at risk of injury, probably, than the younger work force.

Ms HALL—In relation to cost shifting and linking into what you said about a pilot program, one of the issues that we have heard brought up at a number of these hearings has been the

establishment of pilot programs and the fact that it may work out to be quite a good program and then, once the pilot has finished—

Ms Nall—It is sustainability.

Ms HALL—That is an issue?

Ms Nall—We hope that it would not be, because we hope that, by establishing a pilot program, we could demonstrate its effectiveness and it could then be picked up and funded in exactly the same way that a drug is funded now. It would be something that was just prescribed in the same way as a drug with the same sorts of access that PBS gives cardholders and older citizens.

Ms HALL—My final question links back to those work force issues that you mentioned earlier. In here you were talking about a minimum ratio of patients to physios.

Mr Malone—Our rural subgroup has done a fair bit of work on developing what they believe are appropriate ratios for physiotherapy services to rural communities. I do not have that information with me at this moment, but I can get that for you.

Ms HALL—That would be good.

CHAIR—Thank you very much for your submission and also for your answers to questions today.

[2.22 p.m.]

McCLEAN, Ms Carolyn, Community Services Manager, Kingston City Council

McCULLOUGH, Mr Trevor Clyde, General Manager, Resident Services, Kingston City Council

CHAIR—I would like to welcome Kingston City Council representatives to the hearing. 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. Would you like to make an opening statement before I invite members to proceed with questions?

Mr McCullough—We would, Mr Chairman. We have prepared a written submission, and I think each of the members now has a copy. We have also included in that a copy of Kingston's aged care strategy, which was approved by council in December 2002. We are making the presentation on behalf of the Kingston City Council. Kingston is a large metropolitan council located approximately 15 kilometres south-east of the Melbourne CBD with a population of about 128,000 people. Our community is a multicultural community with 28.7 per cent of our residents born overseas. The population is ageing at a rate which is, at least for the next 20 years, greater than the average for Victoria. The number of people over 85 in Kingston will increase by 58 per cent over the next 15 years. Kingston council has a number of roles in aged care. We see our primary roles as planner, provider and an advocate on behalf of our residents on all matters to do with aged care. We are also the owners and operators of three residential aged care hostels, so we would be happy to answer any questions about hostels as well as about community care.

We are aware that you had a submission this morning from the Municipal Association of Victoria, so we will not seek to duplicate any of the material in their presentation. Our submission gives an overview of the key issues as we see them from the Kingston perspective. It is based on the work that was done in preparing our aged care strategy over the last 12 months or so. We have attempted to illustrate some of the issues that are arising by the inclusion of a number of case studies in our submission. We are hoping that by relating some of those issues back to real people who are experiencing some of the difficulties with our current system it might help with an understanding of some of the situations that arise.

In our opening address, there are two things that I would like to highlight from the report. The first is the impact that flows through to clients from the HACC funding shortfalls and the second are some issues relating to residential aged care—in particular, viability issues that are faced by providers. Both of those issues are probably at the top of our list in terms of issues confronting the council here and now. Firstly, with regard to HACC funding issues, Kingston, like most Victorian councils at least, has experienced a simultaneous increase in demand alongside an increase in service costs. Both those drivers need to be understood separately. The issue of costs was fairly well articulated by the MAV this morning and from our point of view it is mainly related to increases in labour costs. The other side of the equation, which is the demand increase, not only relates to the increase in aged population, which we are all experiencing to a different degree, but also relates particularly to people choosing to stay in

their homes longer and wanting to be more active for longer. The demand particularly on our community care services is growing because people are saying, 'I am not going to take that step to go into residential care.' So we are experiencing different issues relating to that.

The funding increases that we have obtained over recent years have been assisted greatly by the recent addition of the Department of Veterans' Affairs funding. But we see this as a temporary addition to our funding stocks. The effect of the DVA funding will diminish over time. Even with those additional funds, it is not coming close to meeting those gaps that are widening, created out of the demand and cost increases. Councils like Kingston are then left with the choice of increasing rate funding contribution to aged care, increasing fees and charges to the clients or reducing services, or a combination of those three. The increasing of property rates has its limitations, as the councillors are generally reluctant to dramatically increase property rates to cover additional funds for aged care, especially as most ratepayers would see aged care as either a state or federal responsibility. There are some political issues for councils in raising rates by too high a degree to cover the shortfall. The scope to increase fees and charges is very limited by the clients' ability to pay, and our scope to increase much beyond the current fees that are set by the Department of Human Services in Victoria is limited.

The conclusion that we draw is that some reduction in services is inevitable. Different councils will respond in different ways and with increasingly dramatic effects on the clients. Briefly, I will run through some examples of the service reductions either that have already been introduced by Kingston or that we are considering. We no longer provide a domestic care service between Christmas and New Year; we close down during that period. We are currently considering closing down this year between Easter and Anzac Day.

