ROAD SAFETY COMMITTEE
Inquiry into improving safety for older road users
Melbourne – 5 August 2002

Members

Mr A. R. Brideson  Mr A. F. Plowman
Mrs E. C. Carbines  Mr G. H. Spry
Mr D. Kilgour  Mr I. D. Trezise
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Witness

Mr P. Jamvold, Group Manager, Southern Division, Insurance Council of Australia.
The CHAIRMAN — I declare open this hearing of the Road Safety Committee’s inquiry into improving safety for older road users. I would like to welcome Mr Jamvold from the Insurance Council of Australia. I believe the Insurance Council of Australia initially did not make a written submission, and you outlined the reasons for that in correspondence, but we felt it was important to speak with the ICA hence the invitation to you, Mr Jamvold.

I invite you to make some brief opening comments to tell us a little about the ICA and to make any other introductory comments on safety for older road users. The committee will then have half a dozen or so questions on issues that it would like to tease out with you, so I invite you to take over.

Mr JAMVOLD — My name is Peter Jamvold. I represent the Insurance Council of Australia. My job is called the group manager, southern division; that means I look after interests in Victoria, Tasmania and the Australian Capital Territory. The ICA represents general insurers; they are insurers who cover all fields of insurance except for health insurance and life insurance. We have something like 67 members, and that covers about 90 per cent-plus of the general insurance market in Australia. Is anyone interested in anything else about ICA or the insurance industry?

The CHAIRMAN — So those 67 members cover vehicle or motor accident insurance?

Mr JAMVOLD — No. they do not, Mr Chairman. Some do. Some specialise in this area — for example, AAMI and RACV; others deal with property; some deal with liability. So general insurance in the sense they cover the whole field but certainly not all of them deal with motor vehicles. It is quite a mix, and some are very specialised. Some are what we call niche insurers — for example, Catholic Church Insurances or Guild Insurance. They deal only with insuring the property of their members such as pharmacists.

Mr SPRY — What percentage of insurers would be members of the Insurance Council of Australia?

Mr JAMVOLD — As I mentioned in terms of a gross written premium basis, which is about the only basis on which you can compare, we cover about 90 per cent of the industry. We have 67 members; we have a whole lot of submembers. We have a total of 147 members and associate members. Associate members are simply subsidiary companies of the full-member company. Obviously there are companies that are not members of the ICA and that extends for some reason to a lot of American writers based here; but by and large the Australian industry is represented by the ICA.

The CHAIRMAN — And does the ICA have any general views on ageing drivers or ageing road users? That is a leading question.

Mr JAMVOLD — It is a leading question! I am glad you asked it, though. We do not have any specific position on it. I do not wish to be trite, but our function basically is to provide the service of insurance, and we price for risk. We are interested in the risk associated with older drivers, and I can comment on that in a minute. As far as public policy is concerned, we feel we are not expert in the field. There are other organisations which are expert. Just a few would be the Transport Accident Commission, for example, here in Victoria, and like organisations which have the statistics on a broader basis for a start; they are particularly concerned about road safety in a very applied sense and they take action to do something about it. We canvassed our members to ask what their comments were on the subject. They came back on an individual basis — there is no industry position on this — and they said there is no discrimination against older drivers.

You are probably aware that insurers can legally discriminate where they can give evidence for the discrimination. They discriminate on the basis of age — for example, drivers who are under 25 years old. P-platers pay a higher premium by virtue of the fact they are responsible for a larger proportion than normal of the road toll. As for older drivers, whatever that might mean — and I was interested in the comments in the discussion paper on that — there is no discrimination against them whatsoever. There is no evidence that they have a higher than normal accident rate. Within that older group — as I said, it depends on how you define it, whether it is over 55, over 65, or what — as you might expect there is a natural increase in incidents as people get older. But as the famous songwriter once wrote, ‘He met a man who was old at 33’. Equally someone can be quite spritely at 75, so you cannot define someone who is old or cannot drive or whatever simply by virtue of age.

So to summarise the comments, there is no discrimination. One company responded saying it does require older drivers when they turn 75 to produce a medical certificate showing that they are in the view of the medico quite capable of driving; but that was the one sense of some special requirement. No other insurers had anything.
Mr SPRY — Conversely I think on 20 May we were given evidence that pensioners on third-party compulsory insurance were given a decrease in premiums. Is there any evidence of the same thing occurring in the comprehensive insurance industry?

Mr JAMVOLD — I do not think so. There is a company which specialises in insurance for older drivers, and I think it does give pretty attractive premiums. I am not commenting on that, but to say they recognise there is a relatively lower rate of incident for older drivers within reason and they price it accordingly. My understanding — just my personal view — is that it is a competitive rate.

I would also say that where an insurer finds that a particular client starts banging into parked cars or has problems seeing at night and that is reflected in accidents then that insurer would underwrite accordingly. In other words, the company would probably ask for medical records or advice or whatever for that person. It is pretty normal in any area of insurance that if someone is a bad risk — basically if they incur a lot of accidents — then it is normal for an insurer to look into the reasons why.

The CHAIRMAN — If a person was denied insurance because of a large number of claims, naturally you would start to shop around for insurance companies. Is information transferred from one insurer to another at the request of another company in relation to a particular person?

Mr JAMVOLD — The privacy act prohibits that, Mr Chairman.

The CHAIRMAN — I was just exploring that. Did it used to happen?

Mr JAMVOLD — In the past it happened between insurers and police and arrangements like that, but generally it would not, certainly not formally. Now it is out of the question.

Mrs CARBINES — As the population is ageing in Australia do you see that there are going to be increasing problems facing the insurance industry in relation to older drivers or do you see it pretty much staying the same?

Mr JAMVOLD — I would say they would stay the same. To the extent that there is probably a lesser proportion of younger drivers it has probably improved. Once again that is perhaps not a serious comment. I would say as drivers get older more consideration needs to be given to their welfare, but from an insurance point of view I do not think you could expect insurers to back off older drivers simply because there are more of them. In fact what I understand from our members is that they are a good risk.

Mr SPRY — They are a good risk?

Mr JAMVOLD — A relatively good risk, yes.

Mrs CARBINES — In America and in Europe as their population ages we are aware of more stringent practices taking place to screen out potential hazardous drivers and insurance risks. Are you aware of any Australian companies looking at that?

Mr JAMVOLD — No, I am not. As I mentioned, each of the respondents to our questions showed that there was no concern and no discrimination either.

Mr SPRY — In the USA we found that insurance companies were often offering a discount to people who had been through a driver education program. Is there a trend that way in Victoria, to your knowledge?

Mr JAMVOLD — I do not know if there is a trend. That is an underwriting issue which is the responsibility of individual underwriters, so on an industry basis the answer is probably no. On an individual insurer basis there could be a cause for a company to decide to do that — for example, a company would give consideration to people who have installed immobilisers in their cars. So to the extent it does affect risk materially an insurer might consider it.

Mr SPRY — I would have expected that the insurance industry, because it is a commercial enterprise, is really the driver of premiums. I guess it must be.

Mr JAMVOLD — I hope so.
Mr SPRY — But it would reflect the relative risks of various age groups. Are you really saying that the industry generally is not doing that?

Mr JAMVOLD — The industry does price for risk, as I said, and the obvious example is a driver under 25 years old. They pay a higher premium by virtue of the fact that they have a higher risk. One other thing is that female drivers have a lower risk too, and their premiums tend to reflect that lower risk.

Mrs CARBINES — Is that carried across the age groups?

Mr JAMVOLD — I believe it is, but that would depend on individual companies again.

Mr SPRY — Could I just change the focus away from cars for a minute on to motorised scooters and the like. There is growing evidence that when people are no longer driving they will in some cases turn to motorised scooters or that sort of thing instead of public transport. Currently they are not required to be licensed — that is my understanding. The status is basically the same as with pedestrians. Do you think that users should be assessed and licensed, and what risk does the insurance industry carry or what risk is the insurance industry prepared to carry if cover is sought from those people?

Mr JAMVOLD — That is a leading question again. I might say my father-in-law was on a motorised scooter and was hit by a car so I have a personal interest in it. A car backed out of a driveway right on top of him. I can only offer a personal comment; I cannot speak for the industry there. I would say basically that it depends on the medical conditions of the driver of the car, whatever. It is the same as with a bicycle, the same as walking. I would question whether it is a useful thing to licence them.

The CHAIRMAN — It is just that we are trying to look into the future, and some 20 years down the track we can foresee that neighbourhood strip-shopping centres could be very congested with these scooters, et cetera. So we would like to tease you out a little bit on whether the insurance industry has in fact even considered it, and again we are also interested in your personal views, given your experiences.

Mr JAMVOLD — Congestion is a different issue from safety, of course.

The CHAIRMAN — But they are related.

Mr JAMVOLD — That is right. I suppose some companies have considered it. To the extent it is not a problem at the moment, I do not think anyone has made a decision on that. I have certainly not had any comment about it.

Mr SPRY — To keep teasing, there is a problem with pedestrians who might be hit by these things, just as there is from skateboard operators or whoever they are, unlicensed bicycle riders, on footpaths. There is no cover for someone who might be cleaned up and incapacitated for life, for example. Does that concern the industry at all? It certainly concerns us at legislators. I guess that innocent victims are unable to claim compensation at present.

Mr JAMVOLD — You are delving into the very deep area of liability here, which I spend most of my life dealing with, and yes, from that point of view it would be a concern. I imagine — once again a personal comment — that if it does become a problem and if it gets worse because of the congestion then a certain percentage of the people driving these cars would perhaps need better glasses or better driver education, I do not know. But to the extent it does become a problem then I would imagine the government would be interested in doing something about that, whether it is driving on the left for a client or parking in the car parking area. But it is like traffic lights at dangerous intersections; they come about after problems exist. You need, unfortunately, accidents that are at an intersection before the traffic lights are put in. I assume it is the same sort of situation with the elderly people driving cars. By the way, it is not just the elderly but people who are incapacitated driving cars.

The CHAIRMAN — In Shepparton some 12 or 18 months ago we noticed a large number of people on footpaths in these scooters and we noticed the kerbing was not all that safe. We have to look at future infrastructure needs as well, and we can foresee where local councils may well be liable for accidents because kerbings are not facilitated.

Mr JAMVOLD — They are very disturbed at the moment with the non-feasance rule, so it is a major issue.

The CHAIRMAN — Perhaps we can move to volunteer drivers and the insurance requirements for them. We have many people who provide Meals on Wheels, which is the classic service. Another service could be use of
a private vehicle for transporting older people around the communities. Does the council or any of your individual member companies have any specific requirements for volunteer drivers?

Mr JAMVOLD — I do not believe so. I think just the standard requirements apply, that they be licensed and in reasonable health — nothing more, I do not think. If it is a commercial concern, which is different, then you have a problem of liability in a broader sense of general liability. Then you get issues of training and proper cover and all that sort of thing, but for volunteers the normal personal driving requirements would apply.

Incidentally, the whole question of volunteers is being addressed at the moment under the general liability issue. I was interested to see in the newspaper this morning that the government has prepared through the Law Institute of Victoria a draft bill dealing with volunteers and food. I expect that over time the issue of volunteers will be expanded to incorporate a wider scope within the community.

The CHAIRMAN — You mentioned earlier that the ICA is not a data collection agency.

Mr JAMVOLD — Correct.

The CHAIRMAN — I take it that individual companies collect their own statistics?

Mr JAMVOLD — Until about 15 years ago ICA had a major data function and it spent millions of dollars a year on behalf of the industry collecting data and distributing it back to the industry. In the late 1980s for a number of reasons it was decided that was no longer appropriate and that function was shut down and basically sold to a private company, Deloittes, which now runs an operation called Insurance Statistics Australia. It is a private concern and it has insurers as customers and those insurers provide their internal data to ISA. It is aggregated and then provided back to those insurers and to anyone else who is prepared to pay a fee.

Apart from the federal government through the Australian Prudential Regulatory Authority, ISA is the only organisation that collects insurance statistics on an industry basis. Each insurer, of course, has to price risk and they need pretty good statistics to price it accurately, so each company has its own statistics as stock-in-trade and they are held by the insurers pretty close to the chests for their own purposes.

The CHAIRMAN — Are those statistics Australia-wide, or are they broken down state by state?

Mr JAMVOLD — Which ones — the ISA ones or the individual insurer statistics?

The CHAIRMAN — Take both.

Mr JAMVOLD — Insurance Statistics Australia collects them Australia-wide to the extent that the member companies operate Australia-wide, though not all of them do. Incidentally they cover between about 30 and 40 per cent of the market, depending on which market you are talking about; so liability cover would be different, for example, from property cover.

