COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

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

TUESDAY, 20 MAY 2003

BRISBANE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Tuesday, 20 May 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 Hall, Mr Hartsuyker and Dr Southcott

Terms of reference for the inquiry:

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

WITNESSES

Committee met at 10.05 a.m.

KENT, Ms Natalie, Manager, Finance, Governance and Community, Local Government Association of Queensland Incorporated

LEYLAND, Mr Mark James, Finance and Governance Advisor, Local Government Association of Queensland Incorporated

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Ageing as part of our inquiry into the long-term strategies for ageing. Today we will hear from the Local Government Association of Queensland, the Australasian Centre on Ageing, the Council of the Ageing National Seniors Association and Mrs Delaune Pollard of the Allen Cognitive Advisers Network. The committee has heard in other hearings of the need for strategic future planning for the provision of healthcare services and the mental and physical conditions that may affect older Australians. Today's witnesses will assist the committee with insights into the experience of Queenslanders in addressing the challenges of ageing.

I welcome the representatives of the Local Government Association of Queensland. I remind you that the evidence 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. The Local Government Association of Queensland has made a submission, No.123, 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?

Ms Kent—The Local Government Association of Queensland represents 125 councils across Queensland, plus some member Aboriginal community councils. Queensland has the most decentralised population of the whole of Australia. It is very vast and is quite different to operate than most states, including Western Australia. We have a totally different make up of community and demography. It has the highest population growth in Australia. It has been 2.3 per cent according to ABS reports. In 2000 there was a higher proportion of over-65s living outside the capital city which, with our diverse area of landscape, makes it a real challenge. The trends for 2021 still show that the communities with the highest median age groups are rural and remote communities. There is a decline in the rural communities' capacity to support the elderly and there is also a decline in the professional expertise in rural and remote areas. This decline is now also being seen in the outer metropolitan areas.

The issues regarding the ageing are both specific and varied, depending on the location of the local governments. Local governments can deliver services for the aged, however, they would like them to be fully funded, including all administration and overheads. They would like to see the application, reporting and acquittal red tape reduced and they would like to be able to employ professional staff and management. These are some of the greatest problems for the outer areas.

CHAIR—Thank you. You have highlighted the issues for local government here in Queensland. Have any local councils done something like the Intergenerational Report and looked into the future about what the impact is likely to be on their own finances and their ability to deliver services?

Ms Kent—Certainly we did ask some councils that particular question and in general the response has been that councils really do not have a lot of the tools. Some councils, particularly large ones—Brisbane, Gold Coast and the other major centres—have done some work. They are very aware of the problem but a lot of them have not got any strategies on how they are going to deliver services in the future. Also, most of them do not have the professional people that could do the planning to build those strategies.

CHAIR—Considering you have mentioned how decentralised Queensland is, what are the particular issues facing local government in Queensland? Obviously you have got major councils like Brisbane and Gold Coast and so on but do the regional centres have particular problems in dealing with ageing in their communities?

Ms Kent—They certainly do. I can give you one particular example that I am fairly close to because I was at Cloncurry in 1991 when they concepted to put in an aged care hostel called William Presley Place. I refer to some paper clippings dated 13 May 2003. Not 11 years on, that centre is now closed. There was a requirement from new legislation to upgrade—there would have been $1 million upgrade. It is only a 15-bed facility and there is no possibility of that ever running at break-even or even as an operation slightly obligated to community services. They went to Blue Care to see if they would run it for them. Blue Care needed $300,000 per annum for the 15-bed facility. It is a small community. It is one that is growing—it has some mining there—but the ageing population is not growing so they could not sustain for a long time a 40-bed facility that might break even. They have problems with getting staff to manage it, and that is one of the greatest issues.

Local governments also have another problem that is not just with managing those services. We are losing CEOs in the west. The ageing CEOs in western councils are retiring and the professionals are no longer willing to move to those areas to fill the gaps. Small councils are starting to offer packages of $120,000 to $125,000 to try to attract CEOs—funds that they cannot afford. So they cannot provide extra services for the ageing when they are struggling to do the basics in administration and management in their own areas.

With regard to William Presley Place, originally when I was there we had difficulty getting someone to manage that facility. The closure of that has been a culmination of a number of things, for example, not being able to get someone to manage it. The original facility probably was not exactly what it should have been. Now that it has come to need upgrading they have not been able to meet the funding of that upgrade, and they still cannot get staff. They cannot get professional nursing staff even to look after the people in facilities like this. Blackall is just getting a facility, and one would hope that it is not going to be the same problem and that in 11 years time that facility will not be closed down because of the local community's inability to keep up with funding and to keep up with professional people.

Local authorities feel that one of the solutions to the problem could be some sort of partnership between the Commonwealth, state and local governments. They believe that the Commonwealth's role would really be to do with the capital outlays. The state role would be operational funding, and the local authority—this particular one—would be willing to pay for the bed licensing. They said that they could put out the $750,000 just to keep a facility going but they cannot manage, without some help into the future, the ongoing costs needed to get the professional people there.

The other issue with the west is where the population actually is. I did some quick work on this because, yes, there is a huge growth in the south-east corner but there is growth in all areas of the population. But in the west and the remote areas the elderly people are staying while the young people are leaving and the growth there is quite phenomenal for 2021. Councils are going to have populations with a median age in 2021 of 49 and over—and there is quite a significant list of them. For instance, for Mount Morgan in the year 2021, 37.7 per cent of the population is predicted to be 65 plus. Only one of those councils that I have listed there is actually on the coast—Redcliffe. All of the others are rural councils.

CHAIR—Could we have a copy of that so we have it in front of us?

Ms Kent—Yes. I will give you these papers.

CHAIR—Thank you.

Ms Kent—To give you an idea of the remoteness of those councils—I have listed five of those councils—we are talking about trips to the coast of 405 kilometres or five hours 40 minutes with no breaks. If they need to come for care, particularly care for cancer and those types of things, those are the trips that those people have to do. I have a whole list here. Warroo is seven hours 20 minutes in travel by road. If I show you on the map it is a little easier to see what I am talking about it. I have here a map of the state of Queensland. The areas I have coloured pink are where the medium age of those people after 2021 will be 49-plus years. The average across Queensland will be 40 years. Those areas are the ones that are a little bit closer to the coast. There is only one that is coastal, which is Redcliffe, but the areas are quite some distance from the coast.

In addition to that, I have had a look at one of the western areas. I went right out to the back of the state. It got quite interesting when I went through these. As I looked through these shires, just by looking at the name of the shire before I got to the number, I was able to tell whether it was going to be an extremely ageing population or not just by whether they were in sheep, cattle or broad-cropping country. I decided to have a look at what is happening out there to the male population in terms of ageing as well. I did that sample that is in these papers. You will find that, across Queensland, about 45 per cent of males were over 65 in 2001. In these areas, about 57 or 51 per cent—the highest is 88 per cent, which is in Isisford—of the male population is 65-plus in those areas now. They are staying there. It may be the case that a lot of them either did not get married or, when they became widowers, they stayed. When the women have been widowed they have gone to the coast or somewhere else. But certainly it is a problem because to deliver the services to those aged gentlemen in those areas is quite different from delivering services to aged women or aged couples.

Ms HALL—It is extremely interesting that, in that community where 88 per cent of the men are 65-plus, only 13 per cent are women. If you compare that with demographics generally where there are a lot more older women than older men, it really says something about those communities and the needs of those communities.

Ms Kent—It certainly does. None of those shires out there have any ability to do any planning on this. Most of them are very small shires.

Ms HALL—How big would that shire be?

Mr Leyland—I would have said that, in the shire—and this is just seat-of-the-pants stuff—there would certainly be less than 2,000 people. As I recall, Isisford is scattered over three or four small villages. It does not really have a major centre. Being south of Longreach, they would look to Longreach for most services.

Ms HALL—How far is Longreach?

Ms Kent—It would be 100 kilometres.

Mr Leyland—One hundred-plus.

Ms HALL—I know that Longreach has problems with allied health professionals and with providing services to older people in its immediate vicinity.

Ms Kent—Certainly with regard to transport as well, Longreach has now been reduced to one air travel per day. That comes in at six in the morning and leaves late in the afternoon, I think. It used to be twice a day. It has now gone back to once per day. We had a case recently, and it was not to do with elderly people, in a remote area where LGAQ brought back with them two people who could not get on a flight out of those areas. We had two seats on the charter plane that we had and there was someone in their family who was desperately ill. That is the problem with the west. And this has been going on for quite a while. The shires do raise this with the LGAQ on a regular basis. I put in a little piece from Tara and it goes back from 1997. They were talking about housing for the aged. They said this:

> Aged lifetime law abiding residents are forced to become residents of Homes in regional centres away from their relatives and this can then be seen as regionalisation in its cruellest form ... people who have been community minded and worked for years for the betterment of their town ... have to relocate when they are less able to cope ...

Tara is a very small place. They could not come up with a 40-bed home to put these people in. They would not have cost effectiveness and economies of scale.

CHAIR—Do you have many aged care facilities in Queensland which are co-located with community hospitals? For example, would they have a community hospital in Cloncurry?

Ms Kent—They do have a hospital in Cloncurry. This was not with the hospital. The hospitals are now being wound back, of course, and their services are not anywhere near acute care any more. They are very basic care. Places like Kingaroy and a few of those places do have them. Hervey Bay is a place where they have really gone after the business of the ageing. Even if you have a look at their demographics, their aged population is not anywhere near that in the bush. They are building their economy around the ageing.

CHAIR—In other states rural communities do have collocation—within the community hospital there are some aged care beds as well. Is that common in Queensland?

Ms Kent—It used to be, but it is not so much any more. They are winding back the services. A few of those communities are trying to do that. Nanango wanted to do that with their hospital.

They wanted to change it from a day-to-day hospital to some palliative care type of hospital for the aged and the rest of the community. A lot of the communities are challenging that because they see it as losing their hospital from their local area. They do not want to go 15 kilometres to the next hospital. In reality the health services cannot sustain all of those tiny little hospitals. They really have to regionalise those. Fifteen kilometres is not really regionalising. If they could change those hospitals to these types of care centres, it would make a big difference, but the communities are resisting that.

Ms HALL—Thank you for your excellent written and verbal submissions. It is good for some of us who live in cities to learn about the problems that people are experiencing in rural and remote areas. I will first ask questions that go to the current operation and then I will ask you for some examples of innovative programs, approaches and strategies that have been adopted in some areas. It was good that Andrew finished there because he was talking about community hospitals and attaching aged care facilities to those community hospitals. Are you finding in those rural and remote centres that some of the problems—in your submission you talked about cost shifting—that are associated with providing aged care beds relate to the fact that health is provided by the state and aged care is provided by the Commonwealth? Looking at what you said a moment ago about how there should be a partnership between all levels of government, do you think that rather than a partnership there is an attempt by levels of government to shift responsibility to each other?

Ms Kent—Mark has worked on cost shifting so he may be the best person to answer that.

Mr Leyland—Stepping back a little bit, the role of local government in Queensland has certainly expanded a lot over the last 30-odd years that I have been involved with it. We are no longer just roads, rates and rubbish. A lot of the additional operations and activities that local government participates in are a result of a community need arising and it not being addressed by other levels of government or by commerce, industry and business. We have instances in Queensland where local communities bought a hospital, medical centre or whatever in an effort to maintain reasonable services for their communities. They have bought schools and they have done all of these sorts of things.

Ms HALL—Do you have examples of that?

Mr Leyland—Certainly. Kingaroy Shire has bought the local hospital. I think it was a private hospital and it has bought it and it is maintaining it as a medical centre. In Charters Towers the two local councils have bought schools. That is an economic development and a community exercise because it is important to those areas.

Ms Kent—Nanango also bought some housing that the mine had which it was not using any more. They wanted to turn those houses into aged facilities and they could not get the $60,000 out of the state government that was needed to change them from one bedroom to two bedroom units so they would be suitable—

Ms HALL—Could you send us written information on those examples?

Mr Leyland—I guess it is aged care along with child care and a range of things that are not central to all local government. You will find that this is something local governments are

addressing when a community need arises. The point of our submission to the cost shifting inquiry is that by default local government has been the level of government that has had to address a lot of these issues and, as we are focusing on age, we can do that here today. The sorts of responses from local government have been in the form of housing, accommodation and senior citizens' centres in places that can afford that. There may be some subsidies for the capital outlays for senior citizens' centres but I am not aware of any subsidies for operational areas—not from the state anyhow. In some communities, local government has become involved in home and community care programs and they auspice those. There are different responses across the state.

Ms HALL—Are they being funded for that?

Mr Leyland—Yes. I have not heard that things are quite as bad in Queensland as they are in other areas I have read about in submissions to the cost shifting inquiry. I think the demand for the services in Victoria is exceeding the amount of funds coming from the other level of government and the local community is having to not do some other works because their funds are being caught up, and necessarily so, in these home and community care services. I will need you to prompt me again about what you are really after; I don't know whether I have helped you with that.