We are also considering providing no domestic care service on other public holidays. The reason for that is obvious: on those days we pay a much higher rate for our staff costs. We simply cannot afford to provide and subsidise to that level for those days. The impact of that on the clients is that they have a dependence on their families for those days. That is okay if they have families to provide that support, but if they do not have that support for a week at a time or a week and a half, depending on the timing of those holidays, then that places a real burden on some of those clients. A second option that we are considering at the moment is to charge clients for the travel costs that are incurred for things like shopping trips or socialisation outings. Clearly the impact will be that some clients will not be able to afford that, which will create a dilemma for us. We will either have to continue to provide that service and subsidise it or those clients do not get the service and, therefore, we would have to cut off those socialisation options.

The last point I want to make on HACC, and the most significant from our point of view, is the issue of how we view the HACC service and whether we see it as a basic service that is at the bottom end of the care spectrum, or whether we see it filling the gap between community care and residential care. To illustrate that, we have some clients that are currently receiving up to 15 hours per week of community care. We have increased that to meet their needs to avoid them going into a residential facility. Almost without exception, they have indicated their preference not to go into a residential facility. We are actively considering placing a limit on the number of hours of HACC care that we provide to clients. We are looking at reducing the number of hours back to six hours per new client and referring any of the clients who have needs greater than that on to the CACPs program, the Linkages program or on to a residential aged care facility. The reasons for that are that we simply cannot spread our dollars any further

than that. We are seriously looking at a six-hour limit. The implications of that are again quite clear: it will push clients on to the residential aged care system or into the higher care programs such as CACPs and Linkages.

Ms CORCORAN—Is that six hours per week?

Mr McCullough—Yes. In our submission, we have included a number of more detailed real case studies of real people that are in those situations just to illustrate that point in a little more detail. The other point I want to touch on briefly is that of residential aged care. The key issue for Kingston council is the viability of its providers. We have 27 aged care providers; 16 of those have facilities with 50 beds or less. The advice that we have from consultants that have worked with us on viability issues in residential aged care is that facilities need to be at least 60 beds to be viable in the longer term and, preferably, up to 90 or 120 beds to have a longer life. Clearly, having that many facilities under 50 beds is going to be a problem for us. In the interviews that we did with providers in preparing our aged care strategy, 12 of those facilities have already indicated that they are struggling and that they will need additional beds to increase the size of their facilities to be viable, even in the medium term. The concern I guess that creates for Kingston is that those providers will either exit the industry altogether or move to outer suburban areas where they can get land cheaper and look at other ways of cutting costs. This will clearly result in a dislocation of our residents from their traditional living place and create difficulties for families and friends in visiting them. Our aged care strategy articulates that issue and that problem in a lot more detail.

Before closing, I would like to point out the existence of some of those case scenarios that are in our submission because they really illustrate some of the binds that we can get ourselves into by having to juggle the different funding streams and understand the different ways that the current aged care system works. I would be happy to talk further about any of those case studies or answer any questions.

CHAIR—You have highlighted the problems with HACC and your conclusion, I suppose, is that with costs rising local government will not be able to provide the level of services through HACC. You don't see any way around that?

Mr McCullough—I think that under the current models of care we need to work out how some of those gaps are provided. The HACC program was traditionally set up to deal with the lower needs clients. What has happened in recent years is that there has been a progression towards using HACC to cater for higher needs clients. We have seen that flow through to the hostels as well. We have now got clients that really should be in nursing homes still in the hostel because they cannot get places further upstream. How we address that I am not clear. We have made some suggestions in our submission about reviewing funding streams and trying to bring some of those funding streams together and about looking at having some sort of growth based funding regime for HACC in particular. Having it linked to property taxes or property rates is perhaps not the best approach.

CHAIR—Also you mentioned that the council is quite a diverse area but that you do have a greater proportion of over-65s—is that right?

Mr McCullough—Our proportion of over-85s is much greater than the Victorian average.

CHAIR—I see. Looking at your projections for the council, you plan out at least 20 years in advance—is that right?

Mr McCullough—The aged care strategy is based on a 20-year horizon—that is right.

CHAIR—Also you have said—and this also came up with the Municipal Association of Victoria—that with HACC, Community Aged Care, the DVA program and so on, there is a lot of duplication. Do you have any suggestions on that?

Ms McClean—I suppose we have a fair amount of sympathy for the model that the MAV is proposing. Clearly, that is to demarcate local government in Victoria as providing a HACC basic service, then with the idea of having an intermediate service and the high needs on top, with the bulk of the funding being at that HACC basic level. I suppose the experience at the moment is that we are currently supporting people who are on those very high needs, and that is in some of those case studies, but they are just not able to access those funds at the top level. The MAV model is that there is one provider who would be able to administer those three different levels without having a whole group of different service providers at those different levels. So there would be that continuity of care for the client as they progressed through the three streams.

Ms CORCORAN—Thanks for coming in at such short notice. Could you talk about the HACC DVA issue that I know Kingston has got? Perhaps for the benefit of my colleagues you could explain that HACC DVA issue.

Mr McCullough—I can give an introduction to that and then I will hand over to Carolyn because she has much more hands-on experience with this. I guess the frustration in a more general sense is the frustration of running two parallel streams of effectively the same service. We have different guidelines and different assessment criteria and it is almost like running two separate programs, and yet we have clients that have gone from one program to the other. In a general sense there is the frustration of those two parallel programs and all the inefficiencies in administration that provides. It might be useful if Carolyn talks about a couple of specific examples that we have had of situations we have got into that have really created some grief for us.