The individual insurers collect data according to their markets, so the larger companies which operate Australia wide would have Australia-wide statistics; those that are niche marketers would not.

Mr SPRY — Can you explain the difference between liability and property insurance?

Mr JAMVOLD — Yes, sure. There is a huge difference. Property insurance is basically what we call first-party insurance. Take the example of a motor vehicle policy: that would be first-party property insurance. You insure your vehicle for damage, theft or fire, and if you have a horrific accident and write it off and you are in the right and have done nothing illegal, the insurer would pay you as the policyholder. Liability insurance is usually third-party insurance — that is, if you run a business and you deal with the public you would have a public liability policy, and if some third person — someone you do not know — comes to do business in your operation and slips on a banana in your supermarket or whatever and is hurt, then you as the insured are the person who has the policy and you have taken it to protect yourself against someone else claiming against you for negligence. The simplest distinction is the difference between first-party cover, which looks after your own property, and third-party cover, which looks after the interests and wellbeing of a third party who is a member of the public. Is that clear?

Mr SPRY — Yes. Does your insurance policy generally cover first and third parties? Who is the second party?
Mr JAMVOLD — The second party is the insurer. Property insurance — for example, your household home and contents policy — includes third-party cover as part of the overall policy to cover you if someone comes onto your property for whatever reason, trips over in the garden on a rake, is hurt and sues you.

Mr SPRY — That is first and third parties?

Mr JAMVOLD — That is a third-party claim, and that is covered under the normal domestic policy.

Mr SPRY — What sort of cover is motor car insurance?

Mr JAMVOLD — It is first-party normally, but then the Transport Accident Commission has compulsory third-party cover. That is for when you are involved in hurting someone else.

The CHAIRMAN — Are the Insurance Statistics Australia statistics different from the TAC statistics or are they complementary, and is that information transferred between TAC and ISA?

Mr JAMVOLD — It can be transferred if TAC sees value in it, but TAC has a good statistical collection and I would be surprised if it needed it. The Transport Accident Commission statistics obviously relate specifically to its business, and it runs a closed operation in the sense that it is very narrowly defined activity, the same as with WorkCover. It is a closed system, which means it is much easier to collect statistics that are useful to it. It has collected detailed statistics for a long time and they are very applied, so I suggest it would not see much value in the general ISA statistics. However, I am sure those ISA statistics would be available to TAC provided it pays a fee to Deloittes. I assume you have spoken with TAC?

The CHAIRMAN — Yes, we have.

Mr JAMVOLD — Yes, that would be a great source for you.

The CHAIRMAN — We do not have any further questions for you, Mr Jamvold. I thank you very much on behalf of the committee for appearing before us. We will send you a copy of the transcript in the next couple of days and we would appreciate it if you would go through that. You may wish to make some corrections, and if you would turn that around quickly we would appreciate it.

Mr JAMVOLD — Good luck with your deliberations.

Witness withdrew.
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Witnesses

Assistant Commissioner R. Shuey; and
Superintendent P. Keogh, Traffic and Operations Support Department, Victoria Police.
The CHAIRMAN — I welcome Assistant Commissioner Ray Shuey and Superintendent Peter Keogh from the traffic and operations support department of Victoria Police. In welcoming you both to this committee I endorse the stance your department has taken in relation to road safety. The parliamentary Road Safety Committee works very closely with you people and we would like to compliment you on the work you are doing. We hope you do not give up and give in to a lot of the public demands that we hear of from time to time.

Our inquiry is into improving safety for older road users. I note that Victoria Police made a submission on 27 February to meet our deadline and, as always happen, time got away from us and information and statistics changed, and you have a fresh submission to put to us today dated 2 August. I ask Assistant Commissioner Shuey to start off by taking us through the new submission. I also thank you for highlighting the additions in red as it makes our task much easier.

Asst Comm. SHUEY — Thank you very much, Mr Chairman, and members of the committee. The new submission highlights a number of additions made to our previous presentation and I will take you through those issues and then expose both myself and Peter Keogh to any questions you may wish to raise.

First, the definition of ‘older’ is a very sensitive issue from everybody’s perspective, and our comments and submission relate basically to the accepted definition of 50 years and onwards. However, we would like to highlight in particular not the aspects of older drivers but of people who are more at risk. If we can get some common understanding of that at-risk group then we will probably be on the way to finding some positive resolutions.

In the table at the bottom of page 2 we have identified the numbers of people in that age group — 50 and above — who were involved in collisions in the categories of killed and injured in 2001 and we have compared those with the figures for 2000.

Basically, we have looked at the positive and negative changes in those categories: motorcyclists are up 14 per cent; pillion passengers are up 30 per cent; drivers are down 11 per cent; passengers are down 25 per cent; pedestrians are down 5 per cent; and bicyclists are up 32 per cent. We have omitted the summary at the bottom of that document, but in all there was a total of 4481 in 2001 compared with 5064 in 2000.

Mr SPRY — They are two-year statistics. How reliable do you think they would be over a longer period? They are quite dramatic figures and some of those increases and decreases are significant. Do you intend to take a longer period to get a better assessment of what the trend might be?

Asst Comm. SHUEY — We can do that, and if there are any particular highlights we will draw attention to that. Normally we run with the other statistics based on a five-year average so we can compare plus or minus as we get a better assessment. Because we have included the injuries in these figures we get a wider database than just picking on the fatalities. I will undertake to get a copy of that to you in the next couple of weeks, if that assists.

We have highlighted in red on the following page relevant statistics that were not included in our original submission. Some 19 older-driver fatalities were not included in the road toll: 15 were caused by heart attacks, 1 was due to brain haemorrhage, 1 was due to suicide and 1 was an off-road death.

Picking up on the statistics for 2002, 11 fatalities were not included in the road toll fatalities. That aspect is relevant when we are considering any remedial issues or issues further afield.

The CHAIRMAN — You have indicated only one road death due to suicide; how do you know if a single-fatality accident, say, in rural Victoria is a suicide or not?

Asst Comm. SHUEY — We do not record them as suicide statistics until after the inquest. There may be a suicide note and they have usually run straight off the road and travelled 100 metres into a pole, a tree or whatever with no attempt to brake or swerve nature. All that evidence is provided to the coroner. Sometimes when there is an indication that a vehicle has run off the road in a straight line and we believe it was a suicide the coroner will not come down with that finding because there is no note and because there has been no previous family trauma or anything of that nature. Such fatalities really have to be bounced through the inquest process before they are declared as suicides.

Supt KEOGH — It is very difficult to record it as a suicide unless the coroner makes a finding of that fact.

Mr SPRY — Why would the heart attack victims not be included in road trauma?
Asst Comm. SHUEY — Because it is through no fault of the individual. We are looking at standards right across Australia.

Mr SPRY — But neither is the dog that runs across the road the fault of the individual. The fact is that it translates to a death on the road.

Asst Comm. SHUEY — It does, and I do not know if Peter wants to comment on that further, but this is something that has been relevant for a number of years. Most heart attacks do not involve other vehicles; if they do involve other vehicles they become a statistic. If I have a heart attack and collide into another vehicle and there are two other fatalities, that obviously becomes a road statistic.

Mr SPRY — In terms of cause and effect it is a serious consideration. If you could predict it — but of course you cannot — it is a significant number of people who are affecting the overall number of statistics in terms of road deaths.

Supt KEOGH — Just further to the point, the Australian Transport Safety Bureau, in conjunction with agencies throughout Australia, has an agreed formula as to what is accepted as a road toll statistic. Where someone dies as a result of a medical condition not caused by the collision it is agreed that it is not included in the road toll.

Asst Comm. SHUEY — The other aspect is by way of the inquest. It is never finalised until after the inquest that a person has had a heart attack and died, or as a consequence has run into some other obstacle, which damaged the car and further injured that person.

I continue with the submission. What we have done, which highlights the issue on page 3 with the relevant graphs, is compare a group of drivers, riders and pedestrians of the over-50s age group with those of the 26 to 39-year-old group. We have done that by way of highlighting that there is not much difference in both those groups. They are similar in terms of their representation of the population of Victoria — that is, 30 per cent of those aged 50 years and over represent the population in Victoria, and the 26 to 39-year-olds represent 25 per cent of the Victorian population. We have highlighted their comparative injuries and deaths.

You will note from the graphs, which are easily identified, that pedestrian injuries and fatalities are the only ones that rate a little bit higher, whereas the others are substantially lower. We have quoted all the statistics there:

4554 'older road users' ... 19 per cent of all road injuries of all ages

Over the page we have drawn the comparison with 32 per cent involved in the 26 to 39-year-old group. We have done the comparative statistics, and identified that there is not too much of a difference in those two sections of the community. The injury rate increases with age, obviously, but that does not necessarily impact upon the aspect of causation of road trauma.

The new additions also at the bottom of page 4, which again we have highlighted in red, look at the fatalities that are caused by the older road users. In 2001, 30 fatalities to other road users were caused by the older age group.

Mrs CARBINES — When you are looking at those statistics with the statistics from this year you can see that already, in the first six months, 21 road users have died. So, feasibly, that figure will rise beyond 30 by the end of the year.

Asst Comm. SHUEY — One would expect so with the trend.

Mrs CARBINES — Do you see that as an alarming trend?

Asst Comm. SHUEY — It is very difficult to identify when you are looking at fatalities only because the statistics are very small. Again, as mentioned before, that is where we need the five year average to draw a reliable comparison to see whether the trend is up or down. I think the comment was raised previously that probably it would add value by providing that five year average for any of the statistics that we have produced here.

The CHAIRMAN — Is that evidence gained from your statistics, a combination of statistics, or coroner’s findings?

Asst Comm. SHUEY — They are based on coroner’s findings with fault because we do preliminary fault analysis and that is corroborated or negated by the coroner. In most occasions we are spot on because we do an assessment. We provide the inquest brief to the coroner, and from that we either get told to do some more
homework in relation to the issues or the coroner will confirm the information that has been presented. Most of the serious statistics come out of our major collision investigation group, which has the expertise to provide the relevant and positive findings.

Mrs CARBINES — In comparing those two charts, the first chart for 2001 indicates ‘rider’, and the second chart for 2002 indicates ‘motorcyclist’ and ‘bicyclist’. You have separated those two. Why is that?

Supt KEOGH — I would suggest that there were no bicyclists killed this year.

Mrs CARBINES — So in the first chart the rider is a motorcyclist?

Supt KEOGH — Yes.

The CHAIRMAN — I come back to the previous point that I was making about the coroner’s investigation. Does the coroner investigate every road death?

Asst Comm. SHUEY — Yes, there is an inquest held for every fatality, it just depends on the extent of that inquest what transpires — whether witnesses are called or whether it is, basically, a hearing. A finding is provided in relation to each of those inquests. Some, obviously, will go for a couple of weeks and others will be dealt with in 2 or 3 hours.

Mr SPRY — I do not think that there has been a statistic produced to compare 1000 kilometres or miles driven; these are just statistics as indicated?

The CHAIRMAN — Raw statistics.

Mr SPRY — Yes, raw statistics. We have seen in this investigation several graphs that show that the younger road users are heavily involved in road trauma, and this is in terms of 1000 kilometres travelled, and at the other end of the scale older road users are similarly on the increase in terms of that statistic. Would you like to comment on the comparisons of those graphs that I have just referred to and these which are just the raw statistics?

Asst Comm. SHUEY — I have not had access to that information, but if I can take it as a question on notice?

The CHAIRMAN — I think that is fair enough.

Asst Comm. SHUEY — We can follow through with those. One would automatically state, I suppose, that younger people tend to drive a lot longer distances than older people in some circles. It is one of those things and it just depends: the older you get you get the less frequently you tend to drive. We would need to follow that up with the proper data.

The CHAIRMAN — To be fair to you we will provide the information that has been given to us for your comment.

Asst Comm. SHUEY — Thank you.

Mr SPRY — It may not matter. I do not know what the significance of that is, and it would be interesting to get your comments on that.

Asst Comm. SHUEY — We know, just by way of the anecdotal information, that we do have a couple — five or six — serious fatalities from the older groups in the country areas, basically going through ‘stop’ signs or ‘give way’ signs in areas that they are familiar with, and those people generally only drive perhaps 20 or 30 kilometres a week, and that causes us some concern. But to get to a resolution or some suggestion in relation to those is very difficult. We have provided some comparative graphs on page 5 in relation to injury severity and, again, identified that there is little difference between the older and middle-aged groups.