Ms HALL—You have helped me. Who is providing day care and dementia services throughout these rural and remote communities? Are they being provided? What sort of access is there to those services? Once again, is the responsibility for providing those services being shifted from the Commonwealth and the state to local government? It is probably more Commonwealth there.

Mr Leyland—Generally speaking, from my limited awareness of this, I would have thought that community organisations, charities and the like might have taken a role in that and they are well supported by local government. However, I am not aware of any councils that would be taking a direct role in providing anything more than perhaps a base or a venue for respite care. I seem to recall that Dalrymple Shire has a respite care centre in one of its buildings, but I am not aware of it being a common practice.

Ms Kent—You are right, Mark. Kingaroy also provide respite care through their community building and they have a community group that is very supported by council that actually runs it, and council feeds the funds through it.

Ms HALL—Does the council fund that?

Ms Kent—The funds flow through the council. They do not fund it; the funds actually flow through them so that they support the community group to get the application and the services. The people working for that service are not working for the council, they are actually working for the community group, but it is certainly leaked through the council. Centres that are smaller than 15,000 people really do not have respite services; they are left to family and friends, and if that is disjointed you will find them pretty much in a poor state. Places like Townsville that run the Home Assist Secure services regularly run out of funds. The funds are coming through the state to them and often they have to top up that service. When I was there, we were topping it up to the tune of $30,000 to $50,000 each year and that was by putting the brakes on it at about

March. The senior community were not getting a lot from March to June because the funds then had to come out of councils and that meant cutbacks in services.

Ms HALL—Another area that I am quite concerned about is that these rural and remote communities have a doctor shortage.

Ms Kent—That is correct.

Ms HALL—Combining that with the lack of facilities available for the ageing population, how are these communities coping with that?

Ms Kent—Some of them do not have the services locally. They have to travel substantial distances to get people to the services. The services have just gone and they have been gone for a long time. When I was in Cloncurry in 1991 we could not get a dentist. They did have one in Mount Isa, which was an hour and 40 minutes away, which was not too bad. What happened at one time was that an Irish girl came over and she was on a work visa. She was an excellent dentist and was in that town for three months, but her visa ran out and she had to go back. The same thing is happening with doctors: they are getting doctors like that on work visas but their time ends and they have to go back. No-one wants to go there. One of the other issues with that is that most of these people have partners who are professionals. In those communities, those partners cannot get work so that is another thing that ensures that it is not for them; it is only the very dedicated people who want to go.

Ms HALL—What about the delivery of community aged care packages out in those areas. Are people able to access them or not?

Ms Kent—It comes down to what I talked about before. You have a local authority that does not have a lot of staff—everybody has to do everything. You do not have any aged care officers, any social planners or anyone working in those fields. In a small community it is usually the administration staff that pick that up and run with it. When we did the William Presley, it was born out of an idea. We went off and did an application and we were successful. There was not a lot of planning around it; there was not anyone in the council that really had the expertise in aged care that looked at it. We just knew the community needed it. Unless those councils have somebody that actually just wants to take this on board as an extra job that they do in their day, it is not going to happen.

Ms HALL—Do these communities have Meals on Wheels?

Ms Kent—Some do, but certainly not in the really small ones. As I said in my paper, the volunteers are now the aged. They cannot be the volunteers anymore and they have moved on in the community. You are left with the people raising children and the people trying to pack away some money for their own retirement, and that is how the communities are made up.

Ms HALL—So there are rural and remote communities that do not have services. There is a shortage of health services. There are no residential aged care facilities. There is no delivery of aged care packages because of the remoteness. Even basic services like Meals on Wheels are not being delivered to these communities, so they are an area of high need. The federal government

needs to have targeted programs to address the needs of these communities. Would that be a fair summation?

Ms Kent—That is right. They are really having difficulties out there delivering. The answer to delivering those services is not easy either. Strategies need to be developed to do that and to boost those communities somehow.

Ms HALL—Would you like to expand on that? We will move to the phase I indicated at the beginning and talk about strategies that could be used to turn this around. Also, do you have any examples of innovative programs that have been implemented in those areas?

Ms Kent—Going through the demographics, you can see that, when any of the communities have had some little boost through mining or something like that, it has really made a big impact on the demographics of that community. You can see which communities are growing and dying by those little injections that are coming in. If you could find some way to stop the death of those communities and keep some people there, you would have some sort of support mechanism. While all the younger people are going, there is no support for the ageing who are staying. That is hard to resolve. Financially, how you do get professionals and keep them out there? We are even looking at CEOs at the moment, because with them we have the same problem of how we are going to do this.

We are looking at resource sharing at the moment. There is the distance factor as well. Some councils have been sharing their environmental health officers for 10 or 12 years because not each council can get one. The officers move around and they might have to drive 200 or 300 kilometres. They feel as though they have been everywhere in a year, because they are moving all over the place. That is the type of innovation that local governments have tried to come up with for services in other areas. Whether those sort of things would apply to health services in those areas, I do not know. Travel takes so much time out of their day, when you are talking about this kind of travel. It used to take an hour and 40 minutes, if you got a good run from Cloncurry to Mount Isa, to go to health services when I was there. It is reasonably close compared to a lot of these people.

Mr Leyland—One of the thoughts that crosses my mind is that it is not just about aged services but about a whole range of community services in those smaller places. We have seen examples—as I say, it is not about aged—such as this one about child care. I heard that on Mornington Island, which is a very small and remote community, they have issues with alcohol and a whole range of social issues. They had quite a successful childminding group that did not meet the sorts of standards that you might see applied in a capital city or a major urban centre, but it had the benefit of involving a lot of the mothers and other people in the community. It had the advantage of keeping children at school. Someone inspected it, I gather, and determined that it was not meeting the sorts of standards that were applied across Queensland.

Ms HALL—It was probably culturally appropriate, though.

Mr Leyland—It was closed, and the principal at the local school reported more absenteeism. The police had more trouble with crime, with people being drunk on the streets and all of the rest of it. Translating that into the sort of thing that we have been talking about, it seems to me that a strategy might be for the professional people who are involved with aged services to look at the

standards that might be required in a small rural and remote area—not to downgrade those services but to have an appreciation of the ability of the community to provide them. They should also consider the other support mechanisms that might be in the community for the care of people and the result of closing them down because they do not meet some high point.

Ms HALL—That is very good. Thank you very much.

Ms Kent—I am smiling, because I am thinking back to the days of the place in Cloncurry that I talked about—the facility that had what we called four mud huts. They were like little concrete rooms with a bit of a veranda on the back. There was a community toilet and shower. Four elderly gentleman of the community used to live there. They would pay $10 a week in rent. I can remember there being a big council argument about expenditure on fans to go into those buildings. They were on the western side of town and they were as hot as hell. They just had louvres and a tin roof. Would you believe that the William Presley has closed down, those four units are still being used and the rent is now $15 a week? The thing that we put in place to try to get the people out of those conditions is still going. Legislative compliance does not apply to them because they are just like little units, and because this was a facility it had to close down.

Cloncurry in particular does not want unsafe conditions. A strategy needs to be built into the regulations—and I am sure that that can be done—to ensure these things are designed so that there is not a high cost in meeting the standards and so that those communities can keep on as they are. The impact of that particular thing on Mornington Island has certainly been devastating. That is having an impact on the community. Certainly, the state government are realising that one size for Brisbane does not fit all. That is why they are trying to encourage local government to provide a lot more insight into the needs of rural and remote communities. That is particularly why I did a lot of work on those. Originally Brisbane City Council were to talk to the committee. They would have given you a very good idea of what is going on in the bigger places and along the coast—that is, how the bigger councils are able to deal with the problem. But it is the little ones that do not have the resources, that do not have even the planning resources to be able to think about this problem, that we are very concerned about.

Ms HALL—You have certainly set us a few challenges at the federal level. We need to give rural and remote areas the same recognition.

Mr HARTSUYKER—You mentioned cost shifting. Do you believe that you are getting an adequate share of the GST to meet the range of services that you are being called on to provide? If not, what should that improvement in funding be?

Mr Leyland—I am pleased to have the opportunity to sing again this song that we have in local government. Certainly, the pressure on the local government rate revenue is reaching an extreme point. Generally speaking, across the state of Queensland most councils would say, 'The moneys that we might have to apply to new activities are only going to come at the expense of some existing service that we will have to cut back.' There are no extra rating funds in the community, on average, across Queensland. Most councils would say they are rating their communities to capacity. As for cost shifting to local government, I concede that over the last 10 or 15 years in only a minority of cases it has simply been moved from one level of government to us. In other cases the issue has been increased standards. Things like environment protection, workplace health and safety, accounting standards and planning have required local government

in Queensland to expend huge sums of money, basically out of their rate revenue. It has not really been supported by funds from the upper levels of government.

So the squeeze is on in local government. It has long been the argument in local government that the financial assistance grants should be a growth revenue stream, and they are not. If they are held at real terms levels, we think we having a bit of a win. Certainly the view of local government is that there is a need for those sorts of funds to be linked to the growth in GDP, income tax or whatever it might be. As I recall it, the first federal assistance grants to local government, back in the seventies, were supposed to be about two per cent of personal income tax. Over the years that dropped back to 1½ per cent and then it became a fixed amount that was simply maintained. With greater funding, local government would be in a far better position to provide the sorts of services in different ways across the state that communities in different areas are looking for—picking up some of things that are obviously in decline because we simply cannot afford to do them as well as all the other basic things that we should be doing. So cost shifting is an issue for councils. We would welcome the chance to advocate anywhere the fact that funding to local governments should be the same as for state and federal governments—it should be a growth revenue stream.

Mr HARTSUYKER—There is fairly strong migration, particularly to south-east Queensland. Does that provide problems, specifically related to ageing, for local governments in south-east Queensland?

Ms Kent—I have had a look at this through the demographics, and it would do, because it is expanding—you have 20 going to 30. But you also have a pretty much even intake of people, not just the aged. They are coming from everywhere. They are coming from down south, they are sending them from Victoria in hordes, and they tend to be of all ages. We have had a look at Brisbane and in 2021 the aged will be just under the average for the rest of the state. So it is not building up. I have had a look up the coast, and it is not building up. The people who are coming represent a range of ages, not just the aged. Certainly there will be a press on for aged care services. But everything will have to expand at the same time. Child care, schools, hospitals and transport will all have to grow. It will not be pitched just at the aged in the south-east Queensland corner; it will be steady as you go for everything. Whereas in these other areas that we are talking about, that particular age group is going to go up and other things will probably come down.

I want to go back to what Mark said: we are talking about local government and how much revenue they raise. In Queensland 80 per cent of their revenue comes from rates. I think the average across Australia is 90 per cent. So councils do get from the community, and from their user-pays system, a substantial amount of their revenue. The FAGs were 1.2 per cent of federal income tax in 1993. In the budget that just came down it is now 0.9 per cent. So it is falling away as the national tax rises; it is not staying constant.

Ms HALL—So you are saying that the federal government is giving less money to local government?

Ms Kent—It is not less, but it is a lesser proportion of their whole ticket item. It is going down. It is now only three-quarters of the whole pie in 1993.

Ms HALL—So local government is being asked to fund more and as such it has to ask the community?

Ms Kent—That is right. So if everything is growing at equilibrium, in reality council is now only getting three-quarters of the funding that it was getting in 1993 to do those services.

Mr HARTSUYKER—How is the funding that you receive from the state government made up? Is it through specific purpose grants?

Mr Leyland—It is through subsidies and specific purpose grants. In Queensland it is mostly directed towards capital works. It is probably skewed a little in Queensland because of the relatively good subsidies we are getting for water and sewerage type activities.

Ms Kent—In Queensland too we have skewed it a little ourselves, because a lot of councils have tried to match the pensioner rebate the states have put in. In Queensland, we gave $30.345 million in 2000-01 and about $31.475 million in 2002-03 in rebates to pensioners across the state. When you are talking about the growth in those, those people are putting the pressure on local governments as a squeeze too, because they are becoming a bigger proportion. How do we pull back from this?

Ms HALL—It is hard, isn't it?

Ms Kent—At the same time, property values are going up where these pensioners live, because a lot of them are living on good, prime land, and they do not want to move. So councils are saying, 'To try to counteract that, we will try to give them a bigger rebate.' So it is pushing them into a bigger problem.

Ms HALL—Is that the discretionary component that councils give to pensioners, as opposed to the amount given by the state government?

Ms Kent—That is right. They try to do it as community service obligations. The rising land prices and the reduced capacity to pay of the elderly have ignited the rating burden debate in local government. I took a couple of things in the last couple of weeks that we talked about in the newspapers. One says:

Caloundra pensioners are seeking a rates rebate concession increase in response to hike in rates charges.