Ms McClean—When the Veterans Home Care Program commenced, Kingston council and other councils were actively encouraged to assist veterans to transfer to that program with the undertaking that no veteran would be disadvantaged by going over to that program.

Ms CORCORAN—From HACC, you mean?

Ms McClean—That is right. So they would maintain the same levels of service that they had with approximately the same payments. We have had a recent example where a male client was receiving veterans home care. He was the eligible gold card holder. He died. His widow then became eligible in her own right, but at that point she was reassessed by Rally. The majority of her high maintenance service was cut.

Ms HALL—What is Rally?

Ms McClean—Rally is the commercial arm of the RDNS. They have a contract to deliver the assessment services for the Veterans Home Care Program in Victoria. So therein is another frustration, because assessment is separate from delivery. This client was particularly distressed because she was probably even less likely to be provided with those sorts of services, plus the timing of the cutback was just a couple of weeks after her spouse's death. We were distressed because it was local government. Her family came back to us and said, 'You actively encouraged us to go on the VHC with the thought that we would never have our services cut, that they would be maintained, but they have been reduced.'

Ms CORCORAN—We had Kingston facility in here earlier this morning. There are Kingston council and Kingston aged care—different bodies. I understand—I hope that you will correct me if I am wrong—that they create a problem for Kingston council and a couple of others because of the allocation of beds. Am I correct in thinking that there are X number of beds per head and that, because Kingston happens to be located within that area, that is an issue? Can you also address the 40-50-10 configuration of high, low and community care places and whether that is still the appropriate distribution of places?

Mr McCullough—The Commonwealth formulas for the allocation of aged care beds include all the aged care beds in a particular local government area. In our case that includes, I think, 212 beds from the Kingston centre, which is a state owned facility. It also includes—again I am speaking from memory—90 beds from the Fronditha centre, which is run by the Greek community. Both facilities are regional facilities that draw from a much broader area than Kingston. The unfortunate part for us is that they count those beds in assessing whether Kingston has its relative number of beds according to the aged care allocation formulas. So that means that if any of our smaller providers want to get, say, another 15 beds to make their facility viable into the longer term, if they present to the aged care approvals round they are assessed against the criteria which say that Kingston already has its full allocation of beds. The argument that we are taking up with the Commonwealth in the coming months is that those regional beds should be excluded or at least a proportion of them should be excluded from Kingston's allocation of beds. It is an important debate for us to win because of the high number of small facilities that we have. Unless we can get some of those small facilities up to a viable size, we will have the dislocation that I mentioned before.

Ms McClean—One of the major things with the allocation is that it is based on an over-70-year-old group. Our experience, particularly in Kingston, is that the majority of growth in our ageing population is going to be over 80. There are certainly fewer people under 80 than over 80 who will access residential services. We feel that the formula would probably be more appropriate if it looked at that over-80-year group, particularly for residential.

Ms CORCORAN—My last question, at least for the time being, is quite different. That is, this committee is looking at things in the next 40 years, and a lot of the submissions focus very much on the immediate problems of aged care which we are all very familiar with. But there is also this thing of positive ageing. We focus on aged care facilities, yet most aged people will never end up in one. Most of them end up staying in their own home. If you can step back from the immediate stuff, do you see a role for councils in promoting healthy, fulfilling lives using the skills and talents of older people?

Mr McCullough—Section 4.5 in our submission, which starts on page 8, is headed 'Commitment to active ageing'. In that sense, 'active ageing' and 'positive ageing' are used

interchangeably. We see local government as having a very big role in promoting positive ageing, and we see our role as twofold. One is in encouraging individuals to be active as long as possible. The other is in providing the environment or the infrastructure to be able to support that. The first role is fairly self-explanatory—it is all about making sure people are healthy and active and have lots of leisure opportunities. The second is not so much discussed. We see it as an issue of 'liveability', which is the term we use. What we are seeking to do in designing our urban landscapes for the future is to make sure that they are liveable for all age groups. We will be particularly concentrating on the older age groups and saying: 'What is it about a particular community or a particular area that makes it more or less liveable and how do we, through the provision of infrastructure, through simple things like making what they call pram crossings on footpaths accessible so there are no tripping points?'

We refer to improving the 'walkability' of communities. That is about making local areas walkable: they have footpaths that are well maintained, they have attractive streetscapes, they are well lit and there is, if not a milk bar on every corner, a milk bar or some small retail outlet within walking distance of most people. Those are the things that really make a community liveable or not liveable. So we are looking in our urban design and our infrastructure design to make sure that we are capturing those things in what we do. That is a long-term goal. We are embarking on a project called the Chelsea Bon Beach urban renewal project at the moment, which we are running as a bit of a pilot project for this concept of making this a liveable community. The needs of aged people are at the forefront.

Ms CORCORAN—I want to get back to aged care and the nitty-gritty stuff again. We have heard, from a number of people making submissions, about the increasing burden of paperwork with the RCS process and sometimes the incompatibility between that and ACAS. Do you want to comment on that?