Issues in relation to motorcycle and pillion passengers are found on page 6. One of the things that has been concerning us is the number of middle-aged and elderly people who have been involved in motorcycle collisions in the past few years. From the police perspective we have undertaken to do a full investigation on those motorcycle collisions over the next 12 months — our major collision investigation unit is attending or being involved in the inquest brief preparation in relation to that and paralleling with Monash University Accident Research Centre — and we will able to provide further statistics in relation to those. It is also relevant to note, and we have not
identified it there, that Narelle Haworth from MUARC is also doing some quality research in relation to motorcycle riders over 30 years of age.

There are some other comments there in relation to older drivers and passengers: speed of impact and collision types. Speed of impact: obviously slower driving results in less impact as far as the severity of the collision goes. Collision types: suggests that complex situations are more likely to result in a collision for older road users. However, the aspect from our point of view is that if we need to make modifications to complex driving environments we should be doing it for the general population as well because there is nothing specific that needs to be done for the older road users as opposed to the younger ones. Everybody needs clarity of signage and less complex driving environments to work with.

Mrs CARBINES — When the committee went overseas it heard evidence that older drivers were more likely to be involved in multiple-vehicle crashes and that the older driver is more likely to be the one at fault in that multiple-vehicle crash. Can you elaborate on the Victorian experience?

Asst Comm. SHUEY — I am not sure that we have got anything by way of firm evidence that would go further than to say what we are saying there with the complexity of the environment — that is, it is more likely to create confusion, slower reaction time — but that is only anecdotal information rather than anything by way of hard evidence.

Supt KEOGH — Just further to what Mr Shuey has said, I do not see that the evidence overseas is supported here in Victoria. I believe older drivers, as Mr Shuey said, tend to drive slower and as such are less likely to be involved in high-speed type collisions. Perhaps there are situations where a head-on collision occurs where there is a lapse in concentration with oncoming vehicles, but we do not see that as being significant in respect of the statistics.

Mrs CARBINES — Do you see roundabouts as causing any particular problems for older drivers as opposed to traffic lights where it is black and white and you know when you are supposed to stop?

Asst Comm. SHUEY — I think generically roundabouts cause problems for all drivers, both by way of clarity and of what the legislation requirement is. We note that at roundabouts there are less severe collisions, but more of them. So if you have a comparison between a set of traffic lights, a roundabout or nothing at all, the roundabouts take the impact out of the collisions, but there is still a lot of confusion as to who has right of way. I think we need to embark upon a very serious campaign in relation to that because people think that as some vehicle is approaching from the right they have got right of way rather than the vehicle having entered the intersection, which is what the legislation is.

Continuing on with the pedestrian crossings. There is a lot of initiative being undertaken at present in relation to various forms of different pedestrian crossings. We have identified in red the issues of the Pelican pedestrian light control and the Puffin lights. As we move forward with technology there will be a lot more sophistication being brought into the system now. I am very impressed with some of the new initiatives that VicRoads is looking at in terms of those pedestrian crossings. Again, it is a balance with road users having access to the road and pedestrians and identifying as much as possible what can be done. A lot can be seen as a wasted effort with the various technology that is in place, but as the cost is brought down then it is probably beneficial across the board if we can bring in any sorts of intelligent operation of those pedestrian light systems.

The CHAIRMAN — You have said that ‘further research must be undertaken’. Is there any process in place in Victoria for this idea to have effect? It is a great statement, but who is responsible? Is it Victoria Police, or VicRoads?

Asst Comm. SHUEY — The pedestrian crossings and signage always come back to VicRoads, but within the partnerships and the base-line projects that we have with the Transport Accident Commission, VicRoads, Victoria Police, and justice, we organise with the Monash University Accident Research Council to undertake the research. I note with many of VicRoads initiatives — I am not saying all — it undertakes automatic performance indicators on its research to see whether it is effective.

The CHAIRMAN — I guess what I am trying to find out is if there is a mechanism in place for this to occur.

Asst Comm. SHUEY — Most certainly. It is a matter of making sure it is triggered at the right time when anything new is brought into play. There are some new lit pedestrian crossings. I see there is one out on Burke
Road near the Monash Freeway, on the Burke Road overpass, that seems to be effective. In terms of that process, I was at the VicRoads advisory board last week and I actually raised that as an issue to see how effective it was in terms of collision reduction and observation. A lot of these involve surveys from drivers and pedestrians, and they take time to provide some response. If they are only put in at a particular location like that, it is very hard to get a proper research product at the end of the day.

Basically the next couple of pages of the submission go through the various issues of motorists and pedestrians sharing space on our roads and providing that everybody gets a fair go in the overall context.

Roundabouts were referred to on page 9. The issue there is the proximity of pedestrian crossings to roundabouts, which can cause confusion, the same as if you have a school crossing or a pedestrian crossing just after somebody has done a left or right-hand turn, which presents a higher risk as far as collisions are concerned.

On bullbars and vehicle design, again there is limited research; everybody says that bullbars are a major problem. Realistically they are, and we have a tendency across Victoria to have a lot more bullbars fitted. There is no such thing as a pedestrian-friendly bullbar. Again, the damage to people generally as opposed to individual segments of our community is well noted.

A number of other issues have been highlighted: the road environment, variable speed signs and things of that nature. Again it is very difficult to highlight one segment of the road-user environment and do something particularly for that age group.

Following through pages 10 and 11, we have picked up some of the issues in relation to education. Again, we need to highlight education as a major factor for the elderly. We have gone into some discussion about mobility aid devices, and I do not see that there is any — —

Mrs CARBINES — Are people who drive those little gophers allowed to use the road?

Asst Comm. SHUEY — We have a problem wherever they are from that point of view. The speed limit is 7 or 8 kilometres per hour, but it is one of those issues. We do not carry on about that so long as people are riding safely. There is a problem on the footpath as well with pedestrians and it is a matter of sharing the road environment.

Supt KEOGH — I believe there is provision for this type of vehicle to utilise footpaths. My recollection is that it is specifically mentioned, but I imagine where a footpath has not been established they could use the road system. Preferably we would like to see them on the footpath.

Mr SPRY — Are you aware of any statistics of these scooters hitting pedestrians? Do the police get involved in those sorts of incidents.

Supt KEOGH — We would get involved if there were an injury of some nature with a pedestrian, of course. No, I am not aware of any injury statistics.

Mr SPRY — The committee would be interested to see any statistics on that to see if there is an insurance issue coming out of shared footpath arrangements, so we would appreciate anything you have in that area.

Asst Comm. SHUEY — I am not aware anecdotally of any big issues in relation to them. We have more troubles with kids on motorised bikes, motorised scooters and things of that nature. They go a lot faster than these, and they will go down the tram tracks and cause all sorts of problems. We will follow that through.

Mr SPRY — While we are on page 11, you mentioned that some climate of fear exists when people are addressing older people, fear of losing their licence or whatever it might be. How do you try to put people at ease? Is that a problem? If people are feeling fearful of losing their licence they might be reluctant to attend these meetings with police.

Supt KEOGH — My understanding is that there is some reticence from people to attend these lectures. However, those who do attend are quite satisfied with the process and are reassured and send the messages back to their friends who did not come because there was some fear from them that we would be taking their licence from them. It is a self-assurance proposition and certainly a reassurance for them that if there is some issue about their confidence in retaining their licence they should seek medical help and guidance from family and that sort of thing.
Mr SPRY — It sounds as if older people, particularly those getting to the advanced ages, want to hang on to their licences and there is a closet fear where they think, ‘We will tell nobody, we just do not want to know about it so long as we can hold on to our licence’. Is that a reasonable assessment of what is happening in the community?

Asst Comm. SHUEY — I am sure there is. I was going to mention it separately. There is an issue in relation to identification and the drivers licence. I think there is room to move in this area with people being able to have a retired licence so that they can still have that identification available. There is the issue of the possession of the licence over a period of 20, 30, 40, 50 years, and it seems basically, from the male’s point of view, that taking away their licence is seen as taking away their manhood. There are a lot of psychological issues, particularly in relation to the male driver. I was going to highlight a couple of those issues when we get over to the sensitivity of any medical tests and things like that. It is really a big problem in the community — that people seem to want to hang on to their licences. They do not want to declare that they have failing eyesight, failing hearing or failing anything. It comes down to basically what can you do with dignity to look at that transition process from one to the other, from being a driver to a non-driver in the future?

Mr SPRY — In terms of skills required by professional drivers and drivers whose living depends on what they do in a motor vehicle, you have mentioned more stringent driving skills. Can you elaborate on what those more stringent driving skills might involve? Are you coming to that?

Asst Comm. SHUEY — Yes.

Mrs CARBINES — Do you think there is a need for driver instruction companies to target older drivers? I have had an experience in the last couple of years with my mother who had a licence but had never driven and at 70 wanted to drive. We did not want her on the road, but she needed lessons to get her back into it. We found it difficult to get a driving school company to take her on. Finally we did and now she is driving, but there seemed to be a real reluctance among driving companies to take on an elderly person, to be patient and to give them the practice they needed. Is that a problem? Are you aware of that?

Asst Comm. SHUEY — I am not aware of it specifically, but I can understand the dilemma that is faced there. You will find that the driving trainers are looking at throughput as opposed to just the commitment of 1 hour for $X. I can see that it would be a difficult task to take that on board, and perhaps there is some degree of responsibility. I am not sure if Peter wants to make any comments, but I have no automatic solution to that issue. People should be entitled to obtain the licence and have full access to anything irrespective of age. It is a difficult one.

Supt KEOGH — I have a fair bit to do with Ann Harris from the Royal Automobile Club of Victoria, and without highlighting a particular company I believe that her company has specific training for older drivers. I guess it is a matter of being able to find the right company to cater for the needs of older drivers.

Asst Comm. SHUEY — The issues that are important in relation to those driving skills and those other attributes are really the capacity to process information properly when you are driving, and the issues in relation to physical ability and some of those aspects. We have mentioned manoeuvring when driving and the capacity to react correctly in sufficient time in an emergency situation. That all leads into driver roadworthiness. Again the dilemma, from the perspective of the committee, policing and anybody else looking at this legislation, is whether you can have a legitimate age at which you can draw the line and start to talk about medical tests and those sorts of things.

We react to situations involving collisions. If we have a collision and there is evidence of some difficulty in the driver’s competence to drive, we refer the matter through for medical advice. Or if we receive information from relatives, we will provide a submission to make sure those people have a medical test to see whether their driving competence is corroborated by the medical evidence. That is an issue.

Annual tests have been raised in various forums. This has always been an aspect that causes us some concern, but again, to provide the magic answer in relation to that is, I suppose, fraught with a lot of sensitivity. If you draw an age limit of 70 or 65 then there are all the debates in the community about whether or not the individual is a competent driver at any particular age, and there are plenty of examples where they will be and plenty of examples, as we have referenced in our document, where you might be 48 but you have difficulty being a competent driver because of various medical impediments.

The CHAIRMAN — Are you happy with the current system; is the current system working? If not, what suggestions for change would you make?
Asst Comm. SHUEY — There is always an embarrassment with the current system, because as soon as we provide a report recommending a medical assessment everybody gets up in arms and blames the police when in actual fact it might be the son or daughter of the elderly person who is trying to get them off the road, so to speak. That is the dilemma. But we have to take that responsibility if we believe somebody should not be driving, or they need an external assessment of their capabilities. Once that issue has been triggered, that somebody needs to be assessed, then they should be going back for a driving licence test again, apart from the medical aspect of driving.

You have to have a two-fold competence test. One is the medical test; the other is the capacity to be able to handle a motor vehicle. That generally scares the community anyway. Everybody in this room would probably have some difficulty if we said that tomorrow we all had to go and have a driving test, a check on the road laws and all that sort of thing; we would all be a bit nervous.

The CHAIRMAN — We would all cringe.

Asst Comm. SHUEY — That is right. It is a big issue. Peter might follow through with that.

Supt KEOGH — Doctors are sometimes reticent to report people who perhaps should not continue driving on the road. They put the onus back on that person. They might say to their patient, ‘Listen, I do not think you should be driving any more and you should do something about it’, without the medical person taking steps to initiate some form of process to have that person looked at. That introduces a problem too, because if that doctor became known as a person who reported situations to authorities, then older people would not continue going to that doctor; they would find someone else to go to. There are difficulties with those situations. I would like to see some form of process introduced where medical practitioners were required to initiate a report when they were concerned about the appropriateness of somebody driving.

Mrs CARBINES — In your submission you seem to be advocating the introduction of a driver roadworthiness assessment. I may be mistaken, but you do not seem to give an age where you think that should commence. Are you saying that everyone should have to undergo an assessment for driver roadworthiness on a cyclical basis, or will you state an age when that should be introduced?