One from the Gold Coast said:

... rates were increasing so that the Gold Coast City Council could 'price people out of their homes for development purposes.'

These are coming from the aged. Another one from the Gold Coast said:

... Gold Coast City Council has rejected the call by the Concerned Ratepayers Group for either a rate freeze or an averaging method to calculate any rise. The rise in property values in the area has seen unimproved capital valuations increase significantly and the Group says many retirees and pensioners are being forced to move elsewhere.

So that is the impact on here. There is a local government election next March, so we are seeing this swell of people. Councils are having groups pitched against one another. The elder people are saying they want more, and the others say, 'We don't want to carry the burden.' If you take it off them, where do you put it—on the families with young children or the people trying to save so that, when they get to be retirees, they do not end up in that position? That is the quandary councils are in at the moment.

Ms HALL—It is very difficult.

Mr HARTSUYKER—There are two issues. One is that you have this tendency for younger people to leave, leaving the elderly back in those isolated areas. The second is then retirees moving a long way from their support base. In both cases, potentially you have retirees with no immediate family nearby. Is that causing a major problem for planning in Queensland?

Ms Kent—It certainly is. From my experience in Townsville, one of the biggest impacts on the Home Assist Secure services was exactly that. The people who were living there—the elderly people—were starting to become disabled in their own homes, and their children were in Melbourne and Sydney and we often could not contact them. They had no support families. On top of that, we had a lot of migrant families who had never had children or whose children had moved away. They did not even speak a lot of English and they were starting to age. They were causing a big problem. I do not know what it was like in Mackay, Mark. You probably can give a bit of an idea on that.

Mr Leyland—I worked for Mackay City Council for 15 years until recently. The thing that we noticed as much as anything was in the local senior citizens centre that we, with the community, constructed originally back in the seventies. By the mid-nineties the membership of the senior citizens groups had expanded so much that we had to double the size of the senior citizens centre. We were very fortunate in Mackay in that there was a very strong committee—people who were recently retired ran it, and so on—so the immediate impact on local government was only in providing the capital and the management of the building project.

The other thing that was a little different in Mackay was that we had 47 to 50 age pensioner accommodation units and, once again, we were on a replacement plan with a slight growth in those as the accommodation became aged in its own right. We relied on grants to replace them with modern, disabled accessible accommodation, while trying to make sure that the tenants were able to stay in the home for longer. Generally speaking, in a place like Mackay, and this is probably so in Townsville as well, there are very strong community based organisations—Meals on Wheels, blue nurses and other organisations providing nursing and visiting services—that provide services to people who are housebound. The library has a housebound service, for instance, whereby volunteers select books and take them out to people who cannot get away from the home. All those sorts of services are more community volunteer driven, rather than being direct services provided by the council. I would say that most councils would probably prefer to be in that situation, whereby they provide some facilitation for these services without actually providing them directly.

Ms Kent—You will find particularly in Queensland—Hervey Bay is another one that I have talked about before; it has really built its economy around the age retiree—that a lot of retirees come from Victoria and New South Wales. Through the wintertime they have come up in their

caravans—they have been doing it for years and years—and eventually they have bought a house in the Hervey Bay area, knowing that there are aged care facilities that they could move through into hostel situations and then into proper care. A lot of them do not have relatives locally. Their relatives are down in Victoria or Sydney, and they do not get to see them very often. With those homes, once people go into care they will not get a lot of visitors. You have 90-bed homes there and you would have only four or five people that would be getting visitors on a regular basis, because most families are so far away. They have come to the point where they do not want to be moved back. The weather is much better for them up here and if they go home they will not have these services. I would say the strain on the services in Victoria and New South Wales is just as great as it is up here, so how do you get them in?

Ms HALL—I would like to go in a different direction and come to something that you have not addressed in your submission. It goes to the planning role of local government in determining land use and making sure that the proper infrastructure is in place when permission is granted for development in areas. One of the problems that are fairly prominent throughout Australia, a problem which is linked to that planning role, is that aged care beds are approved by the Commonwealth and then, when it comes to actually transforming those beds from being approved on paper to actually being built, there are long delays—and we all hear about phantom beds. Do you think that process would be improved if local government were involved somewhere in the initial process, as opposed to being asked to approve the building of facilities once beds have been allocated to an area? I know that in my own area quite often there will be issues of environmental sensitivity: the land that has been identified to build the facility on is totally inappropriate, and then you end up with a community which is desperately in need of having these aged care beds put in place losing those beds in effect because they cannot be approved. What role do you see for council in that approval process and what role do you see for council when new subdivisions and developments come into being to ensure that those communities, particularly if they are geared towards attracting an elderly population, are going to have the infrastructure and facilities that are needed?

Ms Kent—I can probably talk about this a bit because I have seen some of the work that is being done. They are saying that there has been about a two-year delay because of a whole heap of planning issues and then the beds slip away, I think, at the two-year mark or something. So that is what you are talking about. Generally, in Queensland, local government is more involved in town planning, for want of a better word, than other states are. In New South Wales it is really a state activity, whereas the undertaking of that planning scheme and the development of it should really be a local government activity, then it should be approved by the state. It is about getting that into the planning scheme. Councils in Queensland are just renewing their planning schemes under a new law.

There are councils which, like Redland, see some growth for ageing—they are seeing it as a growth industry. They want passive industries; they do not want heavy industry in their areas. So the ageing industry is attractive for them. Those councils are trying to do something about getting those processes up and going. But, certainly, you are right about sensitivities regarding trees and other things. I will say it openly: if you had to compare trees and koalas against ageing services, in a lot of cases the trees and koalas would win.

I guess it has to be a whole-of-government approach. It is not just about the ageing; it is about the whole community and how you balance keeping the natural environment as you want it and

servicing the growth. In terms of the growth of south-east Queensland, Redland are one of the areas that have to take a lot of people—I think they have to take in 47,000 people in the next four or five years. So they will be looking at more small development, and aged care suits that type of area. But they want to go back and put that in amongst the areas they have already developed; they do not want to go out into the undeveloped urban footprint. They want to stay in that footprint, but, of course, in housing aged people in those kinds of areas, packing them in is not necessarily the best thing to do. So, certainly, the planning issues are there.

I do not think they have a lot of solutions. A lot of them do not have the social planning people that they need to have working on the ground within their planning schemes to get this to work. They are planning quite well for a lot of the other things—for basketball courts, recreational usage and those types of things. Certainly, water and sewerage is now becoming a bit of an issue when it comes to where you are going to put the developments, and so are buffer zones and things like that, so planning for the ageing is a problem.

Also, the councils here, particularly Brisbane City Council, looked at the issue of affordable housing. They tried to get the state government to bring into the planning requirements an infrastructure charge that would fund affordable housing and that could be put toward these types of things. That has been canned at a state level. They do not want to impose that on development. Again, it is about how you balance that and who should actually pay for affordable housing for the rest of the community—whether that should be the people who can afford to have housing or the federal, state or local government. Those are the issues.

Certainly, planning for the ageing is a critical issue that has not really been looked at by too many people. Brisbane have probably had a reasonably good look at it, because they have the resources to get on top of it. Most of the other councils are just developing a brand new planning scheme that was supposed to be up by March—and I think it has been extended to next March—and they probably do not have any ground specifically earmarked for ageing.

Ms HALL—Linking in to that, are there any initiatives that local governments in Queensland are taking to encourage the development of adaptable housing that is suitable in design for older people and then building those in new developments and new areas?

Ms Kent—It has probably not been specifically targeted at the aged; it has probably been specifically targeted more to people with disabilities. There have certainly been some nodes. Townsville undertook some developments. I think that would probably have been federal money. When they did the Building Better Cities program, they wanted to renew some areas and they looked at fitting out the ground floors of those two- and three-storey units for people with disabilities. So they were not really targeted at elderly people.

Probably the closest you will get to that is the Aurora development down at the Gold Coast, which they class as a child-free zone, and they are trying to really develop that. But, of course, they are having trouble with people bringing that up as being discriminatory, when it can actually be seen as positive, rather than negative, discrimination towards those people. Affordable housing was certainly raised as an issue, and it is still on our Local Government Association agenda, which would be the closest anyone has coming to targeting how we get some funds and then asking, 'What is the strategy and what are we going to do with it?' I guess a way of funding it is the start. It is great to have great ideas, but if there is no funding mechanism

and the councils cannot see one then they will not develop any further strategies. But once they get the funding mechanisms in place they are probably much more encouraged to go off and start to earmark areas and undertake works.

Mr Leyland—I want to make the comment, though, that in the redevelopment of the pensioner accommodation we had in Mackay, of all of the units that were built—I think there were nine renewed in one complex—some were wheelchair accessible and disabled accessible and all of those sorts of things but all of them were constructed so that they could, with minor modifications, become accessible for disabled people. So as a standard in Mackay, any pensioner accommodation that the city is involved with is going to be easily converted as people age, to look after them. They will not have to move out to some place that they will be able to get around in.

Ms HALL—That is good.

CHAIR—Thank you very much for your evidence today. Is it the wish of the committee to authorise for publication submission No. 152, which is an additional submission from the Local Government Association of Queensland? There being no objection, it is so ordered.

Proceedings suspended from 11.07 a.m. to 11.35 a.m.

BARTLETT, Professor Helen Patricia, Director, Australasian Centre on Ageing, University of Queensland

WORRALL, Associate Professor Linda Elizabeth, Communication Disability in Ageing Research Unit, University of Queensland

CHAIR—Welcome. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament, and therefore that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The Australasian Centre on Ageing has made a submission—submission No. 108—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?

Prof. Bartlett—I would like to highlight two key areas which are touched upon in the submission. The first one is about capacity building in ageing, and there are two components to capacity building. The first is identifying research priorities and the infrastructure to support those priorities, and the second is capacity building in terms of the work force. The 'work force' refers not only to the research work force but also to the work force that is concerned with delivering service and care to older people.

We have heard a lot about the need to identify research priorities in ageing, and I think that there has been considerable progress made over the last year. Ageing is certainly on the political agenda, as is ageing research. There is a Commonwealth initiative called Building Ageing Research Capacity, in which I am involved. This is doing a lot to help focus attention on which research priorities we need to be attending to. It is also bringing researchers together to work more collaboratively and, therefore, to focus expertise and build strength in ageing research. While there are some very positive developments, there are also some challenges that we still have to address. We know the range of pressing issues for ageing in both research and the broader community context. The challenges that still remain are concerned with negative attitudes around ageing and how we can break down some of the stereotypes.

In looking at some of the submissions to this inquiry, it struck me that three key themes can be found: one is the negative attitudes, another relates to economic hardship that older people are facing and another is concerned with scarcity of services and access to services. So we still have many issues to address. In particular, we need to know more about the baby boomers and their expectations of what is going to happen to them in later life—including their experiences and needs. Also, we need to be much more tuned in to community attitudes and perceptions and changing values in relation to older people. I think these are some of the emerging priority areas.

On the other side of this capacity building is the whole question of building work force capacity. Ageing is not regarded as an attractive area. Traditionally, it has been seen as not having the financial incentives and benefits to attract people to work in this area. The education and career pathways have been lacking. We, as educators and researchers in universities, have a lot of work to do to increase the profile and the attractiveness of ageing studies. Later on I will refer to some of the strategies that we are starting to look at in this regard.

In relation to building capacity in both research and the work force, in our submission we have identified some of the research issues that we feel need to be focused on. Healthy ageing is one of those, as are end of life issues, residential care and also the interface between disability and ageing. We would be very happy to elaborate on these areas later.

CHAIR—Thank you very much for your submission and opening statement. I might start by asking you about healthy ageing. In your submission, you said that there is a need for research to look at what determines healthy ageing. Don't we already know a lot about healthy ageing and the sorts of things that you can do to make sure that you have healthy ageing?

Prof. Bartlett—That is true. We know that healthy ageing is a very complex concept. It incorporates the social, psychological and physical dimensions. There is a considerable amount of research that has looked at each of these components independently, but in terms of pulling this research together and identifying what it is that makes an ageing person healthy we are still lacking clarity. There is a lot of confusion around this concept. It is being used liberally in policy documents and strategies, and it is used interchangeably with other terms, like successful ageing, productive ageing and so on. We need to understand more about the existing research and the dimensions that have been looked at, and how they can be drawn together to predict more clearly the determinants of healthy ageing.

Ms HALL—Healthy ageing is not just about looking at the health issues. It is much more than that. It is attitudinal. Is that an area that you would like to look at with future research?

Prof. Bartlett—Very much so. We accept that healthy ageing is not just the opposite of disability. To encourage healthy ageing from the attitudinal, social and societal levels there is a lot that we need to attend to. That might take us into areas around personal community networks, contributions that individuals can make to a community—those sorts of aspects, which have been rather neglected.