Ms McClean—I would not mind referring you to a case study that we have done in the residential sector. That refers to the mismatch between how we are funded through the RCS and what the care needs of the clients actually are. We have three case scenarios. Perhaps I could take you through case scenario 2. That is on page 3.

Mr McCullough—This is under 'Case study 2: case scenario 3'.

Ms HALL—It is the 85-year-old woman.

Ms McClean—Exactly, yes. So case scenario 2 is a lady who is blind, an insulin-dependent diabetic. She requires the service of the Royal District Nursing Service to administer insulin twice daily. The funding we receive through the RCS is roughly $38 a day, but the cost of this service is $47 a day, just for the first 20 minutes of service. We still need to provide all the services that a residential facility must provide, so how is this possible? The comment is that, as people live longer, because of improved medical practice, their health issues become more complex, requiring hospitalisation for periods. Aged care residential facilities are actually penalised financially when their residents go into hospital. We lose funding, but often their needs increase when they get out, and the funding has not been consistent all the way through their time of hospitalisation.

Ms HALL—I would like to spend a little bit of time on the duplication of services, the way programs are funded and cross over with HACCS, community care and aged care packages,

Linkages, and the plethora of different programs that exist, how they are assessed and delivered, and the way this benefits, or otherwise, the community and the people that they are servicing. Would you like to comment on that? In doing so, could you talk a little bit about how you think it could be improved and whether it should be approached by having a continuum of services rather than the competitive approach of each service going in there and being assessed against each other.

Ms McClean—If I could answer the question from the client's point of view, the feedback that we have from many of our residents is that there are so many different programs that they do not understand where the access points are. Once they are able to get into the system, where do they receive the information? A likely scenario would be that a person would develop some incapacity because they are frail aged. They may enter local government home care. They get roughly an hour and a half of domestic care. Something may happen that triggers their incapacity to be much greater. Because of the lack of funding, it is unlikely that local government will assess that person in terms of what their increased needs are, unless there is some sort of crisis.

It may be that the person is receiving minimal amounts of service due to a lack of review, as well as a lack of funding, and may be unaware—or the family is unaware—of how to access higher needs. Once that is picked up and they are referred to the ACAT team for assessment, they then may have a further period of waiting until they can get into whatever is appropriate—a CACPs package or a Linkages package. However, the level of care offered in a CACPs package or a Linkages package may not be substantively different to what local government can provide, because of the $10,000-odd cap. I suppose the benefit is that they are going to get the case management, but they may not get those increased needs of care, which may mean that they are propelled into residential aged care before their time. That is from a client's perspective.

In terms of overall solutions, we need to have one stream of care. I referred earlier to having the three steps that people could progress through, but we would need service providers to have some form of central point where someone is actively managing a particular person and facilitating the actual levels of care with different service providers. If you like, one organisation is contracted, perhaps on a regional basis, to manage that person's care. How the service provider is facilitated does not really matter, because that one person can guide the client and the family all the way through the journey.

Ms HALL—Do you think the competitive process for the allocation of funding and beds works against the service working in a seamless fashion?

Ms McClean—In practice, until the primary care partnership reform was introduced in Victoria there was definitely a lack of networking and partnerships between HACC service providers. PCP has assisted us to work much closer together. However, Commonwealth funded groups such as CACPs are very much on the outer of that so there has not been that ability to work as an aged care service provider network. Certainly, the aged care residential facilities do not tap into the gains that have been made through the primary care partnerships.

Mr McCullough—We are finding that the CACPs providers are seeking competitive quotes from people providing personal care, with the result that sometimes the case manager will swap providers, which has obvious implications for the client. They do not get that continuity of care

if they have different carers coming in. It is not every day—that would be an exaggeration—but certainly it would not be uncommon for a client to have three or four different carers over, say, a 12-month period. That is another implication of that same issue.

ACTING CHAIR—Are there any people falling through the gaps, who are missing out on services?

Ms McClean—Yes. There is the community connection program. We have put a case study at the very back of our submission. Until that program was initiated there was a range of people who were in low-cost accommodation who had multiple and complex needs who often may have become distrustful of the service system. A lot of these people would be living in caravan parks or boarding homes or who are indeed homeless.

ACTING CHAIR—Do you have many caravan parks in your area?

Ms McClean—I think Kingston has 16 per cent of Melbourne's caravan parks. It is quite high.

ACTING CHAIR—That is significant.

Ms McClean—We found that that group of people, in particular people who may have drug and alcohol abuse issues, were not accessing the aged care services. The community connection program has given us some funding to outreach those groups and try to tap those people into the service. That has now been running for four years. I would say that that is probably the most successful program we run because of its ability to have a worker who can get those people through a case management process into the service. We have put one detailed case example in the submission for you. We have also given you further client case examples to give an idea of the sorts of people who fall through the gap.

Ms CORCORAN—Just to clarify, and correct me if I am wrong, but we were up in New South Wales recently and the notion of caravan parks was that they were retirement type villages. The caravans we have in Kingston are not those sorts of retirement type places; they are residential low-cost housing for a range people.