Asst Comm. SHUEY — That is the hard question, I suppose, and it is one without an automatic solution. I think the way we are going now, with 10-year licences, is fraught with danger from the overall community aspect. It creates a whole lot of issues from our point of view, but one can get a licence. I think the way to get around it would be to have an age limit with the renewal period shortened so that we do not have a 10-year renewal. Over a particular age you might have three-year renewals. Again, that is bound to cause a whole lot of community concern: why pick on us, and all those sorts of things.

Supt KEOGH — We struggle with setting an age limit that should be introduced, because wherever you set the benchmark there will be outcries from the community. If we set the benchmark for 70, for example, some people who are 70 or 75 can be in much better health and much better drivers than someone who is 60 and suffers from a medical problem. We struggle with setting an age limit.

Mrs CARBINES — With the renewal system as it is at the moment you are not required to have an assessment, are you, you are just renewing the licence? There is no assessment as part of that process?

Asst Comm. SHUEY — I suppose the difficulty from our point of view is that for us to provide quality advice to the committee we really have to have the research to back what we are saying, and we are unable to get that research. All we can talk about is anecdotal information, which is not really a healthy way to get a substantial finding, from your perspective as well as from ours.

The CHAIRMAN — We will certainly be looking at what they are doing in the other states.

Asst Comm. SHUEY — The best we could say is that we would be very supportive of renewals at a shorter period, and supportive of any initiatives that looked that, say, 65 or 70 years as a benchmark area, but again we cannot identify statistics or evidence to back that up.

Mrs CARBINES — But the renewal on its own for a shorter period would not really make much difference, would it; it needs to have an associated assessment?

Asst Comm. SHUEY — That is right. I believe that is relevant; one of the first steps. I know from personal experience my mum has a licence and will hang on to it even though she has not driven for 20 years beforehand; she still wants the licence, to have it there. If it came up for renewal, she would not renew it. That is an
issue where you can bow out gracefully without the fact of having Big Brother or some central organisation telling you to give it up; this is your choice. A lot of families have told us that they have had to take the licence away from their parents and actually do something. I think they do not have any support from the community or the police to actually do that. They would probably like that ability to say, ‘Look, it’s not my fault that we are taking the licence away from you, they are the rules’.

Again, if people are confident they can ride through those processes. I suppose where we are headed to is a summary in appendix A at the back of the submissions, which I felt was a quality submission that could be put to the committee. It was relevant to a presentation that was undertaken at the Safer Roads conference a few weeks ago. I will ask Peter to expand on the details. This provided a legitimate way of transition from the driver to the non-driver in a fairly effective community strategy that was adopted overseas.

Supt KEOGH — Katherine Freund gave a keynote presentation to the Safer Roads conference some three weeks ago, and she described the independent transport network program which commenced in 1990, and, as is outlined in the appendix, received federal funding in 1996. The program went national in 1997. I guess the success of the program has really been dependent upon the membership. People who register to use the program — it is a user-pays system. I guess it operates in a similar way to City Link, where you provide funds into an account and you are in the black all the time and you pay-as-you-go, so that if you do not use the scheme you do not pay.

Also, as is described, it offers discounts for road sharing and advance bookings. Again, the success of the program really has been based upon volunteers and planning and managing the program in a way that perhaps reduces or keeps costs to a minimum. Of course, it is also dependent upon volunteer drivers. I see a lot of value for that in the community. A lot of people are prepared to provide their services to help people who cannot get around in the community.

Victoria Police strongly support a program of this nature. It has huge benefits to the community and to individuals. A similar program exists in Tailem Bend in South Australia. I was talking to a gentleman last week, and he described a similar program that his father was involved in. I think either of those programs could be introduced and be successful in the community. It just needs some leadership and commitment by people to make it successful.

Mr SPRY — It leads into a question I asked earlier about people’s driving skills — people who were involved in programs, such as volunteer drivers or professional drivers. Was there a reason why you did not elaborate on that earlier?

Asst Comm. SHUEY — Highlighting the issues with driving skills as well, or just on the — —

Mr SPRY — Mainly for those whose professional or main occupation is driving a motor vehicle, and the sort of people we are talking about are the volunteers. You would want to make sure that their skills were pretty good.

Asst Comm. SHUEY — Competent.

Mr SPRY — Yes. You spoke somewhere in your submission about more stringent driving skills. Will you comment on what those more stringent driving skills might be? It is the second-last paragraph on page 13 of your submission.

Asst Comm. SHUEY — Basically we are just saying that if you have the responsibility as drivers of passenger vehicles, buses and things of that nature, and taxis, anywhere where there is a higher responsibility, then we should be looking at the hazard perception tests and things of that nature that actually pick out the ability to be a professional driver; and maybe that you have a different qualification, I suppose, are classified as a better driver as opposed to just a run-of-the-mill driver.

Mr SPRY — Would it apply to volunteer drivers in Tailem Bend, do you think?

Asst Comm. SHUEY — That is a different environment, but there is no reason why you could not transition something of that nature whereby if you have a responsibility for others then of course you need to have a greater level of skill.

Mr SPRY — In Queensland the police accident investigation squad tried to assess in terms of statistics who was at fault. I do not know that we do it here. Do you think there is any merit in introducing such a statistic
into Victoria, particularly in terms of assessing the responsibility of older drivers in terms of who is at fault at accidents?

Asst Comm. SHUEY — I am sure we actually do that, but I would have to look at the Queensland system to see their comparison. We identify every collision regarding speed, alcohol, fatigue and who was at fault, and we can actually identify the percentage breakdown in all of those.

Mr SPRY — Will you get back to us on that one, because speed, alcohol and fatigue might not have had anything to do with it.

Asst Comm. SHUEY — But we do the other 20 or 30 issues that come in as to the cause, such as going through a stop sign or whatever. I will take it on notice to see if there is any difference. The other thing I would like to highlight is that there is the issue of curfews that is raised in the submission, but I am not sure that it is part of what you will be looking at. We see that as difficult to police, but it is an option that may be pursued. It is one of those issues that unless there is a clear mark on the vehicle then we are unable to know whether the people are driving within curfew limits.

The CHAIRMAN — A few people have made submissions that older drivers tend to regulate the hours they drive anyway. You are suggesting there might be some more formal mechanism?

Asst Comm. SHUEY — Driving during daylight hours and that sort of thing, but again if it is a way of resolving issues then perhaps it is a way out. But from our point of view it is basically impossible to police unless you know somebody is on a restricted curfew and unless they have some sign of the vehicle, such as P-plates or O-plates.

The CHAIRMAN — From memory I think there was one submission from an individual who suggested that there be some sort of a label put on the windscreen to suggest that that driver is over a certain age, such as ‘S’ for seniors, something like that. It is something we will look at.

Asst Comm. SHUEY — We will undertake to get back to you in relation to the five year statistics, driving per kilometres, driver skills and a couple of the other issues raised.

The CHAIRMAN — Does the police department advocate any legislative changes in relation to older drivers?

Asst Comm. SHUEY — We have nothing that is on the plate at present in relation specifically to the age group, although we would be supportive of the moves that we have discussed before.

The CHAIRMAN — The reason I ask that, of course, is that one of the terms of reference is to make recommendations for legislative change. We always rely very heavily on the police department for that. If anything does come up before the inquiry finishes, please let us know.

Asst Comm. SHUEY — Yes, and as a result of some of the additional work that we have undertaken to get back to you there may be something there that we can provide by way of assistance.

The CHAIRMAN — I thank both of you for appearing before the committee this morning. This is an important inquiry, and I would like to keep our lines of communication open. I am sure that our staff will have many questions to ask before our report is presented to Parliament. Again, I thank you for that cooperation.

Witnesses withdrew.
ROAD SAFETY COMMITTEE

Inquiry into improving safety for older road users

Melbourne – 5 August 2002

Members
Mr A. R. Brideson  Mr A. F. Plowman
Mrs E. C. Carbines  Mr G. H. Spry
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Mr C. A. C. Langdon

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Executive Officer: Ms A. Douglas
Research Officers: Mr G. Both and Mr S. Coley

Witnesses
Dr R. Bouvier, Community Safety Consultant;
Ms C. Simpson, State Coordinator; Royal Australian College of General Practitioners.
The CHAIRMAN — I welcome from the Royal Australian College of General Practitioners, Dr Ric Bouvier, community safety consultant, and Ms Christine Simpson, the state coordinator. Dr Bouvier has just mentioned to me that he made a submission to the Road Safety Committee when Walter Jona was chair of that committee and was responsible, in part, for the implementation of seatbelt legislation. That has done an enormous amount in the area of road safety. I am hoping today that you can inform us of your thoughts on older road users and hope that something positive will come out of your submission today. Will you present your thoughts to us and then we will ask questions.

Ms SIMPSON — I guess from the GP perspective the onus is quite often placed on general practitioners to assess people for their fitness to drive. Currently, from a GP perspective, there are not many incentives for us to do that. A GP’s life is very full. They are very busy people, and we do not have enough of them. It is, I suppose, difficult to get hold of a set of guidelines that tell GPs what they should be looking at to say that you cannot drive. I am not talking about the obvious cases of people who should not be driving for whatever reason, but for those people with conditions like diabetes, epilepsy and any number of others who have varying levels, and what GPs need is a tool to be able to determine what it is that should take them off the roads, and with that tool they then need the time and financial incentive to put that in place.

The current levels of payment for GPs are such that to give them sufficient time to assess someone there is not sufficient remuneration — they simply are not getting paid enough to be able to do that. I believe to make it better for them they need a better system of payment, because with an older person who presents you cannot just spend only a short amount of time with them. It is not appropriate and it is not fair. They deserve better than that. A lot of these patients are not patients with private medical cover, they are people on pensions, people who seek out doctors who are Medicare doctors. We see a range of difficulties assessing people at present.

The CHAIRMAN — Would you comment on whether GPs should have a mandatory duty to report to VicRoads any patients they deem unfit to drive?

Dr BOUVIER — In a way that would help us because when a patient comes along and we diagnose one of the 142 medical conditions, or if they are on one of the 15 groups of drugs, which I reckon half of our 75-plus patients are, we would be able to say to them, ‘Look, the government has legislated, it is the law, we have to report you, don’t blame me’. So yes, a law would be good. We would follow the law. We would notify VicRoads of half of our elderly patients and VicRoads could assess them. It would get it off us, but it would not prevent any accidents.

Medical reporting, medical examination on age or even disability does not reduce accidents for the elderly. The OECD book is gold standard, and I hope you have read it and studied it, because it refers to most of your terms of reference. This other book is put out by Austroads for doctors assessing fitness to drive, and it is crap. It is not guidelines or anything like the NHMRC guidelines. It is supposed to help us. All it does is list 142 medical conditions in those 15 groups of drugs that might impair driving.

Dr BOUVIER — Just because you have a diagnosis of a disease does not mean that your driving is impaired. It does not help us at all. I have been in medical practice for 45 years, and I do not feel confident or competent in assessing someone’s fitness to drive.

The CHAIRMAN — Are GPs adequately trained in this field?

Dr BOUVIER — No training!

The CHAIRMAN — None at all?

Dr BOUVIER — None at all! I have read nothing on it. It is just something I have acquired through trying to learn it. It is not set out.

The CHAIRMAN — In GP training today is any part of the course directed towards aged driving?

Ms SIMPSON — No.

Dr BOUVIER — No, none.

The CHAIRMAN — Should it be?
Dr BOUVIER — There is no scientific evidence. A criticism of this is that there is no scientific evidence base for what they suggest — that patients should be dobbed in to the licensing authority. There is not a reference to scientific evidence, not at all. It is not evidence-based. They are lousy guidelines, and they are quite unhelpful. But if you mandate it we will obey the law and VicRoads will be flooded.

Mr SPRY — They are interesting comments. What sort of testing would you suggest should be done if you are going to have something that is not, as you call it, simply crap? There has got to be some sort of measurable test available to authorities or to GPs to assess the capability of people who drive. Can you give us some suggestion of what they should be?

Dr BOUVIER — No. In the modern science of medicine there is nothing that I have found that is at all helpful in helping a general practitioner or doctors or specialists in assessing fitness to drive. We cannot assess fitness to drive in the consulting room. At present if we notify someone they are assessed on the road. This is a driving assessment which is defined in the book as that done by qualified occupational therapists. That is an on-the-road job. My wife had it after she had a stroke 10 years ago. It was on the video that the Austin repatriation hospital produced and she got her licence back. That cost $300; that is the cost of these things. There is no scientific evidence I know that they make any difference. That OECD book says there is no scientific evidence. We need science these days to be able to give good opinions on anything in medicine.