Ms HALL—Is that the direction you would like to see your research going—to an area where there has been very little research to date and which can probably deliver quite good outcomes for the community?

Prof. Bartlett—Absolutely.

CHAIR—Yesterday, we were in Coffs Harbour and we heard from the Mid North Coast Area Health Service. Looking at their local area, they were saying that half of local male adults and a third of local female adults were overweight, one in five adults consumes alcohol at harmful levels, one in four males and one in five females currently smoke, and a quarter of male adults and almost half of adult females do not get adequate physical exercise. Presumably, there would be agreement that that is not optimal. Shouldn't research be focused on looking at the likelihood of successful interventions, behaviour change—that sort of thing?

Prof. Bartlett—Absolutely. To give you an example, we are commencing a study at the moment in Queensland where we are encouraging older people to become more physically active through accessing existing community physical activity resources. This is a real challenge. We know that physical activity is important to health, but we have not yet been able to determine what assists older people to access physical activity resources and to maintain activity levels.

Our study is looking at how we can make existing community resources more accessible to older people.

We are introducing a number of interventions that could be sustained in the long term. They revolve around setting up buddy programs, having a gatekeeper who would help older people to access and find a route into services, and also helping services to gear their physical activity programs more appropriately towards older people. If you use a gym you will know that if you walk in a typical gym you see instantly that they are not geared for the more mature adults—the level of the music and the noise in there, the nature of the attire, the nature of the equipment and so on. That is just one example. There are many other possibilities that we are looking at to encourage participation by older people in different levels of activity.

CHAIR—How do you increase activity by someone who, for example, has never been active during their life?

Prof. Bartlett—This is a real challenge. Why should somebody suddenly start being active if they have not had a history of being active? We have to find motivators. Physical activity may itself not be the motivator; a key motivator may be having a friend or a buddy for someone to go with, and the motivator may become the social activity.

Ms HALL—That is linking in to what we were talking about before: the need to look at attitudinal changes and psychosocial issues and, rather than just identifying that these are health issues, looking at how you change a person's desire toward moving in that direction, to be involved in strategies to improve those health outcomes. You can say that those issues contribute to problems in ageing, but the question is how you change the behaviours that lead to those problems. And that is what you are looking at, at the university. Is that right?

Prof. Bartlett—That is right.

Prof. Worrall—Also, there is a big focus on physical health in healthy ageing. You talk about not smoking, not drinking, doing physical activity, whereas in fact some of the major disabilities in older people are things like hearing impairment.

Ms HALL—I think you mentioned that in the submission; you spent a bit of time on that.

Prof. Worrall—That is right. These things lead to social isolation. Those social ageing factors are just as important as the physical aspect of ageing, and I think they are often the neglected part of healthy ageing.

Ms HALL—Stereotyping also comes in to influence those issues, doesn't it?

Prof. Worrall—Yes, very much so.

CHAIR—Given that the inquiry is looking at the next 40 years, has there been any research undertaken into the current cohort, who are likely to be ageing in the future? Do you expect any differences between the current cohort of aged and the cohort which will become aged over the next 40 years?

Prof. Bartlett—I think I mentioned that this is a very neglected area. There is an awful lot of speculation around what baby boomers might be like. The speculation focuses on the fact that baby boomers are likely to be more demanding, to have more leisure, to want to be more active, to want to travel more, to be living further away from members of their family. However, but there is very little empirical evidence as to what baby boomers are actually going to be like when they move into later life.

CHAIR—What is the state of research at the moment about what distinguishes healthy agers from the rest of their peers?

Prof. Bartlett—There are a number of individual studies that identify various distinguishing factors, but it is very difficult, as I mentioned earlier, to compare studies. We have no standards for healthy ageing, or standardisation of measures. Therefore, it is difficult to be very precise.

CHAIR—Is exercise important?

Prof. Bartlett—Yes. We know some of the key factors that will ultimately determine how healthy we are. They are lifespan factors that need to be attended to from childhood. Certainly exercise and nutrition are two very important factors and there are many others.

Ms HALL—Socioeconomic status is also one that is fairly high on that list, isn't it?

Prof. Worrall—It has an effect as well, yes. If you are talking about the level of participation of older people and some of the factors that impede the level of participation, my reading of the literature says that there are essentially two: mobility—that is, the ability to get out and around in the community—and communication—that is, to communicate successfully with other people and peers.

CHAIR—What methods of research are needed to determine signs of healthy ageing and how could the results of the research be utilised to increase the health of an ageing society?

Prof. Bartlett—If we are looking at research methods, there is certainly a case for more longitudinal research studies. There are one or two very important studies going on at the moment in Australia and their findings are already being reported. But we do need to fund more research that can investigate the health dimensions of ageing over the lifespan.

CHAIR—There have been some American longitudinal studies—I think the Framingham study is one. Are there any longitudinal studies in an Australian context as well?

Prof. Worrall—In Queensland there is the LAW—longitudinal, ageing and women; I cannot quite remember what it stands for—study, which is particularly looking at women's health as they age. I am not a participant nor am I involved in that study. John McCallum in New South Wales has done some studies—the Dubbo studies—looking longitudinally at some people ageing in Dubbo. They are the two main studies. However there are other studies like the Blue Mountains study on vision impairment looking specifically at one aspect of older people as they age.

Ms HALL—Thank you for your interesting submission and for the verbal submission you have given us. It is one of the most interesting and challenging areas facing us in Australia. Here we have an ageing population and a declining birth rate, and if we do not do the research and get in place the strategies we need to deal with it then we are going to have a mammoth problem. I think that people like you are at the cutting edge in developing strategies for the future.

One area I am particularly interested in is capacity building from a community point of view. What initiatives and strategies do you think we need to put in place in Australia to improve capacity building at a community level? I think there are a few different community levels there. So we could look at Australia as a community and maybe we could have a state perspective and a very local perspective as well.

Prof. Bartlett—I think this is a very important topic and there are many facets to it. If I just take your question about community capacity building, there is research that already identifies the enormous contribution that older people make within their communities. We do need more research to quantify what that contribution is both in terms of formal and informal support that older people provide within their communities and in terms of the monetary value of that input, which is often neglected. We do need to understand more fully the very significant contributions that older people make within their communities.

Once awareness of these issues is increased, we also need to look the at models of community engagement already existing. We know very little about what is emerging from the grassroots. At the conferences we attend, we hear about the research findings and the relevance of those findings for policy and for practice. However, it seems that there are few opportunities for people at the grassroots who are building different models of support and care to share their initiatives. So we need greater opportunities to hear about what is happening at a community level.

I mentioned earlier the Australian Association of Gerontology conference in Coffs Harbour. The rural division put on an extremely good conference a few months ago. What was so interesting was that half of the presentations were from different community groups who presented what they had been doing. An interesting feature was the many new kinds of partnerships going on between grassroots community groups, local government, state government and the commercial sector. It is an important lesson for the future to consider new kinds of partnerships that can be promoted and to understand what are the successful ingredients of partnerships at a community level. There is very little knowledge about this, and something that we need to learn a lot more about.

Ms HALL—Earlier we were talking about the role—and this links into capacity building—that older people play in the community as volunteers, the economic contribution that they make to our community in that capacity and the funding of organisations that relate to older people. We also talked about the issue of whether or not the pension age has increased and what implications that will have on those volunteer activities that older people play in our community. Would you like to comment?

Professor Bartlett—I think that is a very real danger. If we are looking at raising the pension age, which seems to be a very real possibility, one of the consequences may be that the amount of volunteering that is currently available in the community may diminish because people simply

will not have the capacity and the time to work and volunteer. So there are a number of things we could discuss around that. One of them is that, if we are looking at prolonging the working lives of individuals, we need to change the structure of work and introduce more flexibility around it so that people are not burnt out by the time they reach midlife, simply wanting to get out of the work force and retire. We need to start to look at more flexible work practices and at how people can balance their community contributions with their paid contributions. Keeping that sort of balance in mind is going to be increasingly important if we do not want to lose the very valuable volunteering contribution of older people.

Ms HALL—The other area that you put quite a bit of emphasis on is building work force capacity. What do you think are the underlying issues in the fact that we do have rather a depleted work force in this sector? What do you think the implications are of the salary/wage structure and the value that is placed on the work that is performed in this sector? I would like you to comment on the financial side, the value and the stress and pressure that those people who work in aged care are placed under.

Professor Bartlett—If we take aged care—

Ms HALL—And ageing per se.

Prof. Bartlett—We know that there are huge work force shortage issues at the moment in the aged care field, and these issues are not going to be solved overnight. There is a need to rethink who works in aged care. Perhaps our traditional work force models are not going to set us up well for the future. I am thinking here about other countries which have had to take some very different steps to address this issue. A few years ago in Hong Kong, for example, the territory faced a severe shortage of staff and nurses in the residential care sector, and so introduced a new kind of worker—a health care worker—along with a new training program to address the work force shortage issues. I am not saying that these sorts of approaches are immediately transferable, but we do need to think about whether we can build up a different kind of work force that is not necessarily going to be from the traditional sources, for example, the nursing profession.

In saying that, we still have to recognise that high dependency aged care is a very specialised area of work and we will probably always need that provision. Within the sector there is undoubtedly going to be a continuing need for very high-skilled workers. If we look across the spectrum of aged care, there is certainly scope to think about new models of working and also to consider how we can attract younger people to work in this sector. We know it is a very middle-aged work force at the moment. The reasons are demographic, but also a lot to do with negative images about the sector, including the fact that it is heavy work and low-paid.

Addressing these fundamental issues is really going to be necessary if we are to make a difference to aged care. I think it goes back to a whole of lifespan approach. It has been very popular for, say, social work students to enter careers in childcare, so how can we make the ageing sector equally as attractive for these professions? That is something we are really trying to address at the moment in our centre. We are looking at creating mentoring arrangements for students from different disciplines—not only within universities, but also externally—and also linking them in with the community so that they start to get a better appreciation of what employment opportunities are available in the ageing sector. And that is not just the aged-care

sector, but many other emerging areas that offer opportunities for younger people now to work in, where ageing is a focus. So there are a lot of strategies we need to attend. We are trying to develop some strategies at the moment with our postgraduate and undergraduate students so that ageing—and working with older people—becomes a much more attractive career option.

Ms HALL—What innovative programs and research have been undertaken in Australia, in your centre, that you think could bring about the changes that you advocate?

Prof. Worrall—Some of the work that we have been doing that has been very successful has been what we call the Keep on Talking program. That has groups of older people coming together and learning about how communication changes with age, stressing the importance of maintaining their social networks, making sure that they have an annual check-up of their hearing, their vision, all of those types of things, and stressing why communication is so important as people age. That has been published, but the actual program has not been taken up through any system in Australia because we do not really have a preventative health program or system specifically designed for older people in Australia.

Another program that we are currently working on is ACE or Active Communication Education. I alluded to this in the submission. We have a situation where hearing aids are the panacea for hearing impairment in Australia, and hearing aids are what is funded by the Commonwealth government for hearing impairment. We know that the majority of older people do not wear hearing aids, and even if they do have a hearing aid they keep it in their bottom drawer or wear it on only very odd occasions. We need to find another solution to the problem of hearing impairment, which is one of the most invisible problems of older people but has a major effect on their quality of life. In fact, studies say that the effect of a hearing impairment on quality of life is somewhere between having chronic obstructive airway disease and having a heart transplant. It has a profound influence on quality of life. So we are currently trialling the ACE, which is trying to set up an alternative to hearing aids.

The third area of research is one on which Helen and I have put in an application. This is in the area of 'age friendly'. We know that Australia needs to have more age friendly environments. We need age friendly hospitals, shopping centres and public transport. One of the issues on which we have put in a submission and are looking to do more research is age friendly buses, just to take an example. Public transport has recently had a set of disability standards developed by the Attorney-General's Department, which consulted the associations in Australia for the deaf and for the blind—all of those associations—but not an association for the ageing. It missed one of the major disability groups. So the recommendations that all the buses are following may not actually be relevant to older people.

Also, a lot of the age friendly standards that older people are talking about are probably people friendly standards. Things like the bus driver not moving off until you have sat down, not having high steps to get up into the bus, all of those things, are really people friendly standards. Our research is going to look at the process of developing age friendly standards, seeing whether they make a difference as well: if you develop age friendly standards, in the end does that actually have an impact on older people's participation? Those are three of my projects to mention.

Prof. Bartlett—I would just like to mention a couple. One is our 50+ Registry which we set up just over a year ago. The purpose of this registry is to engage older people in research and to build bridges between the community and the university. One of the problems that researchers

have reported to us is the difficulty of engaging older people in their studies or getting sufficient numbers of recruits. Often that means that the findings of studies cannot be transferable and relevant across the broader population. So we have set up the 50+ Registry to attract research volunteers from the community. We collect some initial data on participants and we give them options about what sort of research they might like to engage in. That has grown now to several hundred and we are hoping that it will grow to several thousand. The benefits for participants include the feeling that they are engaged in the research enterprise. They get invited to various events at the university. In the studies that they engage in, they learn more about themselves and they meet other people as well. Therefore, that helps them to build new social networks and so on. We are now starting to create a study around these research volunteers, which we hope will become a longitudinal study if we can get funding for it. So that is a very exciting initiative that we will continue to work on.