ACTING CHAIR—They are the more traditional style of caravan park with very disadvantaged people. I want to ask you about the Commonwealth-state relationship, the duplication of services, how that impacts and whether there needs to be a greater level of coordination between the state and the Commonwealth. You can include in that the pilot programs and the impact that pilot programs have on service delivery.

Mr McCullough—I will address the last issue first. There have been a number of examples of pilot programs causing us some distress as the pilot program funding tends to run out after a 12-month period, leaving us with what would be a very good program but no funding and, in some cases, no option but to continue the program. The community connections program is perhaps a good example of that. If the funding were withdrawn for that we would be arguing very strongly with council that that program continue because it does pick up those socially isolated people.

In terms of the broader programs, there is a need for greater coordination of the funding streams, particularly the requirements of those funding streams in terms of the assessment criteria, the performance criteria and the goals of those particular streams. We would advocate very strongly that the Commonwealth and state departments get together—certainly in Victoria local government has a very big stake in that, as well—and sort out how those planning mechanisms are going to work and how that is going to flow through for collaborative planning and assessment and a more streamlined provision of services. As to how that happens, I am not able to offer you any solutions. Clearly, with the disparity that we have between some of our programs there is a need to somehow draw those things together.

Ms McClean—From a client's point of view, if you agree to go on a CACPs package you are going to be eligible for some things that you would not be eligible for under Linkages, the state funded program, so you will be advantaged in some ways. But then Linkages clients are eligible for some things that CACPs clients are not. People get hold of this information and say, 'Why is this? Why can't we attend a day centre as part of our package? Mr Bloggs across the road, who is on a Linkages package, gets that.' There is certainly some program eligibility that needs to be ironed out.

Ms HALL—My final question goes to the section on page 8, the commitment to active ageing. I know you have mentioned a couple of programs that you instigated in your council. What and how many programs do you have? How do you get the message out to the community that these programs exist and how accessible are they? Thrown in with that is your other role as council. I know you have mentioned a little about that and the infrastructure and the connectiveness that older people can have to their community and how you are encouraging that in all your planning decisions.

Mr McCullough—There is a range of programs that address the needs of older people. I have mentioned a couple of examples of leisure programs in our submission. The most successful leisure program that we run is called 'The fabulous 50s'. I think it should be renamed the fabulous 70s because I do not think there is anyone in the group who is under 70. The oldest lady in the group is 93. The group meets every week for an organised program but they also have social outings outside that that they organise themselves. The starting point or the base for the program is that they do water based exercise in the pool. There are two programs: one in each of our leisure centres. They use that as a starting point for socialisation and mutual support systems. They create very good friendships through these groups and that creates support mechanisms for all the participants. We had a 20th anniversary of this group about two or three weeks ago. Over 2,000 people have been through this group in that time. It has been an extremely successful way of not only keeping those people active and fit but also extending their social support mechanisms. That has probably been our most successful program.

We are also looking to leverage off that same concept and set up other programs for people with different levels of physical ability. We have started one group in our leisure centre for people who are physically inactive in some way—I will not call it a physical disability; they have a hip problem or joint problems—and they need specific training. We have some funding now to facilitate them in getting strength building so that they can be more active and get outside what becomes a very physically limiting environment for them. They are doing very light weights work in the gym. If you go up to the gym, instead of seeing great big guys with muscles everywhere you might see half a dozen older people working out on their weights or the treadmills. There are a number of programs that we have tried to build into our programs.

Ms HALL—Do you have council run gyms?

Mr McCullough—We have two of those.

Ms HALL—That is a difference, too, between New South Wales and Victoria.

Mr McCullough—We do encourage the private gyms to participate in the same program or to set up their own programs. We facilitate them when they do that by advertising for them in the council's magazine. We will advertise private gyms that effectively are in competition with us. We figure that if they are providing community programs we will advertise and promote their programs in our magazine.

I would like to touch on another part of your question about how we develop infrastructure to take into account older people. Partly through our aged care strategy and partly through other strategies, such as leisure choices for older adults, we take those strategies and their findings and promote them internally within the council, for a start. For instance, council officers are preparing strategy or policy on infrastructure—whether it is for roads or even for our rubbish programs at the moment. We have a small project going to try and develop more user-friendly rubbish bins. We have had complaints that some people are finding the bins difficult to manoeuvre, so we are looking at developing a program to design something that is a bit more user-friendly for people who are physically not able to take their bins out to their front nature strip. We are promoting those concepts right through the council so that when our staff are doing strategy work or design work they have that in their minds all the time. Particularly where there is a disability issue or the access of a particular group involved—whether it be an age based group or an ethnic based group—they are considering those issues in all the work they do.

Ms McClean—Council is currently working with one of the local public hospitals to develop a proposal where, if someone has had a chronic heart failure, they can have a case manager who will guide them for a 12-month period, with the emphasis on activity and diet. The idea is that the person will plug into our leisure centres and have someone who will continue to motivate them for a 12-month period to work towards lasting lifestyle changes. The idea is to minimise incapacity through chronic heart failure and to reduce the potential for further admission into the acute sector and the potential for further reliance on the home care service.

Ms HALL—It sounds like a good program.