The CHAIRMAN — Can I clarify whether they are your personal views or the views of the college of GPs in relation to that book *Assessing Fitness to Drive*?

Dr BOUVIER — I do not know how you ever ascertain the views of our members. How many have we got?

Ms SIMPSON — Eleven thousand.

Dr BOUVIER — Eleven thousand members! You will never get views on them, but they are the feelings of the group within the college to whom I presented my original assessment, and they were all nodding.

The CHAIRMAN — I want to come back to that book. What would you actually change? Should the whole book be scrapped and we start afresh?

Dr BOUVIER — Probably, because it is on a false assumption. This book lists diagnoses or medical conditions which might impair. What is necessary is to look at impairment itself, not necessarily the diagnosis. Alzheimer’s disease is not easy to diagnose, but if some professional has diagnosed it for us, I ask the professor of psychogeriatrics, ‘How do you assess an Alzheimer’s patient’s ability to drive?’, and he says he cannot and does not, so he gets the occupational therapist to do it.

How the hell are we in the consulting room to tell whether a person is competent to drive out on the road? There are a few medical conditions which are definitely a no-no. If someone is blind I do not think they should drive; Alzheimer’s disease is common and is blamed for all sorts of things; what sort of diabetes; epilepsy. There are different levels. The levels of impairment are not defined in the scientific literature. This book is false because it looks at diagnosis and medications and there is no evidence that any particular medication is very likely to impair driving. The science is nowhere near it.

Mr SPRY — Wouldn’t there be guidelines or indicators of which group of people perhaps should be referred to an occupational therapist for assessment?

Dr BOUVIER — Yes, but at what level of impairment? If you have vision which is worse that 6/12 we notify them, then VicRoads can determine the medical assessment. There is a shorter cut. If we suspect someone is not quite up to driving we can counsel them and say, ‘How about surrendering your licence?'; they do not come back and see us.

Mr SPRY — I take Ms Simpson’s point of view that perhaps it is not appropriate for GPs to make that decision, particularly because there is no incentive to do it.

Dr BOUVIER — Yes.

Mr SPRY — There is a positive disincentive?
Ms SIMPSON — Quite! We are already in crisis with medical indemnity. We are not happy to be responsible for that too.

Mr SPRY — If it were mandatory to refer people who were on prescription of a certain drug or their diagnoses were such that they could be impaired as drivers, and it were mandatory for GPs to refer them for assessment, would that make it easier?

Ms SIMPSON — Yes.

Dr BOUVIER — Yes, it would cover our arses, so to speak, from a medical indemnity point of view. The patients would not like it; they would go through a great big rigmarole. VicRoads would not like it; they would be overloaded.

Ms SIMPSON — The costs have to be addressed as well. The cost to that elderly person of then being referred for assessment are huge. As I said before, a lot of these people are not well off, and they then might not do that; they may just decide they cannot drive any more because it is all too hard. So it has to be made easier for them too. We cannot just throw the responsibility to someone else because it is all involving extra money all the time.

The CHAIRMAN — Which professional grouping should come up with a set of guidelines?

Dr BOUVIER — You; your committee should find someone. At present I am not too sure of the VicRoads system, because I have written to them and had no reply. I do know that some occupational therapists — and VicRoads are not able to tell me — do set themselves up as driving assessors. They have had some training, but I do not know their value. I know their costs — $300! — but I do not know their value in scientific terms. This OECD book says there is no proven evidence that they make any difference. I do not know. With a bit of training and guidance from someone who is an expert in mobility we can get a bit of help in counselling patients who we think might be on the borderline to help them.

There are two things that elderly patients do not like. One is their inability to live independently. They do not like us to say, ‘Look, you have got to go in a nursing home’. The other one they do not really like at all is to be told, ‘You are going to lose your driving licence’, because their legs are cut off and their mobility is lost. We have not got the technical ability to advise them on mobility.

While I am on that point, I want to get in that these new low-floor trams are great. They will be greater when there are superstops to make the stop level with the floor. If you have been on a 109 tram you will know there is nothing to hang on to. I cannot reach the vertical heights and the poles are so far apart I have trouble in them. I use them quite a lot. I have seen people fall over in them. I know some elderly people who sit at the tram stop and wait till one of the old trams comes along.

Ms SIMPSON — And they are difficult to get in and out of.

Dr BOUVIER — Once you get out of them it is all right, but once you get in them you can hang onto something.

The CHAIRMAN — They are separate issues which we can certainly take on board.

Dr BOUVIER — It is a mobility issue.

The CHAIRMAN — For sure.

Dr BOUVIER — How to advise on mobility? There is a bit in this OECD book, but I have never found anything else in the general medical literature.

The CHAIRMAN — It is easy, as you said, to determine whether the sight is good enough. I suppose we can use an optometrist or an ophthalmologist.

Dr BOUVIER — No, a doctor can use a Snellen chart — that is, one of those little things up on the wall.

The CHAIRMAN — What other people ought to have a very big say in whether you are fit to drive or not?

Dr BOUVIER — Occupational physicians ought to. I am qualified in occupation medicine, but none of them seem to be interested in that. There are some rehabilitationists, but they do not seem to be into that. Some
occupational therapists ought to be. Some are into that. It needs to be a bit multidisciplinary because if we are to be involved in decision making about someone or giving information about someone’s diagnosis or medical impairment, then we need to be in on the basis of determining what the criteria should be. I do not know of any organisations. There is a conference in a couple of weeks, but I have not got much faith in conferences producing anything except tax deductions for those who go.

The CHAIRMAN — We are a major organiser of the conference!

Ms SIMPSON — There you go!

The CHAIRMAN — We are hoping something positive will come out of it.

Dr BOUVIER — It is challenging for you to get something practical out of it.

Ms SIMPSON — The other thing is that you have got to encourage the elderly to go and be assessed, to go for their yearly medicals and be put through all those things. Again, the doctor needs encouragement to actually provide that service, because that is not 5 or 6-minute medicine, that is a long consultation. People who feel that perhaps they have something that might prevent them from driving are not going to present it to the doctor anyway, because they are going to be concerned that they will lose their mobility. There has to be a lot of work as far as addressing the fears in the community and getting those to actually come forward and be assessed.

Mr SPRY — Dr Bouvier, do you find that self-assessment is a factor in people surrendering their licences? Are there many people who just give it away.

Dr BOUVIER — A bit of both. Some do not have insight, but some have insight into saying, and I am one of them, ‘I am losing it a little bit so I restrict my night driving; I want to turn right at traffic lights and I try to turn left, so I have learnt’. A lot of people have no insight. Most people are well above average as drivers on their own assessment — we cannot all be well above average! — and some families are concerned and bring their elderly parents along for assessment.

On this OECD book you will have to put 50 000 off the road, suspend their licences, to stop one serious accident a year. It is on page 81 or 83. It is a pretty big decision. There is a system whereby doctors are paid by Medicare to do an annual health examination of those aged over 75, except Aborigines who get it at age 65. That annual health examination is not structured, but it could be structured so that doctors asked you a few extra questions like, ‘Are you a driver?’. That is a start. Then, ‘Do you feel your health is affecting your driving?’ and a few more things. They are just questions: ‘Do you think that you should perhaps notify VicRoads?’. This would be a bit easier if instead of at 75 when they were given a 10-year licence it was shortened down a little bit so that as they picked up these conditions they got less time to put them off and a greater incentive to notify VicRoads that, ‘Yes, I have got this condition’ instead of putting it off for 10 years. The licence period should be shortened after — —

Ms SIMPSON — Seventy.

Dr BOUVIER — I’m almost 80. I do not know. After 65 years it should be shortened to five years.

The CHAIRMAN — To follow the trend of some of the other states?

Dr BOUVIER — And then three years when they are 75 so that it gives people a shorter time so that when they do collect a disease they have to notify VicRoads of their disability rather than being at 90 and leaving it to 100. You can get a lot of diseases between 90 and 100 that impair your driving. You are bound to be on some medication that might affect you and there is no good science about the effects of medication. There is good science on the effects of alcohol on driving, but there is no good science on the effect of prescribed medications on driving.

Mr SPRY — What we have heard so far is that there are lots of disincentives for the medical profession to make a judgment on a person’s capacity to drive and a reluctance, as I can see it, on the part of the medical profession to declare someone incapable.

Dr BOUVIER — Yes.

Mr SPRY — If there were a mandatory requirement at a certain age that everybody should be assessed, would that make the profession more comfortable?
Dr BOUVIER — It would make a lot more work and it would not reduce accidents. It would not! It would make a lot of people who are otherwise fit to drive reluctant to submit themselves for examination and just surrender their licences. It would also be a disadvantage to the patient, because they would say, ‘I do not want to tell the doctor I have so and so, therefore I will not be treated for it, otherwise he might dob me in because I have got X disease and I might lose my licence or have to go through this process’. It is not just the doctor; the patients can be disadvantaged too.

Mr SPRY — Good point!

The CHAIRMAN — What conditions do you think it should be mandatory to report? Are there any?

Dr BOUVIER — Blindness, but we do not know at what level. It says 6/12 in here, which is down a bit, but I know of no scientific evidence about people of 6/12 vision. It says you can drive a car if you are deaf. I have heard stories that you can drive a car safely if you are completely deaf. I am not too sure about that; I have not read it.

The CHAIRMAN — Are there any other conditions? Epilepsy?

Dr BOUVIER — Advanced Alzheimer’s, yes.

Ms SIMPSON — And epilepsy.

Dr BOUVIER — Somebody may be frozen up with a stroke or cerebral palsy, but it is a matter of degree. Some of them are okay to drive, and some of them are okay at times and not okay at other times. You drift in and out of Alzheimer’s and you are not stuck at a permanent level all the time.

The CHAIRMAN — What about the advanced stages of dementia?

Dr BOUVIER — Alzheimer’s is a form of dementia. It is the fashionable one, but we do not know at what level of dementia nor how to test it to detect impairment which the community would not accept as safe to drive. That is why this professor of geriatrics gets someone else to assess them. We cannot assess it.

Ms SIMPSON — It is very difficult, anyway. I have an 80-year-old mother who drives and I am encouraging her to stop driving. The reason is that I do not believe that she is aware enough on the road. As far as I am concerned she does not have anything wrong with her at all; it is just that her responses are not perhaps rapid enough and it is often difficult driving out there. I worry for her in that way.

The CHAIRMAN — But then you have the problem and she does not.

Ms SIMPSON — That is right, and she is perfectly happy and that makes it very difficult. If I sent her to her doctor he would say she is fine, because she is fine. So it is difficult to make those assessments.

Mr SPRY — Do you go out with her as a passenger?

Mr SIMPSON — No. I always drive!

Dr BOUVIER — If you put too many of these older drivers off the road more will be killed as pedestrians than as drivers so you are sort of safer to drive than to walk.

Mr SPRY — We saw that in Sweden when I pointed out the statistics in adjoining Finland where there are mandatory driving age tests, and the number of pedestrians — —

Dr BOUVIER — That’s right. We are aware of that.

The CHAIRMAN — Are GPs adequately trained to even advise pedestrians? Once society has taken aged people’s licences away are GPs adequately trained to assist them?

Ms SIMPSON — No.

Dr BOUVIER — Nor how to use these motorised scooters. I do not know at what level of disability a person should be advised to use a mobile scooter or at what level of disability they are dangerous driving a motorised scooter. They cost $5000, and if you have them all over the footpaths, it is worse than bikes being ridden
on footpaths! They do not have a licence and they are supposed to be limited to 8 kilometres per hour but some can go at 13 kilometres per hour, which is a bit fast if you are walking along a footpath.

Mr SPRY — Do you think those operators should be licensed?

Ms SIMPSON — I think they should have some footpaths skill, yes, having been hit by one. Definitely.

Mr SPRY — I would not like to be terrorised by those things.

Dr BOUVIER — Yes. So there is not enough science yet and I do not know where it is coming from. This is getting closer to it, but there are still a lot of unknowns in there.

Mr SPRY — I would like to go back to one question to Christine. You mentioned disincentives for GPs to have anything to do with the assessment of people, basically. What sorts of incentives, if any, could you suggest might encourage GPs to actively participate in trying to identify drivers who are not capable any longer of driving?

Ms SIMPSON — I think they would welcome guidelines, something they could sit down and look at with their patients and determine what questions to ask, what to look for within that person.

Mr SPRY — You want guidelines?

Ms SIMPSON — Yes. I believe they need a bigger rebate, so they will be encouraged to spend more time with that patient.

Mr SPRY — Cash, no. 2?