Another project that has been recently completed, and I have tabled the report of the findings from that particular study—looked at the research policy interface as it relates to ageing. We have completed this work in partnership with the state Department of the Premier and Cabinet. A number of recommendations have been formulated, that we feel will help Queensland at least and may be of relevance to other states, on how to go about formulating policy that better utilises research evidence. One of the observations made about the proliferation of policy, strategy and discussion papers on ageing over the last year or two is that we have not always been sure about how evidence has been selected to inform policy and, in particular, how research evidence has been used. This study took a sample of different government departments, it looked at how they were addressing ageing issues and the extent to which they were drawing on various kinds of evidence. We came up with some very interesting findings with implications for both researchers and those involved in policy development in particular, about how they relate to each other. We found that there is a need for greater understanding of the different processes involved in research and policy, and a number of recommendations may hopefully lead in the future towards better synchronisation of the research and policy cycles. It is a very difficult and complex question, but we feel we have made a start in trying to understand some of the issues around promoting evidence based policy making in ageing.

Mr HARTSUYKER—I am interested in the encouragement of people to work longer. Do you think that that has a role to play in the healthy ageing processes that we talked about, with regard to self-esteem and value to the community?

Prof. Bartlett—I think that is right. There is research that demonstrates that where an individual is making a contribution to the community, be it a paid or an unpaid one, there are significant mental health benefits. So the whole question of working longer may have a very positive impact on the mental health of individuals. But I say that with a few caveats, and they have to be around choice. It is very clear that if you are in a professional career there may be possibilities to adopt more flexible working as you age. We are particularly lucky in academic life that as we age we probably have some options to change the level of our input. But in other professions or in unskilled work, individuals will not necessarily have that choice. I am thinking in particular of manual work. If individuals are forced to continue higher levels of manual labour into later life, there may be issues that really are counterproductive. I think there are a lot of issues around that. But we cannot ignore the mental health benefits associated with working longer.

Mr HARTSUYKER—Associate Professor Worrall, you touched earlier on the issue of communication. Could you expand your thoughts on barriers to effective communication by the aged and the impact that that has on them?

Prof. Worrall—Sure. There are different levels of barriers. The first level is certainly an attitudinal one: if a younger person sees someone with grey hair, they talk to them differently than if they were talking to a peer. This is called accommodation. We see examples of over accommodation, where people think that the person they are talking to is old, and therefore senile and hearing impaired. So they will shout at them, raise their voice and speak to them in a way that is not appropriate. You often see that in residential nursing homes; it is called elder speak. The other issue is under accommodation, where people ignore the signs that a person cannot hear them, cannot process the information they are giving to them verbally or is having difficulty reading the information being provided to them. Ignoring those signs is under accommodation. So it is all about people accommodating the differences in communication of older people and respecting that there are differences.

The major difficulty that older people report is hearing impairment. We are not just talking about a decrement in hearing in terms of hearing things in the environment; it is the speech frequencies that are mostly affected. Talking and background noise is one of the major complaints of older people. Trying to hear what someone is saying in a situation with background noise creates many difficulties. Hearing impairment is the more obvious communication problem. We also know that older people report problems with naming and word retrieval. Particularly for words used less frequently in our language they struggle to find the word they are trying to say. They frequently talk about the difficulty of remembering peoples' names. This is also linked to visual impairment because about 13 per cent of what we hear is through our eyes—it is speech reading: we are actually seeing what people are saying as well as hearing what people are saying. So some of the communication barriers that older people face are: vision loss; hearing impairment; neuronal degeneration, so that they are slower to process things; and more difficulty retrieving words. On top of these barriers they have people treating them differently because they are older.

Mr HARTSUYKER—Does elder speak have a negative effect on many elderly people?

Prof. Worrall—Yes. It reinforces to the older person that they may be senile or they may be deaf. It is not good for their self-esteem and it creates a cycle of increased dependency in that if a person speaks to them like that, they become more passive in their communication and they do not participate in decision making as much. Therefore it creates this cycle of dependency in the residential care sector.

Ms HALL—There is one other question I would not mind asking you about. Have you done any research on mature workers, community attitudes to mature workers and how employers can be encouraged to offer opportunities for mature workers?

Prof. Bartlett—We have not done any research on that, but I am aware that there is a need for more research into that area, in particular into strategies that encourage the maintenance of mature age workers in the workplace and also their recruitment. We go back to the earlier issue of negative images and stereotypes, and I think this really needs to be addressed.

If you think about it, most of the human resource staff who are employing, mature age workers are likely to be in their 30s. It is amazing how they still have a very negative approach in their thinking about the capacity of a mature age worker. It is still believed that they are going to be unreliable or slower, they will be off sick more and so on. But the research I have looked at shows this is not the case, that mature age workers are in fact more reliable and offer many benefits to the workplace. So I think the question here is to do with education and training within the workplace to increase awareness about the capacity and potential of mature age workers. It is also necessary to address some of the issues around more flexible working patterns we referred to earlier.

Ms HALL—Have you done research, Professor Worrall?

Prof. Worrall—No, I have not done any research, but I would like to support it by giving examples of how attitudes affect any sort of issue in ageing. I teach speech pathology students, and every semester I have about 100 speech pathology students sitting in front of me. I start off by putting the word 'ageing' on the board and I ask them to freely associate with the word ageing. Every word is negative: wrinkles, grey, senile, forgetful—there are no positive words that come through their mouths.

Mr HARTSUYKER—Not 'evergreen'?

Prof. Worrall—No. Occasionally, you might get 'wise' or 'a good listener'. That is usually people who have had positive experiences with their grandparents. These are speech pathology graduates who are going to be in management positions and who will be employing people. It is just an example. They do not see older people in a very positive light

Ms HALL—I think that the committee has received evidence on a number of occasions where university lecturers have put forward exactly that scenario: they have asked, 'Age, older people—what is your impression?' Everywhere there has been a similar response.

Prof. Worrall—As an educator, my challenge is to change those attitudes. Before I even try to give them any knowledge or skills in gerontology I have to try to shift those attitudes, and I try to do it through confronting their attitudes. I bring very active older people into the classroom who have been to more places in the world than the students are ever going to go to, and I really try to challenge the negative stereotypes of ageing. There is an issue of leadership. We need to look at the leaders of our community and challenge their negative stereotypes of ageing.

Ms HALL—Also, that needs to be challenged within all those at institutions within our community who are responsible.

Prof. Worrall—And that is particularly the leaders, who are going to be employing mature age workers. I give speech pathology as an example.

Ms HALL—It is a very good example.

CHAIR—Thank you very much for your submission and also for your evidence today. The committee resolves to accept exhibit No. 29, 'Linking the Ageing Research and Policy Agenda: towards a strategy for Queensland' as an exhibit for the inquiry.

Proceedings suspended from 12.25 p.m. to 1.35 p.m.

DEANS, Mr David Randall, Chief Executive, National Seniors Association

REEVE, Ms Patricia, Director, National Policy Secretariat, COTA National Seniors Partnership

CHAIR—I welcome the representatives of the Council on the Ageing and National Seniors Association 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. COTA has made a submission, submission No. 91, to the inquiry. Copies are available from the committee secretariat. The National Seniors Association also made a submission, No. 81, to the inquiry prior to the merging of these two organisations, and it is also available through the committee secretariat. In what capacity do you appear before the committee.

Mr Deans—I am the Chief Executive of National Seniors Association and the Joint Chief Executive of COTA National Seniors Partnership.

Ms Reeve—I am Director of the National Policy Secretariat of COTA National Seniors Partnership. I was previously employed in the Victorian Council on the Ageing.

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

Mr Deans—Yes, if I may. I would like to, first of all, comment on the two organisations. You are probably aware that COTA and National Seniors Association are in partnership now working towards a merger, which will take place in the next 12 or 18 months. We were the two largest organisations representing seniors before we came together. Of course, we are by far the largest now with 270,000 individual members, plus about 1,500 organisational members. I think the best way forward today is we will deal with our own submissions and then we can jointly take questions on the issue of ageing.

National Seniors believe that the future costs associated with population ageing have been overstated by many people. In our paper we challenge policy makers to consider older Australians not as a drain on social services but as active contributors to society. The recent establishment of the National Seniors Productive Ageing Centre at the University of the Sunshine Coast, which is in partnership with the federal government and National Seniors Association, demonstrates our commitment to this concept.

Is there an ageing crisis? We believe not. There is a challenge ahead of us. Certainly some analysts predict a decline in the proportion of younger workers. That is a serious issue that needs to be dealt with. A shrinking tax base as more people move into retirement and increased spending on health and age pensions will create significant pressures on national budgets. I do not think anyone would object to that observation. However, fears about the population ageing are founded on negative stereotypes of older people being dependent, burdensome and frail. Of course, that is not necessarily the case.

It is important to remember that health services and long-term care are most needed in the last two years of life, regardless of age. It is disability and poor health which are associated with increased medical spending, not just old age itself. Health promotion and disease prevention are required throughout the whole life course, and that would reduce the burden in later life.

Access Economics have stated that the average per capita income would rise if only 10 per cent of people aged between 55 and 70 remained in the work force. Participation, as we have read, is a serious issue in that age group. It is a very low percentage. In fact, at the Productive Ageing Centre we are doing research on that very subject, and hopefully we will bring out a report early in the new financial year.

We believe appropriate training programs and job-matching services are necessary. There is a lot of work to be done in that area. Flexible hours and phased retirement are critical issues for the future. We need to rethink labour market policies that encourage early retirement and to do away with them. For example, what is so magic about 55, when you can pick up your super? People tend to think that is retirement age rather than the first time they can pick up their super. We need to create opportunities for lifelong learning so that mature-aged people in the work force can in fact continue working, and be willing and able employees. We should encourage mentoring for older people within the work force as well as in the community.

In the health area we should be looking at prevention rather than just dealing with illness. We have a long way to go in order to be able to do that, but it is certainly a critical issue that needs highlighting. We need to increase the availability of home care services. We will need more respite care as more people reach the older age groups. We need step-down facilities for people coming out of acute care hospitals, and between that and going home we need convalescence type facilities.

If we are not careful, dental health will become a huge issue. I spoke recently to some experts in this area who said that in the future more and more people will keep their own teeth rather than have dentures. So this will be a greater issue for those people who maintain their own teeth.

We question the adequacy of the single age pension. We believe that needs to be looked at compared with a couple's age pension. Anyone who steps down from a couple's age pension to a single age pension will tell you it is much harder to live on.

We need to encourage personal superannuation contributions so that people can provide for themselves in retirement rather than being dependent on social security. We need to simplify superannuation, which of course is being dealt with by other inquiries. We need public education on superannuation. Knowledge of superannuation is lacking. There is not much knowledge about how it really works. We need to exempt people over 50 from the superannuation surcharge so they have an incentive to contribute more to superannuation. Finally, we need to investigate the inadequacy of women's superannuation, which will become a huge burden as women get out of the work force. Even though the situation is improving because women are staying in the work force longer, it is a critical issue.

CHAIR—Thank you very much, and thank you for the two submissions, which I thought were excellent.

Mr Deans—Chair, I would like to pass over to my colleague, who would like to add to my comments.

Ms Reeve—I do not wish to repeat all the things that David has said because we do now hold all of them in common. But you can see from our submissions that even when we wrote them we had a common approach in relation to challenging the idea of a crisis looming because of an ageing population and we were both interested in increasing people's participation in the work force, particularly between the ages of 50 to 65.

I want to highlight in particular that we believe that it will take sustained policy work and strategy to manage the bulge of the baby boomers and that there is a need for some long-term goals that are acceptable across all political parties so that we can have a long-term approach to measuring progress on them. To make some gains we need quite a focused strategy rather than a compendium of all the good ideas everybody will put before you. The social determinants of health and the way they impact on the life course to produce healthy or not so healthy people in older age are now much more widely recognised in worldwide research and are particularly promoted by the World Health Organisation.

We do have time to make a significant difference to the health of different cohorts, including the aged. It is never too late. People in their 90s can regain muscle strength and muscle mass, given the appropriate programs. We can certainly make huge changes with sustained public health promotion and prevention strategies, and many things that we take for granted now as being part of old age could be eradicated, because they are in fact, as David said, connected with ill health, disability and also stereotyping. Age discrimination and the stereotyping on which it is based infuse all of our thinking and, if we are not very careful in questioning all of our assumptions we could all easily fall into the trap of making very pessimistic assumptions and not putting in place really rigorous programs needed to produce different outcomes.