Ms CORCORAN—I have a final question regarding the role of agencies in finding an aged care place. This is an industry I have become aware of only in the last 18 or 24 months. For instance, one's mother-in-law needs to go somewhere; I ring up Joe Blow, who runs away and comes back with a place, or a series of places. Do you have any comment to make on that industry? Do you see it as useful or not useful?

Mr McCullough—You are really describing a brokerage service, I guess, for aged care facilities. One of the discussions we have had as a council was about whether there is a role for the council to act as, effectively, a broker for those sorts of services. There are some competition issues in that the service would be provided by private agencies but in future there may well be some role for government generally, in at least making those sorts of choices available and making the system a little bit easier to navigate. The fact that there is a market for brokers is a

bit of an indictment of our system. If it is so complicated that we need brokers to work the system, then there is something wrong with the system.

CHAIR—Thank you very much for speaking with the committee at such short notice. Thank you also for your submission and the copy of your strategy.

[3.19 p.m.]

FLORENCE, Ms Janice Marea, Information Officer, Paraquad Victoria

WEST, Ms Raelene Anne (Private capacity)

CHAIR—I welcome the representatives from the Disability Support and Housing Alliance to today's hearing. I remind you that the evidence that you give at this public hearing is considered to be 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. Do you have any comments to make on the capacity in which you appear?

Ms Florence—I work at a disability support organisation called Paraquad Victoria and I am on a committee at Building Commission Victoria called the Accessible Built Environment Working Group, which arose out of DSHA's interest in accessible housing and legislation towards accessible housing.

Ms West—Previously I was with the Australian Quadriplegic Association. I was providing peer support for spinal patients going through the spinal unit.

CHAIR—The Disability Support and Housing Alliance has made a submission to the inquiry and copies of the submission are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Ms Florence—Our concern has been as a support organisation for people with disabilities. It is very difficult to find accessible accommodation if you are a person with a disability. Usually it involves a great deal of expense in converting houses or apartments that already exist. There is not much funding for that unless you have transport accident compensation or WorkCover compensation. On top of that there is also the fact that the population is ageing and these concerns will become more widespread because people will inevitably, if they get mobility impediments as they get older, need to move house or need to have the upheaval of moving to a new community and will possibly need more services because they are not coping very well in their own home or may need to go earlier into a nursing home. That is sometimes the case even for younger people with a disability because they cannot cope in their own surroundings. We have noted that in the past 20 years there has been a lot of overseas legislation—notably in Britain in the last three years—to introduce a basic level of access to all new dwellings. There is also older legislation in other European countries and in the United States. We feel that it is time that Australia caught up with that and had a more just level of choice for people with disabilities and ageing people in the community.

There has been a lot of resistance within the building industry to such changes because of a feeling that they will be very expensive, but there have been studies to show that, once they are introduced at the building stage, there is not really a large expense and it would become less expensive as time went on. We feel that accessible housing would solve a lot of other problems that are not immediately obvious. Another important thing is that, once people have mobility impairment, they are also very limited in their ability to visit their friends and relations and to

stay at the houses of their friends and relations—they cannot get in the front door and they cannot use the bathrooms or the toilets—so this adds to their social isolation.

CHAIR—Do you want to add anything, Raelene?

Ms West—No, not yet. That is fine.

CHAIR—Thank you very much for your submission. We have had a number of submissions which have focused on this issue, including one from Jeff Heath in South Australia, who has been very passionate in pushing this issue. Do you have any estimates of how much it would cost to have new housing made to adaptable housing standards?

Ms Florence—There have been a few estimates. I have my information via papers from South Australia. There is one estimate that was made by a guy called Jack Frisch, who is an economist who has done a lot of work for the Physical Disability Council of Australia. His estimate is that, as it is now where people have to modify their homes, it costs them approximately $20,000 on average, with about $6,604 worth of financial assistance available from a range of sources. That has to mostly be met by the individual. Jack Frisch feels that, in contrast, if houses are designed sensibly during new construction, the total added cost has been estimated at less than $200 if a ramp is needed. Wider doors cost nothing extra. Only one entrance needs to be without a step and that can be accomplished at little or no cost on the great majority of building sites. Bathroom wall reinforcements require a small amount of extra timber while accessible placement of power outlets and switches costs nothing.

I have another estimate here from the South Australian Housing Trust. It estimates the cost to be in the vicinity of $3,000 and believes that costs are dropping because the features are becoming more commonplace. The modifications included in the project in this estimate included a stepless entry to front and rear doors, 900 millimetre clear doorways, a stepless shower alcove, trims for grab rails, flexible pipe work, non-slip tiles in wet areas, circulation space in various rooms and power points at an accessible height.

I recently spoke to someone from the Office of Housing in Victoria who has been instrumental in getting together designs for accessible housing as I understand that all the new housing stock is now built to be accessible. Through design they have built a house that is smaller in area than the normal houses they build, and one of the arguments people always make is that such a house would be larger in area and that would inevitably be more expensive. Good design has a lot to do with expense.

CHAIR—Instead of establishing a legislative regime, have you explored voluntary options through the Housing Industry Association, the master builders and so on?