Dr BOUVIER — Yes, though not necessarily in that order; but yes, cash no. 2. I also think that your GP is the person you go to for advice at certain times in your life, whether you are sick or not, and some of these elderly people may have a long-established relationship with their GP. It would be nice if the GP were able to tell them about alternative ways of getting around — what is out there — and I believe the government could provide a great deal of help in that respect perhaps by providing open forums or certainly improving the network of transport we have, but certainly to advise people on what they can use and how to utilise it.

I think we need to be more user friendly. We are an ageing population. Things like tram conductors: old people really miss tram conductors, someone they can get assistance from. It is like stationmasters and people like that. So there are lots of things a doctor can help with. A doctor can encourage his patient not to drive any more and suggest what other alternatives they can use; they need that material to be able to do that.

The CHAIRMAN — How many GPs would attend the safe-drive medical presentations?

Ms SIMPSON — Not a lot.

Dr BOUVIER — Very few.

The CHAIRMAN — Why is that? Is it time?

Ms SIMPSON — Yes, time.

Dr BOUVIER — We have thousands of educational programs.

Ms SIMPSON — Are there CME points attached to that? Are there points attached to continuing medical education?

Dr BOUVIER — Yes. There could be continuing medical education points.

The CHAIRMAN — On advice?

Dr BOUVIER — There are, but there are no courses available. It is not a high priority at present. It would not want to make you go out on a July or an August night to hear someone talk and talk about what we should be doing. It has to be very well presented, it has to be practical, it has to be relevant, and it has to be worthwhile in going out, getting CME points and being be able to put it into practice. It has to be practical.
Ms SIMPSON — And it has to have tools attached to it. You have to come away with something you can utilise.

The CHAIRMAN — So perhaps just in summary, what recommendations would you like to see this committee make?

Dr BOUVIER — That over a certain age, and I am not sure what, licences should not be for 10 years; they should be for five years, and over another age that should be down to three years, so that gives the driver responsibility to report to VicRoads. I think somehow or other doctors should be encouraged to ask certain questions in their annual medical examination of drivers of 75 years and older. Those questions have to be tried out. They have to be piloted, they have to be not dreamt up by me but tested out to see whether they are valid questions and whether they produce some benefits.

I think that whoever decides on mobility at this conference ought to be able to translate it into user-friendly information for general practitioners who could use it in a day-to-day practice. I have a shelf about that wide of guidelines and they have to be accessible and user friendly. I think that annual medical examinations are out. We should be encouraged or taught somehow or other to counsel patients about, ‘Look, you are getting near giving up your licence, how about some alternative mobility?’ It is not available. It might be available elsewhere in the world: the booklet on assessment of fitness to drive refers to it a bit in trials, but they haven’t been proven as yet.

So yes, we need a lot of help and we need an indemnity for reporting someone — we have that, but then if we do not report someone and they are involved in an accident, this liability for medical negligence has to be changed because we could be sued for millions of dollars if that patient injured someone else and they ended up quadriplegic, so we are going to practise defensive medicine even more so. Change the medical negligence.

The CHAIRMAN — Okay. And I take it that it goes without saying that the college would be more than happy to participate in a rewrite of that booklet?

Ms SIMPSON — Absolutely.

The CHAIRMAN — Was there much input from the college into that?

Ms SIMPSON — That is a sore point.

Dr BOUVIER — There is a whole lot of endorsement. It has been endorsed by the college of GPs and by the Australian Medical Association, but they did not get very good advice. They did not have to ask me — but, yes.

The CHAIRMAN — They could have sought better advice, I think is the message I am receiving.

Dr BOUVIER — Yes, they did not look into it properly. That book is written by a committee, and it shows it. I will not alter it, with respect, Mr Chairman!

The CHAIRMAN — We will be trying very hard, I assure you, Dr Bouvier, to produce a very competent report.

Ms SIMPSON — The other thing, too, is that we did so much good with the flu injection campaign, getting elderly people to go and have flu injections, that this could be approached in the same way. It just needs a bit of enthusiasm injected into it — now, that’s a good word!

The CHAIRMAN — And public education.

Ms SIMPSON — Yes. Of course it is going to have budgetary implications.

Mr SPRY — On that theme for a moment, are there drugs that actually make people better drivers?

Dr BOUVIER — Yes, there are, and this is a problem. Some of the drugs probably reduce impairment. I mean, drugs for hypertension that lower your blood pressure should reduce the chances of your having a stroke when you are driving. So there is balance and counterbalance. Untreated, they are a menace; treated, they are less of a menace.

The CHAIRMAN — Christine, is there anything you would like to put to the committee as a final statement?
Ms SIMPSON — No, I think Rick has covered it fairly well. Obviously I have to go in to bat for doctors as far as the budgetary implications are concerned and I would like to see them better remunerated if they are going to have these longer consultations, which it will require. But then I believe the community would benefit from that in the long term, so I think this is very worthwhile.

The CHAIRMAN — All right. If you have any further thoughts please contact Alex, and even though technically our submission date is well past we will still take any information.

Dr BOUVIER — Yes, I did submit a detailed report answering your questions which were related to traffic safety because I have had the experience of covering safety generally, so they are somewhere.

The CHAIRMAN — I would like to thank you both for appearing this morning. We have had a very interesting conversation. You will receive a copy of the transcript in the next few days or so and if you can make any necessary corrections in that and send it back as quickly as possible we would appreciate it.

Witnesses withdrew.
ROAD SAFETY COMMITTEE

Inquiry into improving safety for older road users

Melbourne – 5 August 2002

Members

Mr A. R. Brideson  Mr A. F. Plowman
Mrs E. C. Carbines  Mr G. H. Spry
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Witnesses

Professor H. Taylor, Department of Ophthalmology; and
Associate Professor J. Keeffe, Eye Health Promotion Unit, Centre for Eye Research Australia Ltd, University of Melbourne.
The CHAIRMAN — I welcome, from the Centre for Eye Research Australia Ltd at the University of Melbourne, Professor Hugh Taylor, who is the head of the department of ophthalmology, and Associate Professor Jill Keeffe, who is the head of the eye health promotion unit. We would like to be relatively informal, so I will hand over to you and ask you to make your presentation. If you do not mind we will interrupt with questions for clarification.

Prof. TAYLOR — Thank you very much. We are delighted to be here — I should say we are almost thrilled to be here — because it is very important in an area such as the consideration of road safety that we address the issue of vision, which is so fundamental to it.

We made a brief submission some months ago and we are delighted to have the opportunity to expand on that submission and talk to it. A submission from the Victorian branch of the Optometrists Association Australia has also been put in, and there is a lot of very good information in that, particularly on the need to provide information to optometrists and general practitioners. I do not want to dwell on that so much but I will focus on the issue of vision and driving performance and safety.

We have given committee members a little pack which includes copies of the presentation I will give and a paper that Jill Keeffe wrote recently on the results of our research into vision and road safety, which will be the basis of what I am talking about. There is also a copy of a booklet called Eye care in the community which summarises our epidemiologic studies on eye disease in Victoria. That was launched by John Thwaites, the Minister for Health, about two years ago, and it is really a distillation of about 10 years of research work which I will talk about initially. There is also an annual report of the Centre for Eye Research Australia so you know who we are and where we come from.

The first thing we found out in this big epidemiologic study was that there is a lot more eye disease in the community than we had thought there would be.

Slides shown.

Prof. TAYLOR — This graph is taken out of the booklet Eye care for the community and it shows the way the amount of visual impairment trebles with each decade from the age of 40. It does not matter if you take the definition of legal blindness or if you take the definition of visual impairment; although the rates are somewhat different for those different definitions, the change with each decade is a trebling — a threefold increase — in the number of people with poor vision, such that half the people in their 90s have visual impairment and about a sixth are legally blind.

Ninety sounds terribly old, but if we look at life expectancy in Australia, 100 years ago the life expectancy was 43; today it is about 80 — a couple of years younger for women and a couple of years younger for men — so there has been a huge change in our life expectancy. If you go back another 100 years to 1800, the life expectancy was 25. There has been a huge change in the demographics of our community. Any child born today can expect to live to 80, but if you have had your 40th birthday you have a two out of three chance of having your 90th birthday. When we are talking about people in their 80s and 90s, we are talking about what will happen to half the population, if not most of us here today.

With this changing life expectancy there is this huge change in the population distribution in the community. This slide shows the population distribution for Australia in 1990 compared with 2020, and there is this huge change in the number of older people over the age of 40, 50, 60 and so forth into these older age groups. In fact, by 2020 there will be twice as many people over the age of 65 as there were in 1995.

With that doubling in the number of older people — and when I say ‘older’ I am talking about people who are 60 or 65, and that is really quite young for many of us — there will be a doubling in the number of people with eye disease and visual impairment in our community by the year 2020.

This slide shows that there are about 400 000 people with visual impairment in Australia today, which means about 100 000 in Victoria, and that will double by the year 2020. There is a huge amount of vision impairment in our community, and with the ageing of the population there will be twice as much in the next 20 years.

The second thing we learnt is that poor vision is bad for you. It sounds silly, but we now have some real data to show the impact of poor vision. These documents have not photocopied well, and I apologise. A couple of the slides are black — that is to emphasise the importance of good, sharp and clear vision!
The CHAIRMAN — We understood that.

Prof. TAYLOR — Visual impairment significantly restricts social independence and impairs the physical and mental health of people. In the context of driving in particular, the social isolation experienced when you are no longer able to drive because of poor vision is terribly real. When measured overall, if you have vision of less than 6/12, which is the vision you need to legally drive, there is a significant increase in social isolation. The difficulties of daily living increase twofold and the ease of social functioning is reduced by half. These factors have been measured by a number of means: the utilisation of community services, the ability to look after yourself, religious participation and participation in other social activities are being reduced by half. For every line of vision lost there is a 12 per cent increase in the use of social services, so even a little bit of reduction in vision has a huge impact on the ability of the individual to age healthily and to function normally.

The CHAIRMAN — Can you explain to the committee what 6/12 vision is?

Prof. TAYLOR — To put it in this context, it is the amount of vision you need to legally drive. What it means literally is that the person has to come up to within 6 metres to read a letter that a normal person would have been able to read at a distance of 12 metres. The 6 at the top is the distance at which the test was done and the 12 at the bottom is the number given to the letter, and the 12 letter is a letter that a normal person could read at 12 metres. If you have 6/6 vision, which is normal vision, when you are tested at 6 metres you are able to read the letter that the normal person can read at 6 metres; if your vision is 6/60, which is just before legal blindness — legal blindness is less than 6/60 — you would have to come up to 6 metres to read the letter that a normal person could read all the way back at 60 metres.

The difference between 6/6, which is normal vision, and 20/20 vision, which you will often hear, is that the 20 is in feet and the 6 is in metres, so 20/20 is used by the Americans. It used to be 20/20 here, but in 1966 we changed to 6/6!

Poor vision has a very significant impact on social isolation and also a very significant impact on morbidity. People with this moderate reduction of vision are twice as likely to have a fall, four times as likely to fracture their hip and three times as likely to have depression. It also has a significant impact on mortality because people with poor vision are twice as likely to die, once we factor in diabetes, cancer, heart disease and all those other things.

Poor vision is bad for you. The first thing we learnt was that there is a lot of it; the second thing was that it is bad for you; and the third thing we learnt is that much of it is preventable.

This slide shows the causes of legal blindness — that is, vision less than 6/60. The leading cause of blindness in our community is macular degeneration — that is a disease where the centre of the retina burns out. It is something like a stroke, Alzheimer’s disease or dementia, which affects the centre of your vision and you just cannot see what you are looking at. There is some treatment available for some people, but mostly there is not a lot that can be done about it at this stage. The other causes are glaucoma, cataract, diabetic retinopathy and undercorrected refractive error — that is, people who do not have the right pair of glasses. They account for almost half the people who are legally blind, who would not be legally blind if they had those diseases either treated or prevented.

The picture is even worse if we look at visual impairment — that is, people with vision less than 6/12 — because half of the vision less than 6/12 is due to undercorrected refractive error and some is due to macular degeneration, glaucoma, cataract and diabetic eye disease. Three-quarters of the vision loss and three-quarters of the blindness is due to these treatable or preventable diseases.

In our study, which was specifically looking at driving, we had this group called the Melbourne Vision Impairment project. It was a very carefully identified randomly selected sample of people over the age of 40 living in Melbourne. We also did some other work and went off and looked at people in nursing homes and at people in rural Victoria. This was funded by VicHealth and the National Health and Medical Research Council (NHMRC).