COTA(A)—I am now working for COTA National Seniors Partnership—also put forward in their submission the need to have a strategy working at a number of levels to change the experience of ageing, first of all in the broad economic, social and environmental context. Older people are part of the community. The things that impact on the whole community impact on them. Some things are common to old age, but there is more in common across the whole life course, such as having a sound economy, good levels of employment and sustainable growth. It has been shown that having a more egalitarian society with less inequality is connected to health outcomes. So, apart from social values, one may want to look at that as a health strategy. Also, there is looking at building respect and tolerance in society. Getting those sorts of environments right is the most important thing we can do for older people, though that is not in our detailed submissions, which tend to focus on the specific programs. Also, at the community level, clearly communities which are strong and support each other and which have high levels of civil action have very favourable conditions for healthy ageing and for older people continuing to have productive lives. So in those two areas older people together with people of all other ages will benefit.

Then of course we have the specific programs. I could run through the same headings that David has, but I think I will hold those for any specific questions that you might have. Of course, we need to work on a lot in the health area because the current generation of older people do have a range of health issues that need addressing. Although we are promoting positive, healthier

approaches to ageing, there is still a need for good health services, particularly programs which are accessible and affordable for people on low incomes. Of course, not all older people have low incomes, but the longer we live the more we slide into the lower income groups, so very high proportions of older people are on very low incomes. Even among baby boomers, who themselves suffer from the most amazing stereotyping, one-quarter are not home owners. So there are huge differences amongst baby boomers as well the older cohorts.

We think the principles adopted by our partnership as part of our work are good principles for a strategy to address the ageing of the population. We are looking at maximising the economic and social participation of older people in work and in voluntary activities. I see from this morning's *Australian* a reported $72 billion of voluntary work is done annually by people over 55 in our community. We are looking at fairness and sustainability of programs—fair across all age groups. We want a fair go for older people, not a special go. We are looking at services and programs that specifically meet the needs of seniors, and dealing particularly with disadvantage and discrimination suffered by specific groups within the older population. It is within that context that we have put forward the specific initiatives around health, employment, learning, retirement incomes and participation in general.

CHAIR—Thank you very much. Firstly, I would like to ask you about work force participation rates in mature-aged employment. You have a bit about it on pages 7 and 8 of the National Seniors Association submission. What sorts of initiatives do you think are required to increase the work force participation rate amongst people over 55?

Mr Deans—Because our membership starts at 50, we say 50—and in fact in many cases there is a low participation rate in people even younger than that because of retrenchment. From my point of view, we have a job in educating employers. In fact, to that end in Sydney in August National Seniors and the Australian Chamber of Commerce and Industry will be running a symposium which the Prime Minister will be addressing on that very subject. It is for employers to hear the message about what will happen to the work force over the next 20 years when we will not have the young people coming through into the work force. So, first of all, it is education of employers and getting them to understand that they are making redundant a lot of skills. I think HR practitioners have a lot to answer for. You find that the average HR practitioner is probably in their 30s. They think someone at 55 is old enough to be their mother or father and so should be in a position to retire. So we really need to tackle that.

We need to also deal with issues regarding employees. Of course we are generalising here, but many employees tend to say, 'No, I don't want any further training, it gets too hard.' They have not kept up with the computer world, so they are scared of it. They do not get their training in a user-friendly environment. So I think employers and trainers have to learn how to bring their employees along with them. It is easy to say it is all an employer problem. It is not; it is an employee problem as well.

I think the government should take a lead. In fact, we have been talking for some time about this symposium, which is being encouraged by the Minister for Ageing. It is an enormous step in the right direction to educate employers about what is happening and what will be happening in the next 20 years.

Ms Reeve—Over the last five months the partnership has been doing workshops with mature-aged unemployed people. Between 800 and 1,000 participants have attended them all around the country. The job services provided through Job Network et cetera need to be specifically targeted and the people in them need specific training. It is not the case that no young person could offer good advice, but a very young person with no specific training or support and very limited life experience is not well placed to offer career and participation advice to people who in many cases are quite well qualified within their trade or area of work but have been retrenched a number of times and need quite complex support, not just first-up answers. Working through that has proved very difficult for job service providers and the people seeking support when there is not that understanding.

There is also quite a lot of discontinuity in relation to unemployment benefits, the pension and superannuation benefits, and it is creating barriers for people in those years leading into retirement. Being unemployed is very devastating to people of all ages, but if it occurs in that last stage of their working lives, when many are accumulating their savings for retirement, it will have a long-term impact. So there are all sorts of issues surrounding people being prevented from taking up part-time work or moving back into work after they have been out of work for some time.

In relation to attitudes, a lot of people over 45 are targeted for retrenchment and redundancy, and that is just based on stereotyping. We all retain a capacity to learn until very old age. We all retain a capacity for physical action, unless we have been injured in our jobs and are carrying long-term injuries which need treatment. We need to work on changing that attitude. Also, because of our society's attitudes towards unemployment and the shame of being unemployed at a very critical time of life when people have teenagers or family members going into higher education, people feel much more secure saying they have retired rather than saying they are unemployed. A lot of people get that 'I have retired' mind-set as a face-saving gesture. So a lot of work is needed on changing attitudes and actual programs to change what is going on. As David has said, it would have economic benefits to the country and the labour market as well as individuals.

CHAIR—You have raised the issue of social isolation, which can occur in a nursing home and in the community. How does COTA National Seniors Partnership and National Seniors Association see this issue being effectively addressed?

Mr Deans—First of all, we are doing something ourselves. Our organisation has branches where people meet. We have found from surveys we have carried out of those people who come to branch meetings—and they are like a Probis club meeting or a Rotary Club meeting— once a month that certainly that helps them no end. They are largely single women, for obvious reasons—well, maybe not for obvious reasons, but they outlive men and so there are more single women in that age group. Providing our branch network is certainly something we can do to help overcome that social isolation. The programs we have for aged care need to be looked at very seriously for that very reason, because the aged can be surrounded by people but still find themselves in that situation of being isolated.

CHAIR—Ms Reeve, you mentioned the value of unpaid work done by volunteers reported in an article in the *Australian*. The Country Women's Association has given evidence to the

committee that many of these volunteer groups are having difficulty obtaining insurance for members who are over 80. Does your organisation have any plans to address this?

Ms Reeve—Yes. We negotiated some years ago with our insurer to make sure that there were not any upper age limits on volunteer insurance, but it is quite difficult. As you are aware, any discrimination based on actuarial data is not illegal, even where age discrimination legislation would otherwise come into effect. But I think there is just an assumption and a use of the term 'actuarial data' as an excuse often rather than having actual significant data at this level, particularly data relating to people who are doing voluntary work. Presumably you would not include in your data accidents that might happen to people not doing voluntary work but are getting high levels of care because they are ill.

The costs of voluntary work are quite significant, particularly in areas where there is not good community transport or other connections. Many of the current cohort of older women do not drive, so they depend on public transport or community transport. Particularly in rural areas the costs associated with driving are quite high. Being able to maintain your social roles I think does depend on your having some disposable income, on what exists in the community, on the way you are valued as an older person—whether there is a 'it's time to retire from voluntary work' attitude; there are some pressures in some places for people to do that—and on the sort of community involved.

The other thing that makes a difference is whether people feel safe in their communities, whether they feel able to move in and out and connect. There is a strong connection between social isolation and ill health. It is usually thought that ill health leads to social isolation, but some research seems to suggest that it is sometimes the other way round and in fact isolation can lead to poor health outcomes. So it is quite difficult to pick up. I think some services could be adjusted to better deal with this. Rather than compensating people for loss of friendships or engagement networks by sending along a visitor to be their friend, they might do better if a community development approach were taken to reconnect them to their communities. Following a bereavement or if someone has a health issue impacting on them they might need particular initiatives to encourage them back out again. For instance, if someone has had a stroke, rather than bring all the services to their home, perhaps they might be transported back to a group in which they had a particular interest and could still have a role.

Mr Deans—Could I make a couple of comments on the insurance issue. We just happen to have two different brokers and different insurance schemes, which is rather interesting. We will come together in that way as well in 12 months time. We do have an age limit on volunteers. It is 90. When we set that years ago I thought no-one will ever work as a volunteer for our organisation when they are 90 and over. We do have someone who works in our office three days a week and he has just turned 90. So we have had to negotiate upwards that age group.

We are able to get insurance. We have always had it, and we are able to continue. Sure, it has gone up 30 per cent, but you cannot afford not to have it when you have all these people around Australia who are volunteering, even if it is just going along to a branch meeting. A couple of local senior citizens organisations want to become a branch of National Seniors so they can in fact come under the umbrella of the insurance. That shows that it is difficult for the smaller organisations to get insurance. I am surprised that CWA have had difficulty getting it or continuing it.

CHAIR—They mentioned it as an issue. In an article in the *Age* on 26 April this year you commented on the difficulties that older Australians are having in obtaining credit. Would you care to expand on that for the committee?

Mr Deans—Yes. This was all built around something that happened I think in January. The American Express platinum card had automatic travel insurance and it did not matter what age you were, but American Express said people over 80 do not get it. That threw all the talkback shows into chaos. I spoke to American Express about it. It is purely because of the risk factor, and it is a matter of finding an underwriter who would do it. Our organisation runs a big travel and tour business. We have travel insurance available for any age group; it is dependent on only the health of the person. In January when one of the Bee Gees died at 53, I made the observation, 'I wonder whether he could have got travel insurance?' He would have. He died of a heart attack, yet someone at 80 or 90 cannot get travel insurance just because of their age. But there are products available where in fact no age limit applies, depending on health.

CHAIR—Was it with just the American Express card that people over 80 were not able to access the travel insurance side of it? There are no other problems that you are aware of of older Australians having difficulty accessing credit?

Mr Deans—Credit, yes. In another article somewhere—it might have been in the same one that I mentioned—there was a story about a quite wealthy person who does not work; he is retired. He applied for a credit card, and he said he earned more than $100,000 a year. The automatic reaction to that was, 'He is a liar, and he will not get credit. We will not give him a credit card.' That is where you start from; and age is a factor, of course. So, if you are retired and you are earning a huge amount of money, in their mind you cannot possibly do that and so they think you are not telling the truth; and you have to challenge that. So there is that mind-set.

In fact, I was talking to a bank about that only yesterday. With their system that is how they work out credit and who gets a card and who does not. That can happen even with programs that we have. We have a credit card. We have got our credit card provider to look at it differently. But I would suggest that the seniors credit card market is not very attractive to providers because seniors do not use the credit part of it. They use it as just a convenience and they pay it off in time; so there is no churn. Providers do not get any return for it; all they get is the annual fee. Because seniors pay it off, they do not pay any interest on the credit they have used for 55 days.

Ms HALL—I found both of your submissions interesting, and I will quote something from I think the National Seniors submission:

> ... we challenge policy makers to consider older Australians not as a drain on social services but as active contributors to society.

I think that is the underlying premise of all that you have put to us today. You have really thrown down the gauntlet in relation to stereotyping and discrimination in all spheres of our community. Can I start with employment. I notice that you concentrated on employers and employees and maybe a little on community attitudes, and you linked in Job Network. Can you think of any initiatives the government could undertake that would lead to better outcomes for mature-aged unemployed people in particular?

Mr Deans—It is very difficult for government to do things to correct something that employers have to fix themselves.

Ms HALL—So you believe there is no role for government in it?

Mr Deans—I do, because they can set directions and of course they are an employer themselves in that they have an awful lot of people working for them. Government need to understand this because they are guilty of it: Canberra is full of young people who are 'retired'. First of all, public servants are in fact encouraged to retire at 54, 11 months and 30 days, or whatever it is, because it is better financially. So governments can in fact, to keep people in the work force, fix that. I am not quite sure that public servants would be happy if it were fixed because there is currently an advantage for them.

Government can set only the guidelines, the parameters, that you work within. Government can do something about superannuation, taxation and the social security elements that we have touched on today, but really it is up to the marketplace, the employees and the employers. The employers, first of all, have to come to grips with what is happening in the economy and what will happen to the work force; and this is not something new. When I came back to National Seniors in 1991 it was probably one of the first issues raised. I think in 1992 the first white paper or green paper was brought down on employment. That is 11 years ago and we are still talking about it. We should do something, but certainly government could take a lead. The government is taking an active role in the symposium we are bringing together in August in that it is sponsoring it. It is working on the committee to bring the symposium together.

The government of the day, and might I say the opposition of the day, need to be actively involved in this area. It is a matter of freeing up the market. Basically the government can only fix the economy, if it can, to operate so there is greater employment, less unemployment. That is one of the first moves.