Ms Florence—Yes. They are involved with the access to the Accessible Built Environment Working Group. A bit of lobbying went on before that group was formed. That is happening and that group has produced a publication called *Welcome*, which is aimed at builders and developers. It is a coffee-table book which gives a really good idea of accessible features. That is meant to be an educational tool. However, there still seems to be a lot of resistance. Melbourne City Council is also on that Building Commission group. It is making moves to set up a template for builders as an information education tool.

CHAIR—In your submission you mention the introduction of housing visitability requirements in different parts of the UK and Ireland. What does that involve?

CHAIR—Have they done that through legislation or regulation?

Ms Florence—Yes, through legislation and regulation.

Ms CORCORAN—I understand that your focus is on housing. However, are there comparable movements for commercial areas, shopping area and industry areas?

Ms Florence—That area has more legislation and movement at the moment. The Building Code of Australia is enshrined in law so basically builders are supposed to build new buildings that dispense a public service to a basic level of access. That is specified in the building code. The building code is being upgraded at the moment to a higher level of access because there has always been a bit of a discrepancy between the Disability Discrimination Act and the building code. You could build a building according to the building code, but you could still fall short of the Disability Discrimination Act and somebody could still lodge a complaint against you. However, that only applies to public buildings; it does not apply to private buildings.

Established buildings can sometimes be brought up to a level of access if there is a major renovation but there are what I call loopholes in the law that sometimes prevent that from happening. Because of the current system in Victoria where private building surveyors can approve planning permits, sometimes they are not interested or educated to access and it is not required. As a result, restaurants, shops and public buildings of various kinds are still having major renovations without access being introduced. That is quite frustrating because it means access is not becoming as widespread as it should be.

Ms CORCORAN—I know you came in while the Kingston council representatives were giving evidence. I do not know whether you managed to hear all their evidence but they talked about steps they are taking to cope with the ageing population. One of those was urban design. They talked about making neighbourhoods more livable for older adults, which I am assuming would also assist people in wheelchairs.

Ms Florence—Yes.

Ms CORCORAN—Theirs is still a pilot project; I do not think it has actually started yet. Are you noticing a trend towards more accessible buildings? Is it working? Are they addressing the right things?

Ms Florence—In buildings or in the outdoor environment?

Ms CORCORAN—Both.

Ms Florence—Under the building code, if a new building is being built, then certain standards have to be met.

Ms CORCORAN—My question is: are those standards things that you would like to see?

Ms Florence—Yes. On the other hand sometimes they are not met. Also, in the built environment, because things have been done to various standards over the years and standards have gradually been upgraded, there is such a huge variety—some places are accessible and some places are totally inaccessible. Even if, say, a footpath is built with a kerb cut, that does not necessarily mean it is useable. It can be quite dangerous because the gradient can be too steep or there can be cobblestones at the bottom. It is all terribly inconsistent, because there have been various stages of upgrading.

Ms West—They seem to be very slow in implementing them. The Disability Discrimination Act does not comply with the building code, so people do it at their own discretion, really. I think it is very slow in getting it through, basically.

Ms Florence—Local councils also need to upgrade the infrastructure, but that can take a long time. Also, lately there have been footpath trading policies—stuff has been moved onto the pavement to make access better for the public.

Ms CORCORAN—Is this something that is driven at the moment by local government? Should it be driven by Commonwealth government and state government?

Ms Florence—Which part of it?

Ms CORCORAN—The building design requirements.

Ms Florence—It really varies from state to state. In Victoria, because private building surveyors are approving building permits and then it goes to council, the council need not necessarily even see it. It is filed at the council but they do not necessarily look at it. As soon as they know that the private building surveyor has approved it, that is all they need to know. It used to be that they oversaw those things and regulated them. In New South Wales, they actually have committees in the local councils that oversee all planning permits that go through in regard to access. At the moment I feel that it is not overseen enough; it is not regulated enough. That is why in some cases access is not improving.

Ms CORCORAN—What I was really getting at was whether there is consistency across the state or whether if you go from one council to the next one you see big differences—

Ms West—I think it is very much based on council to council, depending on who is in there, because there is no uniform legislation across the state or any uniform guidelines; it is just done depending on which council decides to implement any compliance. If the council does not have any agenda or nobody is pushing them at a local level, most of the time they will just gloss over it.

Ms Florence—From my discussions with some councils, they see themselves as not adequately resourced to oversee planning permits to make sure that access is introduced et cetera. As far as the infrastructure is concerned, that is really variable too. Some councils are more interested than others, are more ready to upgrade and have disability action plans which say that they are going to do that at a certain rate. But other councils are very slow at taking that on board. The building code legislation is Commonwealth legislation but the actual approval of permits loosely goes through councils. At the moment, because private building surveyors are

overseeing that, councils do not always have much to do with it. But they do have to deal with the infrastructure.

Ms Florence—Yes.

Ms HALL—I am not even sure whether there is a requirement on local government and state authorities to have a disability/ageing access working party within their organisation in Victoria.

Ms Florence—In regard to housing?

Ms West—In regard to each council?