We started in 1991 and it took us about 10 years of work, and then five years later we went back and re-examined the people in the metropolitan area. There were 3171 people in the study and we followed up all those who were still alive. We were able to examine 85 per cent of them and get full data on nearly 2500 people. We found that of these 2308 people there were 1949 people who had ever driven, and of those 1787 were still driving and 162 had stopped driving. Of those who were still driving 81 per cent had not had an accident, but 339 had had an accident in the preceding five years.
We had examined these people at the start and we examined them again five years later and found out what they had actually done with driving. The problem with the research on driving and accidents is that it is very hard to collect the data because it is very hard to get a denominator to know who is actually out on the roads and how much they are driving. We collected that information and then — this slide is sleight of hand because I have put another bottom bit on it — we took those who had ever driven and the current drivers and measured their vision and we found that 46 of the current drivers — or 2.3 per cent — had poor vision when we tested them, but they were still driving. Of those 46 people, 40 had a moderate reduction in vision and 6 had a quite profound reduction in vision but were still driving.

We were able to look at what the factors were associated with poor vision; what the factors were associated with driving; and, in particular, how driving and poor vision interacted in this five-year study of people in the metropolitan area.

First of all, just looking at the number of accidents we had, the majority, some 1400 people, did not have an accident at all — that is, 81 per cent — but 291 people had had one accident, 40 people had had two accidents and 8 people had had three to five accidents in this five-year period. It was what you would expect in a range of numbers, but most of them had only been involved in one accident. Obviously none of these accidents were fatal otherwise the people — the drivers anyway — would not have been there in the study. Overall, about 8 per cent of this sample died from causes unrelated to traffic accidents.

In some ways the bottom line is looking to see the impact of poor vision and accidents. Of those people, there was no difference in the number of people who had had an accident due to poor vision and those who did not have an accident — that is, those who had had an accident and those who had good vision. In these data, on this table, we could not confirm that poor vision was associated with an increased risk of accidents. This is not what you would expect, not what you would like to see, but it represents the problem of collecting these data. Even with about a $10 million study over 10 years the number of people you need to follow in the community is so large that to establish those data from that base is very difficult.

We approached a number of funding organisations five years ago, and Jill might want to speak about this a little bit more, and talked about doing some collaborative research with the group out at Monash.

Assoc. Prof. KEEFFE — Monash University Accident Research Centre.

Prof. TAYLOR — Using their simulators and taking people with poor vision, but everybody said, ‘Oh no, that wasn’t interesting’, or ‘It wasn’t important’. I guess it was not biomedical enough. The Victorian data do not show that poor vision is linked with increased risk of accidents, but the data are very limited because they are counter-intuitive.

We did some other fancy analyses, and this table shows the result of two analyses. The first shows the effect of age if you adjust by the distance the person has driven; the second shows the effect of distance if you adjust for the age. When we adjust for the distance driven there was no increase in the number of accidents for older people, but there was a marked increase in accidents by distance. What happens is this: older people tend to drive less distances. Age itself was not a factor, but it was the distance driven that gave one the increased risk — the increased exposure.

These data show that overall there are about 85 000 people in Victoria, or about 2 per cent of Victorian licensed drivers, whose vision is not good enough to legally drive. A huge number of people! With those 85 000 people out there you must drive past at least one or two a day. That is a lot of people. If you look at the data for over the age of 80, one person in three who is currently driving does not have vision that is good enough to drive — that is those who are still driving.

We looked at people who had poor vision and found that 40 per cent of them had stopped driving themselves. We looked at the reason for stopping driving and found that overall 20 per cent of people stopped driving because of poor vision. When people notice they have poor vision, one thing they do is stop driving. When you stop driving you start to spiral down into all of that social isolation.

The other thing we noticed is that people with poor vision reduce the amount of driving they do. They significantly reduce the amount of driving they do at night — particularly older people — at peak hour, in city traffic, when driving in bad weather and they restrict distances travelled. People with poor vision who keep on driving are reducing their exposure, which is maybe another one of the reasons why they do not show up as in major risk of accidents, but it is a question of social isolation and not being able to get to the places they could before they had poor vision.
Mr SPRY — They do not take much notice of the bad weather then, do they?

Assoc. Prof. KEEFFE — Not a lot.

Prof. TAYLOR — Not a lot; it is a bit.

Mr SPRY — That might be the equaliser.

Prof. TAYLOR — That is right. But what was really amazing when we looked at the poor vision of those people who were still driving was that 87 per cent — almost 90 per cent — of it could be corrected or relieved; 80 per cent of it was just due to people not having the right pair of glasses, so a new pair of glasses would have given those people better than 6/12 vision so they could drive safely; 7 per cent of them had cataract, so they could be operated on and they would get better vision; a couple of other groups — six drivers in total — had other causes that one could not treat or correct. Some 87 per cent of those driving with poor vision had simple eye diseases that could be treated easily. The message is that we need to be finding these people and giving them the correction they need.

The conclusions to this study are that because it is a population-based study, and we are looking at a whole lot of people, the number of accidents is relatively small. Although accidents are relatively rare and visual impairment is relatively rare, and when you put the two of them together you are looking at quite rare events of people with poor vision having accidents, which is why the power is small there, I think it is still very important that it shows that people with poor vision stop driving, they restrict their driving, although there was no change in the accidents.

But 87 per cent of the poor vision is correctable and the bottom line from this is that we need to institute in the community a much greater awareness of the need for regular vision testing, and this would be for all people not just drivers. That would be our recommendation.

The CHAIRMAN — Whose responsibility would that be?

Prof. TAYLOR — It is a broad responsibility of the community, including people interested in vision, including government, including others who are interested in health — that is, the private sector. One of the things that we have done over the last three years is to create an organisation called Vision 2020 Australia, which is an umbrella organisation for all those working in the vision area in Australia. We have got about 46 or 47 partners of this organisation and part of the work of this industry group, if you like, has been to develop what we have called a ‘vision initiative’ that was presented to Minister Thwaites on Friday for consideration for funding, and that looks at a specific program aimed at increasing the awareness in the community of the need for vision testing — the same way that programs have been out for increasing the awareness of breast screening or pap smears — to get it out into the community. So it needs public education, education of the practitioners, some change in practice. It is a major initiative because poor vision has a much broader impact in the community than just the impact on driving.

Mr LANGDON — I am not sure which graph it was that you showed us, but one of them said if they had those tests and had been wearing the right glasses their poor vision would not have occurred. Is that correct?

Prof. TAYLOR — That is right.

Mr LANGDON — What percentage was that again?

Prof. TAYLOR — If you looked at the people who were driving it was 80 per cent. This is the table for people actually driving. Then there was a pie chart for the whole community, and for the whole community it is 53 per cent.

Mr SPRY — How do you know what crashes are caused by poor vision? How do you determine that?

Prof. TAYLOR — We had the people’s vision at the start, we had the people’s vision at the end — because we had examined and measured them — and then we asked them. So it was recall and then reporting to us that they had had an accident and asking questions about how the accident occurred and in their estimate whether the accident was due to poor vision or to other conditions. So we had two measurements in between. We did not examine them at the time of the accident, but we had the two points in between and their assessment. I do not know whether you want to expand on that, Jill?

Assoc. Prof. KEEFFE — The important thing was that people had their vision measured, whereas in a lot of studies that look at driving there is quite often just self-reporting of vision problems. So with this one we were
definitely able to say what the vision was and whether it met the driving standard or not. There was not the ability
to go back and double-check on accidents — that was self-reporting.

Mr SPRY — Is that a world standard? It is not developed in isolation, just down here in Victoria?

Assoc. Prof. KEEFFE — Less than 6/12?

Mr SPRY — No, the world standard of testing. Would you say in crashes?

Assoc. Prof. KEEFFE — Yes.

Mr SPRY — Crashes were caused by poor vision? That is a standard that is adopted world-wide?

Assoc. Prof. KEEFFE — The standard form of testing, yes.

Prof. TAYLOR — And this work leads the world. These are world-leading data that we are presenting.

Mr LANGDON — In your submission you propose that people should have a regular eyesight check. I
assume your contact with the Minister for Health and the public campaign would also be focusing on getting
people to have eyesight checks. Is there an age group? Is there a target?

Prof. TAYLOR — If people notice a change in vision they should get their eyesight tested right away, but
when you are over the age of 50 you should have your eyes tested once every five years, even if your vision is
normal. There are other high-risk groups, such as people with diabetes who need their vision checked at least once
every two years, and there are Aboriginal groups. The very elderly need routine testing. For the population,
generally, either right away if people notice a change in vision or every five years if they do not notice any change.

The CHAIRMAN — Do you think there should be eye vision tests upon renewal of licences? Would that
be one way of getting around it?

Prof. TAYLOR — Yes, but I do not think it goes far enough, because I find it anomalous that I could get
my licence at 18 years of age and drive until I am 90.

The CHAIRMAN — Ninety plus.

Prof. TAYLOR — Ninety plus, and not have it tested again. I think that is an anomaly.

The CHAIRMAN — I think we are all a little bit perplexed by that situation.

Prof. TAYLOR — My objective is to try and help people with poor vision get the most use out of their
vision, including driving safely. It is not to try and put people off the road, and that is a critical thing because there
is a lot of resistance about with people saying, ‘Oh you know, you’re just trying to stop these old people driving’. Eighty-seven per cent of them should be able to drive much more safely with good vision if it is fixed up.

Mr SPRY — Professor Cynthia Owsley of the University of Alabama uses terminology like ‘size of
useful field of view’ compared to your assessment of visual acuity. Would you like to comment on the two
expressions?

Assoc. Prof. KEEFFE — Visual acuity is the standard measure throughout the world for testing just how
well you see a distance, how clearly you can see. Useful field of view is a test that is done at relatively short
distance. Do you know the test?

Mr SPRY — No.

Assoc. Prof. KEEFFE — Do you want me to explain the test?

Mr SPRY — Yes, please.

Assoc. Prof. KEEFFE — Small images are projected on a screen. The test asks people to look at one and
another one is presented. It is pretty much an attention task — that is, asking people to look at one thing and look at
something else. So it is not testing how well you see, how clearly you can see, it is an attention task — can you
look at something and as something else is presented look at that? It is quite a different thing in the ability to be able
to recognise people, cars or something else.
Visual acuity, and the same standard used in Victoria is the most common standard throughout the world, was a test used because there is so much anomalous information about visual acuity — that is, the standard test of vision. Some people say it is related to poor driving and accidents, and there is as much to say it is not. So they were looking at what other tests you might do to be able to predict which people might be more likely to have accidents. It is not testing vision. Even though it is called ‘field of view’ it is asking whether within a restricted visual field you can attend to different objects that are flashed at you.

**Mr SPRY** — Do you think that test has got some merit?

**Assoc. Prof. KEEFFE** — I think that is one of the factors related to driving and accidents — and obviously vision is certainly one — because what we have found is it is things like ability to attend, so it is whether it is cognitive impairment or just being able to look at different things. Some of the research is saying that vision is related, but it is usually that people are more likely to have accidents if they have more than one thing wrong — for example, vision and attention or physical problems. Each one is related, but it is about putting a number of them together, and that is why that study was undertaken — to look at not just strictly vision but ability to pay attention.

**Mr SPRY** — Going back to the old chestnut of mandatory reporting, or the social obligation to report, do you think optometrists should be legally required to report people with poor vision?

**Prof. TAYLOR** — No, I think where you have compulsory reporting — mandatory reporting — that brings in a totally different flavour in the optometrist–patient or doctor–patient relationship. I think that on the one hand you need to make sure that the practitioners are well informed of what the rules and requirements and options are, but you also need the public themselves to be aware and responsible, which is where I think the public information campaign is important. If you think, ‘Heck, if I go to the optometrist or ophthalmologist and they find my vision is bad they’ll take my licence away!’, that is absolutely the wrong thing. We want people to get their new pair of glasses and see safely. We want to encourage people to get their eyes examined, not frighten them away.

**Mr LANGDON** — Do you think the cost of glasses stops people, especially if they are retired, going to get their eyes checked?

**Prof. TAYLOR** — Yes, that is one of the reasons. We looked and found about a dozen different reasons that will affect small numbers of people. The biggest reason was that people had not recognised that their vision had dropped. They were surprised at how their vision had dropped, which is one reason they keep driving — they do not recognise that anything is wrong. That is why we need to say, ‘You should get your eyes checked at least once every five years even if you haven’t noticed any change yourself’.

Another thing people say is, ‘It’s normal for my vision to drop as I get older’. You know, as you grow old you get grey hair, your vision drops and so forth. Some people say that glasses are too expensive and others say that they do not have anyone to take them. There are a variety of other reasons.