Ms HALL—What about the role in developing communities' attitudes? Age discrimination legislation; there are legislative requirements that could impact—

Mr Deans—That is basically almost in place; and that is if you include the employers in 'community', because it is the employers and the employees of those employers who have the right to hire and fire, and who are making the decision to target older people, whatever that means. We should have defined at the beginning what we meant by 'older people', but I am talking of people—

Ms HALL—You have defined it according to seniors.

Mr Deans—Yes.

Ms HALL—I think those are the parameters we are working under here.

Mr Deans—Telstra are a prime example. They have been shedding people for years. Whom do they target? They target people who are 45, 50, 55. They give them $100,000 plus a superannuation package and expect them to live in the community for another 35 years. Society is different these days. We have a greater life expectancy. I was going to ask before: in general,

who is the person of 55? Generally they are divorced and remarried with a new mortgage and young children rather than the 55-year-old we used to know.

Ms HALL—That is for a male?

Mr Deans—Yes, the remarried part, yes.

Ms HALL—And young children?

Mr Deans—Well, think of women who are divorced with children and a mortgage. Being 55 like it was 20 or 30 years ago is not the case today; and that is a very serious issue. That is the mind-set, unfortunately, of the people in the HR profession. It really is. We need to tackle the HR practitioners.

Ms Reeve—Apart from those roles, I think we need to educate people about late life so they get a sense of what it is and how long retirement will be. There is such a low level of retirement planning in our community and also low levels of thinking about and understanding of retirement beyond dreaming about a holiday and fixing up some things in the home or whatever. People have a kind of long service leave notion of retirement which does not then sustain them for 25 or 30 years. Frequently they have not consciously anticipated that retirement is perhaps a third life. We as a community do not even have a sense of what that stage of life is about. We have to realise that an ageing population means more people in their 90s and 100s will be active participants—perhaps still even golfing and doing other sports—in their communities. We do have to change the whole mind-set. So I think David is right: government can take a lead in that and encourage others to do the same, as well as put in place legislation, which both organisations support, for age discrimination and take up its own role as an employer.

Ms HALL—I am a little disappointed, Mr Deans, because I was hoping that you would pick up something that you mentioned in your submission, and that is the government's role in looking at one issue that you identified: phased retirement and linking that to employment initiatives. I thought you might have expanded on that under that section.

Mr Deans—That is quite right, and I apologise for that. I thought about it earlier when Patricia was talking about it. It is a very serious issue. Under the age pension bonus scheme, which is actually one of our policies that the government introduced, people get a bonus if they work beyond 65. Certainly there is a need for phased retirement. It is all about choice. We are great believers in people having the choice.

Ms HALL—But you must have the legislation in place to support the choice and you must have government policies directed in that direction.

Mr Deans—Yes, quite right.

Ms HALL—I would like you to expand upon what you had in mind with that—a model.

Mr Deans—The government introduced half of our original model in the pension bonus scheme. The other half of it was geared around the mature-aged unemployment issue—it was some years ago—and it was that if people want to retire earlier and they are eligible for an age

pension maybe they could start at 50 per cent of the age pension going up to 100 per cent of the age pension. There are various ways of doing it. Again, I think employers need to be a party to this. I am an employer. It would not be easy to convince me to have several of our staff working only, say, two or three days a week as they get towards retirement in maybe a few years time and they want to slow down. So I have a mind-set that it would take some management. You would need to have the other half of that equation: if someone will be working only two or three days a week, you need to have someone else like that. So employers generally need to get an understanding of that, that it is part-time work.

The project we are doing for DEWR that Patricia touched on earlier is on portfolio employment—in other words, people can have two or three jobs. It is like being a consultant. In fact, that can be seen as stepping out of the busy five-day-a-week job back into something less than that, and that could be in a portfolio of jobs. It does not necessarily need to be in one. So you need to make sure the taxation system does not crucify people for being in that position.

Ms HALL—That is a good point.

Ms Reeve—There are issues in unemployment too and the social security arrangements about whether we treat people around the retirement age in the same way as we treat younger people, particularly in relation to assets. As we said before, we do not want to be unfair to younger people. Hopefully, people close to retirement have accumulated some assets. But, if they need to run those funds down because of the way the social security system operates, that can cause difficulties too. Drawing down some of your superannuation to supplement part-time work to have a phased retirement causes a lot of difficulties.

We have a particular case which is related to public sector superannuation and a defined benefits scheme which is not what the general community would have. People can finish up with a lower pension overall or with unfair pension treatment in a defined benefits scheme because, if they retire between 55 and 65, their pension is discounted because they will presumably be drawing it for longer, but if they work past 65 to 70 or 75 they do not get a percentage increase on it because they have shortened the years they will be drawing on it. So there are quite a lot of anomalies like that which impress upon people's decisions as well as the ones about trying to find the jobs that they can manage in that way. We know there are a lot of people wanting to mix paid work with family support as well, particularly people who support their grandchildren—those sorts of issues.

Ms HALL—I think lifelong learning was in a COTA submission. You made a comment about lifelong learning and the importance of lifelong learning. Would you like to expand on that?

Ms Reeve—Yes. I think lifelong learning has been on and off for the last 30 years—it has its day in the sun and disappears again—but it does not seem to really bite much into the Australian community. This is not just related to specific vocational training or education, which of course is important—as the nature of work is changing, people do need opportunities to learn and develop new skills and knowledge—but also related to what effect learning has in relation to general engagement, health and maintenance of your participation. Learning assists in that whole process and assists in making you remain part of the community.

A lot of retired people feel bypassed by the move to information technologies if there are not particular strategies in place. Those people were not in the workplace, so there were not many opportunities for them to pick up that information. Without those sorts of initiatives, they feel they have missed the boat and society has left them behind. We have particularly noted the role that informal learning and fear education plays with retired people. Fairly small investments by government or the community at large can bring big results. We find groups like U3A et cetera are often struggling for just the basic facilities. They are putting in all the voluntary work, but you just need that bit of infrastructure around it.

So once again we are trying to get across the notion that everybody can learn. You do not get too old to learn. You do not start forgetting things from the age of 40 onwards because of your age. That is one of the abiding myths in our community. You may forget things because you are stressed or busy. People who have had poor educational experiences in their earlier days, and of course there are many of those amongst older populations who had—

Ms HALL—I think that is a very good point.

Ms Reeve—I am in my early 60s. I went to a school reunion this week and there were numbers of people there who had left school at 14. In my mother's generation of course that was much more common. But even in this generation, just ahead of the baby boomers, leaving school at 14 was quite common. We have forgotten that. Of course, many people went back for mature-aged study, but quite a lot did not have a chance. So people who have had little formal education or have had bad school experiences are often reluctant learners and nervous learners. So you need specific initiatives often to encourage those people.

We need to get across the notion that late-life learning is like all adult learning: it needs to leave room for you to draw on your previous experience and knowledge and apply it. So, if there is any change in memory and learning, it is due to the somewhat lessening of our capacity for rote learning and not to the lessening of our capacity for complex engagements. There is the old saying that you never forget how to ride a bike. Riding bikes, sewing, dressmaking and those sorts of things do not deteriorate, but you need a way of bringing those skills to the fore and connecting your learning to your previous life.

Ms HALL—I have two more questions. Would you both like to comment on capacity building and community development—looking at capacity building from a community perspective and involving older people in that. I think the COTA submission spoke about capacity building, but I am sure you are both across the issue.

Ms Reeve—We all clearly know that older people do lots of work in organisations in communities. When people are active in their sports club, in their social welfare organisation, in the SES or whatever, whatever their age, they are not seen as old. We manage to see only the sick and the frail when we think about old people. So, often when you get around to community-building initiatives, people focus on older people needing things rather than people having personal assets in wisdom and life experience that they can contribute. Frequently, communities overlook a huge asset that they could have that is actually operating at many levels, but they do not set about planning for and connecting with that asset.

We are a very age stratified community somehow. We do not think across issues in fairly simple but not simplistic ways. So approaches to community building which start from an assets base—assets in people—and how you maximise them rather than the problems and how you come to compensate for them really could pull on enormous resources amongst older people, both in the analysis of what would be needed in the communities and in the way they could go about doing them. That is part of that intermediate level, the most important things being getting the economic and social frameworks right. The specific programs for older people are important, but that social glue work in the middle is what we are trying to point to there.

Ms HALL—I would appreciate it if you could both comment on my last question, which is to do with retirement and preparation for retirement. Centrelink conducts sessions about financial aspects of retirement for people who are retiring. Many other organisations conduct sessions on the financial aspects of retirement for people who are about to retire. Do you think similar sorts of sessions looking at planning for life after retirement need to be included in the retirement process?

Mr Deans—One of the things behind the Productive Ageing Centre is people being productive in their later years, and that could be in the work force. In relation to education, we are going to introduce some courses through the Productive Ageing Centre, through the university, in different subjects that are of interest to people in their later years. When you talk about retirement planning, you are right in saying that people immediately think of the dollars, just the financial side. It is a lifestyle change and it is a dramatic change because most people work one day and are retired the next day and do not go to work.

It is a bigger problem for men because generally their network is at work. They are not very good at socialising. Women are much better at that. A professor at the university always uses the example of when a woman goes to the corner shop to get a pint of milk she might take half an hour or even an hour but, if you send a bloke there, he will be back in five minutes. He will go and get the milk and come back straightaway because he does not socialise. Men do not have their network in the community. That is generalising; not everyone is like that. So it is an even more critical issue for the males. But there is a need to have education on lifestyle. It comes together with phased retirement—people know they might be able to have a phased retirement rather than be not retired one day and the next they are.

There are health issues. We have run many seminars for several banks. We have not done it for a few years now, but we used to run seminars. Finance was one issue, but health, education, recreation and community work were all involved. There is a great need for them. Maybe the government could take a lead in looking at what packages there should be for those people who are going to come out of the work force and retire. People are coming out of the work force at different ages—55, 70 or perhaps even older. People in the professions have a tendency to work past 65. They reduce the hours they work—they go and play golf on Wednesday afternoons—but they stay on in the work force. The insurance sector has fixed up the medical profession, but that used to be a pretty good example of how people had a phased retirement and worked longer in their age group.

Ms Reeve—Some of the state and territory COTAs have run small-scale courses on this—sometimes supported by government funds to develop those courses. But it is certainly very clear that people need, first of all, to marshal their resources to deal with constant change,

because one of the things about planning is that your life is never going to be the way you planned it. None of us really, even in government or business, plans for the next 25 or 30 years and thinks that plan will hold. People need to know how they will cope with constant change—being one of the messages—and to get realistic notions.

A lot of the courses, for instance, pick up health issues, but they tell you about putting in ramps because you might not be able to climb the stairs. Really! Some of us might need to do that right towards the end of our lives, but we do not all need to rush around the day we leave work and put in ramps. We do need to know that, if we are losing strength and muscle mass, we can regain it if we go and do serious exercise; so the need for ramps will be even less. So people need realistic knowledge about what is going to happen in their lives based on their health status, and they need that sense of the possibilities. That is not put into a lot of the courses offered.

Frequently, even the financial advice is somewhat strange. A number of places do not structure their advice around the lives of the people they are offering advice to. I did not take very well to my being told how I could structure my partner's money so the kids had it and I paid less tax. Excuse me, I wanted it. I did not think it made much sense to talk to a room full of wives who were in their 50s and whose husbands were being made redundant as if they had very young children. It was not spelt out, but that was the assumption behind the advice proffered. So there is a need to increase the knowledge and the skills, amongst even the financial planners, that relate to retirement as well as other aspects of life.

Mr HARTSUYKER—Amongst your membership is the feeling that people are wanting to work longer or are they still wanting to retire earlier? What is the thrust of people's attitudes? Are they looking to work past 65? What is their feeling? What is their wish?

Mr Deans—My observation is that it is too early to tell because we have just started to talk about it. We have been talking about it as an organisation for some time, but now we are seeing a bit in the press. So long as people have choice, it is okay. You cannot talk about putting up the pension age without the debate becoming political. But take the politics out of the debate. At meetings of our membership I often say it makes sense that one day we will have to increase the pension age. The members are okay with that because they know they are past the age which will be affected. But a younger group might not be so comfortable with that. If we did a survey on that issue—and that is some of the work we are doing at the Productive Ageing Centre, so that information will probably come out of that research—I think the message would be: so long as people have choice. The pension bonus scheme has been reasonably successful, except it has not been promoted enough. People are in there working, understanding that they can get a bonus of $20,000-odd when they turn 70, depending on what work they are doing. That would be my assessment of the feeling of our membership.

Ms Reeve—Among the people we meet at the workshops we run—many of whom are our members but many of whom aren't because we offer the programs to everyone—there tends to be those who are unemployed but want to be employed and earning. These are people aged about 50 and onwards. I think there are huge numbers of unemployed people under the age of 65 who are wanting to work. I was just looking for the figures. I think a third of people who go onto the pension at the minimum pension age come off other social security benefits. So these people are not making a choice. They are forced into unemployment and then into calling it retirement as soon as they can.