Ms HALL—Yes, in regard to accessibility to community facilities and then looking at housing.

Ms Florence—In regard to accessibility to community facilities, as I was saying, there is legislation through the building code covering any building that dispenses a public service. Councils can be asked to approve a planning permit or it may go through a building surveyor, so it is variable. They are not regulating or overseeing access much, except, if the planning permit comes to them, they may oversee access because they are doing a planning permit.

Ms West—Also, with this legislation coming in, it applies only to buildings that are built after the specified date, so then you get into the drama of what you do to existing public buildings and residential buildings that currently do not have any access. There is no funding anywhere and no-one is going to be encouraged to create access in any of those buildings.

Ms Florence—They can be required to do so if there is a major renovation, but there are all sorts of rulings. For example, if it is less than 50 per cent of the renovation you do not have to introduce access. If there is no change of purpose and if it is still retail—that is, if it changes from a shoe shop to a restaurant—you do not have to introduce access because it is still in the same classification, which is retail.

Ms HALL—Are there any models, advice or guidelines given by government or council on adaptive housing or on the most suitable style of housing to be built for people with mobility and other restrictions?

Ms Florence—Some councils are starting to take a bit of interest, notably in Melbourne.

Ms HALL—Is a model being promoted through the government or through anyone else? Are there incentives?

Ms Florence—I am on the Accessible Built Environment Working Group at the Building Commission. It has produced W*elcome*, which is a glossy book about access features which can be purchased by people in the building industry. The Melbourne City Council is probably the main one that is taking an interest and it is producing a template to be distributed to builders and developers. It is also going to build an environmental and accessible model house somewhere in West Melbourne, I think. That is the main one that has taken an interest so far.

Ms HALL—Have any incentives been put in place to encourage builders to build houses that are suitable for people with access and mobility problems?

Ms West—I do not think there are any incentives at the moment.

Ms Florence—No, not really, just trying to talk people into it through suggesting that it might be good business.

Ms HALL—So the message is that there is not a lot happening and that maybe we need to look at being a bit more proactive in that area.

Ms Florence—I believe that not much will happen until there are regulations, judging from experience with public buildings. I doubt whether anyone would have introduced a disabled toilet unless there were a regulation. That started happening only after legislation came in. There has to be legislation, and that seems to be the experience in overseas countries. There are other areas of expense that accessible housing addresses. If an elderly person with a mobility impairment or a person with a disability has accessible housing they are much less likely to be reliant on HACC services. If they can function independently in their own house they do not need those services. I function almost totally independently in my house because it is set up. But a lot of people who cannot afford it because it is not readily available—houses are just not built that way—put up with less than maximum access and rely on other people, including their family. There is a great strain on families and friends and on HACC services to do things for them that they just cannot do because of the way their house is built.

CHAIR—What are the most significant barriers to mobility for aged people?

Ms Florence—Being able to get around their own house, being able to use the environment, the streetscape, and being able to get to the local shopping centre. That also involves the means of transport that are accessible—accessible buses, trams, trains. Also, it is a matter of whether the public buildings that they want to use—shops, restaurants, shopping centres, government buildings, council buildings—are accessible; whether they can get in, use the toilet, move around inside. It also comes down to whether they can afford to buy the equipment that they need to help them get around—whether they can afford all of the aids that are necessary, some of which are less necessary if their environment is a bit more accessible, but they are still often necessary.

CHAIR—I have read your comments in the second part of your submission relating to accessible public areas and facilities. How are the Commonwealth government offices doing in this respect? My impression is that most of the universities and government buildings have been really trying to make sure that they have disability access.

Ms Florence—Yes. I would say places like Centrelink and universities are making a really big effort to be accessible. They pay a lot of attention to it.

CHAIR—Is there anything that you would like to add?

Ms West—From a disability point of view, what we have been experiencing in the disability community is what the ageing group is going to be experiencing on a wider scale in 10 to 20 years time. The same sort of issues that the disabled are facing now will be faced by the aged

group in about 10 to 20 years. Increasing the time that they can stay at home, increasing house accessibility to keep them out of nursing homes longer—those issues will affect the aged. It is the same sort of line that the disability community is trying to achieve in the same ways.

CHAIR—I think that is an excellent point. You mentioned shopping centres. What has been the experience there? Are the newer shopping centres which are being built—

Ms Florence—It is really variable. Some of them are good. In my job I will get a phone call from somebody saying, 'There's this new shopping centre but the lift is too small or it doesn't work for me.' Sometimes they still get things wrong in some instances.

Ms West—Strip shopping centres are harder to access. Somewhere like Brunswick Street or even Fitzroy Street are harder to get along, whereas Chadstone is not as bad now; they have disability parking now, lifts and wider doorways. There is easier access to those services.

Ms Florence—You also find, exasperatingly, that new cinemas are built that you cannot get into. It still happens sometimes. I feel it is to do with the way planning permits are regulated at the moment.

CHAIR—Thank you very much for appearing before the committee and thank you for your submission as well.

Resolved (on motion by **Ms Hall**, seconded 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.

CHAIR—I wish to thank all of the witnesses who have appeared before the committee today.

Committee adjourned at 3.45 p.m.