Of course there are other people who have had a long work history and good careers with good superannuation and perhaps defined benefits schemes who are very happy to retire. So, without raising the pension age, even though there is a huge capacity to move up the participation rate of willing workers to the level of 65 years of age without any trouble, you would find that people would want to get out and work—not because it is a rule and they had to as then you would get resistance. But there are plenty of people who would work on.

Numbers of people have been in jobs which are body destroying and are carrying high levels of injury or disability related to work. They do not want to be forced to continue in those sorts of jobs for even longer. But, putting that aside, offering the capacity, increasing employment opportunities and recognising the worth of older workers can make a big shift.

CHAIR—Thank you very much for both your submissions and also for your evidence today.

[2.37 p.m.]

POLLARD, Mrs Delaune Verna Francis (Private capacity)

CHAIR—I welcome Mrs Delaune Pollard 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. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of parliament. Mrs Pollard has made a submission, No. 32, to the inquiry and copies are available from the committee secretariat. In what capacity do you appear before the committee?

Mrs Pollard—I am an accredited occupational therapist and I am an Allen cognitive adviser from the United States.

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

Mrs Pollard—Yes. I would like to begin by stating what I see as the problem. Civilisation and longevity go hand in hand. With longevity, there is a great chance of any aged person suffering some degree of cognitive disability ranging from minimal to maximum in intensity. Cognitive disability can be absolutely devastating for the individual, the family and the community. There is a copy of what I am doing in the information I have handed to you.

CHAIR—Thank you.

Mrs Pollard—Advanced democratic countries have experienced unrelenting accelerated changes over the past 20 years while at the same time retaining strongly held beliefs about ageing, such as retirement age. Today's aged and middle-aged population are finding it increasingly difficult to cope with and adapt to change in many areas of their lives, whilst still taking on the nurturing and caring roles and responsibilities embedded in family life. Changes can be extremely taxing and are made even more so when one or more family members have a cognitive disability.

Facts concerning a cognitive disability: why has this disability in the aged not been fully understood until now? Last century two Soviet psychologists presented studies relating to brain function observed through activity. These studies were expanded upon by Professor Claudia Allen when she presented the prestigious 1987 Elena Clarke Slagle Lecture to the American Association of Occupational Therapists. The distinguished Russian neuropsychologist Luria, in his book *Working Brain*, acknowledged the existence of global cognition but chose to work with focal deficits of the brain.

Everyone is aware of the stages in the development of abilities in babies and young children, yet few people are aware that there is an equal decline in ability with ageing. As individuals go up the scale of level modes, they master those level modes that integrate the sensory motor information they gain. Conversely, as an individual goes down the scale of level modes, they are not able to use the skills associated with the higher level modes. Cognitive decline is concealed

by habits, routines and rituals developed over a lifetime. A cognitive disability can be concealed by the thick strata of habits that have accumulated in the basal ganglia of the brain. This, coupled with a high level of verbal skills, may mask mild, moderate and severe cognitive deficits. When differences are not visible, they can often be overlooked.

A limited capacity to think and feel in order to function or to adapt to change is pervasively spreading through every aspect of a person's life. It is the biologically predetermined ability to attend to and functionally process sensory information using external queues. The capacity to function follows a sequential order of cognitive complexity that is programmed into human biology. How a person is able to pay attention defines the performance level mode on the Allen cognitive scale. Historically the cognitive and physical components of disability have been assessed and printed separately. In reality they are intrinsically related as the central executive style operation of the prefrontal lobes of the brain organises function and behaviour as well as the lobes being responsible for coordinating the activities of the sensory regions of the brain. As with physical disabilities, a cognitive disability limits the person's participation and involvement in life situations.

In 1987 Claudia Allen, together with her husband, who was a professor of psychiatry at the University of Southern California, published a paper which stated that 20 per cent of the general population has a cognitive disability. People with a mild disability can talk and walk normally but their disability becomes apparent only when they have to change their work pace and/or learn new skills. Human brain functions are recorded by a measurement either of the electrochemical activities or of the body behaviours that by intention represent their internal state.

The Allen cognitive level scale measures bodily functions and functions that humans do. Behavioural problems occur in response to the whole brain's inability to switch to global and exploratory forms of reactions. Aged people with a cognitive disability have no concept of why they are not able to do the things they used to be able to do and vehemently deny there is anything wrong with their ability to manage their own affairs. The brain, being a dynamic, complex system which thrives on novel and trial and error learning, is affected by the level of mental and sensory stimulation from the environment and not by age.

CHAIR—Thank you very much for that. What can be done to enhance and protect cognitive function? We have heard that cognitive disorders are increasing. What can be done to protect that function?

Mrs Pollard—I have written about three areas: concern, consequence and recommendation. Do you want me to read that or just talk about it?

CHAIR—Just talk about it, because at the end of this hearing we will take it as an additional submission so it will be part of the public record as well.

Mrs Pollard—Okay. One of the big things, looking at the next 40 years, is keeping people physically fit, particularly people over the age of 55 years. They need to be referred by health professionals, particularly GPs, to centres. There are centres developed throughout the country, including country towns, based on a wellness centre program, which is in America, but a lot of them are attached to hospitals. I believe we have to get the focus on ageing away from issues of

health or ill health. I have put in a proposal for 'live life centres' where people get in and do a lot of physical work. Another thing is that people must go on learning. I feel there is not an option. Some people learn technology and some just say, 'No, I am not going to do that.' It is getting to the stage now where there is a need for people to really get in and learn technology. Maybe there should be places in schools where older adults can go either at night or during school holidays because the equipment is in the schools and can be utilised.

The other thing is diet. Last month the World Health Organisation, WHO, and the UN Food and Agriculture Organisation, FAO, launched a program on diet nutrition and the prevention of colic diseases. They have found that only 10 per cent of calories should come from added refined sugar. The sugar industry in the United States is not happy, and the sugar industry here would not be very happy. But it is a fact that some of the main causes of cognitive decline relate to the cardiovascular system, diet and sugar. It is a basic point everyone has been making: you have to have exercise and you have to look at diet. But we have to look at learning as well.

Ms HALL—You, as an occupational therapist who has worked in that field for, I would say, most of your working life, and combining it with this, would be very familiar with teaching people techniques to cope with loss of function. I have noted in what I have read—and forgive me if I have missed something here—you are saying that, once a function has gone, it has gone forever. Are you involved in the teaching of new tasks and learning compensating techniques?

Mrs Pollard—Yes.

Ms HALL—How are you doing that?

Mrs Pollard—We can help people with cognitive decline to a certain level, and then we cannot because they cannot take in new learning. The working memory is gone.

Ms HALL—What about people who are given Webster packs to cope with?

Mrs Pollard—They cannot.

Ms HALL—They have lost the function?

Mrs Pollard—They cannot.

Ms HALL—And other techniques people are taught. So you basically think it is not worthwhile teaching those people?

Mrs Pollard—In that packet I have given you is a scale.

Ms HALL—One to six, isn't it?

Mrs Pollard—Yes. Definitely when people are functioning at level 5, yes, and maybe in the high 4s, but once they get below problem solving, which is 4.6, no. When they get down to level 4.2, they discard any form of aid. So they cannot find their glasses.

Ms HALL—I must be in trouble! That is a common problem I have; I can never find my glasses.

Mrs Pollard—Things like hearing aids do not mean anything to them. You can find well-worn hearing aids in drawers in nursing homes. I was the head OT at Wolston Park. In those wards there would be a drawer full of glasses or residents could not see because they had someone else's glasses on. They have no concept. Glasses paid for by the government are all one colour, which does not help. The only thing we can do for people is assist them. The best people to talk to are caregivers because they understand that.

Ms HALL—Your submission went into the issues of carers and support for carers.

Mrs Pollard—Yes. Being a carer is a huge job. I have given you the scales in that packet.

Ms HALL—I am looking forward to going through that and looking at it in depth on the way home tonight.

Mrs Pollard—This is another book that I have put out. This is when I do training. So each page is a level, as to what you can expect. There are particular behaviours. Somebody could say, 'There is something wrong with Aunty Flo. I wonder what she is.' They can say, 'My God, she is this one.' That is how they are thinking at that level.

CHAIR—Could you tell me about the Allen cognitive disability scale?

Mrs Pollard—It was developed by Claudia Allen, who was a professor in occupational therapy and is a fellow of the AOTA in America. When she was very young her mother was bipolar. Claudia, when she was only very young, realised that her mum could not do these things. From there, Claudia with other therapists came up with the six levels of how these people were making sense of their universe. If they are using simple vision, that is it. That is why I said things must be clear, they must be seen. So the therapists came up with that. Then they realised that other therapists were saying, 'My patients are a level 4, but they are a high 4, they are a low 4.' They had to develop those different level modes. They did this at the County Hospital in LA. They assessed thousands of people at the County Hospital. They had a wonderful program there and it was very well supported. It virtually came to a halt with the big earthquake in 1994, I think. The building was too unsafe to use. The therapists, including Claudia, were sent to different hospitals and the whole program broke up. We have all gathered together and got the program moving again in only the last few years.

CHAIR—Is there any common ground with neuropsychologists on this subject?

Mrs Pollard—Yes, there is. When I was working at Wolston Park we had to do two lots of assessments on groups of people, DVA patients and patients in Wolston Park. The DVA requested that all 76 patients be looked at.

Ms HALL—The DVA asked you to look at the patients from what perspective?

Mrs Pollard—What could happen to them because—

Ms HALL—Were you looking at them from an OT perspective?

Mrs Pollard—No, there was a psychologist, OTs—

Ms HALL—So there was a neuropsychologist and you?

Mrs Pollard—Yes.

Ms HALL—You were approaching it from a multidisciplinary team perspective?

Mrs Pollard—Yes. So we did that. The assessments were marrying well. The difference between what neuropsychologists do and what we do is we give people something new to do and they have to work it out. So we look at only new learning, and the patient has to be doing something. The latest complex dynamic theory is the learning is the doing. Unless the patient is doing something, the learning is not as good.

CHAIR—In your additional submission you have made some comments about the model of care. What model of care do you favour for those with cognitive impairment?

Mrs Pollard—There is a huge range of cognitive impairment. Some patients are at the higher levels, and really people have no idea they have a cognitive deficit. In this pack I have given you there is information on protection. In the model of care there, people in society have to know about this disability. Informing the public is a huge relief for people with cognitive deficits because an informed public will not force someone to do something that is impossible for them to do. We stop pushing people to do activities and let them use their best ability to function. If we look at the lower levels of cognitive disability, we see it takes a tremendous amount of effort because they are using a caregiver's brain and that person can use up to 70 per cent of that person's brain. Even patients at the high levels will ask, 'What do I do next?' or, 'Where do I go next?' or they wake up in the morning and ask, 'What is happening today?' The cleverer they are verbally, the more they can mask this disability. They put questions in such a way that people answer.

CHAIR—What services are available at the moment in terms of education about cognitive disorders? Your book addresses making sure people are much more aware of cognitive disorders. What services are available which educate family members about dementia and so on?

Mrs Pollard—There are ones run by the Alzheimer's Association. In America the Alzheimer's Association is using this particular one, but not here. There is nothing here that—

CHAIR—Apart from the Alzheimer's Association, there is not much public information on dementia and other cognitive disorders?

Mrs Pollard—No, I do not think so. There are small things. I have written about how people get the run-around, when they realise that somebody needs help and they keep ringing up different organisations.

Ms HALL—Am I correct in my assumption that you feel the information that has been given out by the Alzheimer's Association and health care professionals is not the right kind of

information; rather, it should be geared towards the kind of information that you have here in the package?

Mrs Pollard—I do, yes, but I do not know whether somebody else does.

Ms HALL—I wanted it clear in my mind that that was where you were coming from.

CHAIR—You have said in your handout entitled 'Allen Cognitive Levels':

- A functional performance beyond an individual's cognitive level cannot be expected in novel or non-routine situations.

Can it be expected in any situation?

Mrs Pollard—No situation. Once you find out what their level of function is, that goes across the board. For years people have been saying, 'Go and manage your money,' or see whether they can manage their money or get on a bus or drive a car; but, once you know that, it goes straight across life.

CHAIR—That has some implications in acute care settings and so on. If people with dementia are in a new surrounding, often they can get quite confused.

Mrs Pollard—One of the more tragic occurrences is where a person in a car accident or even playing football suffers a mild head injury and, not always but sometimes, drops dead. It is devastating for the family.

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

Resolved (on motion by **Ms Hall**, seconded by **Mr Hartsuyker**):

That the additional submission 'Impact of cognitive disability and the development of long term strategies for the ageing population of Australia over the next 40 years' be accepted as submission No. 153.

Resolved (on motion by **Mr Hartsuyker**, seconded by **Ms Hall**):

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

Committee adjourned at 3.02 p.m.