In Victoria, and in each state of Australia, there is a low-vision scheme to provide glasses at very cheap rates to health-care cardholders. The system in Victoria, I think, is starved of cash. It is run by the Victorian College of Optometry, and it does a good job of running the system, but it is giving out a fraction of the amount of glasses a year that New South Wales or Queensland is. That is not this committee’s mandate necessarily, but it is an area that more funds need to be put into.

**Mr SPRY** — It was rather diserving to learn that poor vision does not necessarily cause more accidents.

**Prof. TAYLOR** — I would say that numbers are small. This was not the best study designed to find that. I think a better way to do that was what we proposed to the Transport Accident Commission and NHMRC with the funding through MUARC where we could take people with eye disease — not a medical student that you put some vaseline over their glasses or something — and put them on the simulator and see how they go. This is where you could test the real use of that field vision — —

**Assoc. Prof. KEEFFE** — Useful field vision.

**Prof. TAYLOR** — To see how well it works. I think there is a need for more research, but I do not want to come to this committee and say — because every university professor does it — ‘Give me more research money’. I am trying to say that there are some clear lessons we have learnt from our research that will make a big difference if they are applied now. There is always more research that needs to be done, and it would be useful.
Mr SPRY — Even if the figure is 87 per cent, people could easily have their vision fixed if there were a public education program. If there is no justification for it in terms of reduced road trauma, it is pretty hard to convince government to spend money on that public education program.

Prof. TAYLOR — I would say the reason comes from the impact on healthy ageing and on social isolation. Forty per cent of these people have stopped driving because they do not feel their vision is good enough. Those who are driving are restricting their driving. For the group as a whole, looking at the whole person and the holistic approach to health and the community, these people have a significantly increased risk of injuring themselves from falls and accidents and morbidity, and also an increased risk of death from poor vision. It is not only on the road, but the whole way these people fit into the community — their lives.

Assoc. Prof. KEEFFE — When you said poor vision causes accidents, obviously some extent of vision loss will cause accidents. If your vision is bad enough it will happen, but where we looked at the legal limit of less than 6/12, comparing that with better vision, that did not come out in that study. Because there were relatively small numbers with really bad vision, there is not enough to say at what level that will happen. It is a logical extension that it will.

Prof. TAYLOR — The numbers in our study were very small. Of those who said their accident was due to poor vision, there were 31 who actually had good vision but who felt under the circumstances vision had played some part in the accident. There was only one person with poor vision who had an accident and who felt it was due to vision, but there were seven people with poor vision who had an accident and who said the accident was not due to poor vision. When you get down to one and seven, the numbers are very small. If it were 300 in each group, then you would have the power to see the difference. What it can talk to is the number of people who have stopped driving, the number of people who are driving with poor vision, and the fact that almost 90 per cent of that could be fixed with an eye exam and appropriate management. That is the good news message — that almost 90 per cent could be fixed with simple eye exams.

Mr LANGDON — In February and March every year we have the seniors festival. There is almost a need for the health department to see how proactive seniors can get if they have better vision by having a check-up and by being part of the proactive approach. It is not so much about health, but also about their ability to mix in the community.

Prof. TAYLOR — I absolutely agree with you. When we look at this expansion, implementing these activities and bringing in those elderly citizen groups and those organisations is very important. We have done a pilot study in the City of Whitehorse where our aim was to get to all the aged care groups and other groups where older people congregate, such as the Returned and Services League and so forth, looking at mobilising that community-wide awareness of vision and vision testing. That was a very successful pilot run, if you like, and led us to go on and make these proposals for a statewide project.

Mr SPRY — This issue concerns me on a personal basis because I know someone who has just one eye. What do you call that — singular ocular?

Prof. TAYLOR — Monocular.

Mr SPRY — What are the implications for one-eyed drivers?

Prof. TAYLOR — There are two implications. One is that you do not see quite so far. Your field of vision, what you see out of the corner of each eye, is not quite as much if you only have one eye because your nose cuts off what you see, say, out of your left eye. Your field of vision is reduced. You can see that yourself. Just shut your right eye. You will notice Graham disappears as you shut your right eye, so there is that lack of field. The regulations now are that you have to have rear-vision mirrors on both sides of cars. That is no big deal now because 40 or 50 years ago it was a big deal to have external rear-vision mirrors.

The second thing is you lose your stereovision, which is your three-dimensional vision, and for most driving that does not matter because once something is over 12 or 15 feet away you do not use your stereovision to see how far away it is. Your stereovision can be important, particularly if you are parking or moving in close quarters. The regulations say that if you had two eyes and you lose one eye you cannot drive for three months until you adjust to not having stereovision and learn some of those cues. Three months is arbitrary. The idea is right. I do not have any particular argument with that time, so I do not see a need to change those regulations at this stage.
Mr SPRY — As people get older do they tend to lose vision in just one eye, or is it generally both eyes together?

Prof. TAYLOR — Most of the vision loss is caused by diseases that will affect both eyes, but it will often affect one eye more than the other. So if it is cataracts, some people go and have one cataract done and the other one done a month or so later, but sometimes they go and have one cataract done and wait some years before they have the other done. Macular degeneration will start in one eye, but about 20 to 25 per cent of people will develop it in the other eye each year afterwards, so it becomes symmetrical fairly quickly.

The CHAIRMAN — On behalf of the committee, I thank you for appearing today. It has been a very enlightening session. You have given us a lot of information to go through. There may be reason for us to come back to you; I trust we can do that.

Prof. TAYLOR — We would be delighted to try to answer any queries you might have; it would be our pleasure.

The CHAIRMAN — We wish you well in your endeavours. You will receive a copy of the transcript in the next couple of days. Feel free to go through that and make any necessary corrections. I do not think there will be any, but you never know.

Witnesses withdrew.
ROAD SAFETY COMMITTEE

Inquiry into improving safety for older road users

Melbourne – 5 August 2002

Members

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Witness

Dr J. Gowan, Pharmaceutical Society of Australia.
The CHAIRMAN — I welcome Dr Jenny Gowan, representing the Victorian branch of the Pharmaceutical Society of Australia. Dr Gowan, I apologise for not having a laptop here.

Dr GOWAN — I should have checked. I checked whether there was a power point. I thought it might keep you awake being the after-lunch session. Instead I have provided you with a shortened version of the submission, with perhaps some of the points that you might like to raise and discuss for your clarification.

The CHAIRMAN — I will pass over to you, for you to take us through your submission.

Dr GOWAN — Thank you. I work at the Pharmaceutical Society as manager of training and development. I am responsible for the training of the fifth-year pharmacy students. Those are students who have completed their Bachelor of Pharmacy and then they do a pre-registration year. I am also responsible for continuing professional education of community pharmacists throughout Victoria with providing some of the education sessions. I do that on a part-time basis.

As well I work in community practice and I am heavily involved in home medicine reviews. That might be an aspect relevant to this inquiry. That involves visiting people in their own homes and carefully going through their medications to assess the best use of medicine, so we will develop that as we go through.

If I walk you through the presentation it might make a little more sense of the submission for those who do not understand medicines. I apologise if I use the word ‘drug’ today. The word I will use is ‘medicines’, bearing in mind that medicine has the connotation of a prescribed medicine, and a drug, the term we used to use, has the connotation of an illicit substance. In our latest Australian Pharmaceutical Formulary and Handbook we have encouraged all members to use the words ‘medicines’ and ‘medications’ when talking to consumers rather than ‘drugs’. I know we used to talk about the drugs-and-driving campaign, so we need to clarify that it is medicines.

I first refer to the page showing the second slide. A number of medicines may impair driving skills. In the SUSDP, which is the Standard for the Uniform Scheduling of Drugs and Poisons throughout Australia, there are some 115 medicines that are listed that can actually cause sedation; and, of course, that can then impair driving ability. A number of medicines can cause dizziness and make you feel not quite right, as well as cause blurred vision. The previous speakers, the optometrists, would be well aware of the eye ointments and eye drops that people put in where you might have to wait a few minutes after putting using them before you can actually drive.

Hypoglycaemia, where the blood sugar drops down, may occur. Where somebody is suffering from diabetes and they are treated with insulin or with medications to treat their diabetes, their blood sugar may drop down which may in turn affect their driving skills.

There are other medicines that may decrease motor skills, making people less able to respond; others that lead to erratic behaviour; and others that can lead to aggression and stimulation. Currently one that we are seeing a lot of is the use of pseudoephedrine, which occurs in many of the cough and cold products and which in some people can basically ‘hype’ them up. If they are used in a manner in which they are not meant to be used they can cause aggression and stimulation.

Mr SPRY — How does hypoglycaemia affect the driving?

Dr GOWAN — They seem to be confused and cannot react as well under those sorts of situations.

What we need to establish is: is it the medicine causing the effect, is it the actual medical condition — and I am sure you are well aware of the conditions that can have an effect — or is it the personality of the driver, leaving aside the roadside environment and the condition of the car? With any of these analyses it is extremely difficult to work out what actually attributed to the accident, or the accident’s causation.

If you add alcohol — looking at the fourth slide — to medicines, of course you will have additive effects. You might have picked up in the submission that I raised the question of whether with some of these medicines maybe alcohol should not be taken with them at all. It is a very debatable and ethical discussion.

We alert people to the adverse effects of these medicines by Label 1. In front of you is a card with labels. Label 1 is a bright yellow label. It is a mandatory requirement in Victoria that our pharmacist members, community pharmacists and hospital pharmacists dispensing PBS (Pharmaceutical Benefits Scheme) prescriptions attach that particular label to those medicines listed in the SUSDP. If they do not they are liable to be called into the Victorian Pharmacy Board to explain why. With that warning comes counselling to the consumer to alert them to those dangers. That is Label 1, which says:
This medicine may cause drowsiness and may increase the effects of alcohol. If affected do not drive a motor vehicle or operate machinery.

The question is: how do they know if they are affected? That is a tricky one.

Mr LANGDON — On the issue of the labels, on a previous road safety inquiry the issue of labelling and drink-driving and drugs other than alcohol was mentioned. As has everyone else around the room, I have been to pharmacists with scripts, and they are often little packages with writing everywhere and labels everywhere. The concept was mentioned that the labels are still not clear enough. If you have this on a small object with a lot of other writing, does it stand out well enough?

Dr GOWAN — I believe it does if the pharmacists use the stick-on labels, which are bright yellow. Yellow, being one of the road safety colours, really does stand out. There are some 18 labels that can be put on. This is Label 1, the most important. With the others we decide whether it is sensible to put it on or not. Pharmacists who may not use the labels can have the requirement just put on by the computer. I encourage consideration that that coloured yellow label, to take up your point, is actually physically adhered to the medication each and every time it is dispensed, because otherwise, you are correct, it disappears and merges into the other writing on the pack. Label 1 is the yellow one with the pictograph of a triangle.

At a previous road safety inquiry one of the findings was to have a look at various pictograms which we actually trialled. Under VicRoads there was a focus group conducted with consumers and with pharmacists to investigate this. The reports were put to the committee. I am not quite sure what actually happened after that, but I know that it was not progressed with.

This particular label is used for those medicines where the primary or the secondary effect is sedation, sleepiness, so it has particular relevance with the early treatment of benzodiazepines — that is, your Valium and Serepax — and where it is required to be put on to sleeping tablets, which might surprise you because you think, ‘Well, if I’m going to take a sleeping tablet of course it’s going to make me go to sleep’, but with some of the sleeping tablets they have what is called a longer half life in the body so they stay in the body longer.

If any committee member were to take a tablet such as Mogadon, nitrazepam, tonight, you would still have the equivalent effect on your driving ability at about 2 o’clock tomorrow afternoon as though you were above 0.05 per cent blood alcohol in the body. The use of the long-acting benzodiazepines for sleeping has really decreased in my time because of quality of medicines programs. There are still a few going around. People develop tolerance, which is of major concern.

Some of the shorter acting ones, such as temazepines, are much shorter acting and are usually out of the body in about 6 to 8 hours, so you would expect them to be below reasonable driving skill levels in the morning after taking them, but if you have somebody who has low body weight, an older person, the effects will last longer — they build up. Any questions on that?

Mr SPRY — You mentioned tolerance. Does that decrease the effect?

Dr GOWAN — Yes, it does. It is hard to measure because you cannot always predict because some people become more tolerant to them than others, so a lot depends on their renal function, their liver function and the length of time that they have been taking them.

The others that go on with Label 1 are antidepressants that have sedative effects, the antihistamines which are used for hay fever of the sedating class. They are the ones like dexchlorpheniramine and promethazine that used to be used a lot for hay fever but are not used as much now because of the second-generation antihistamines, loratadine, fexofendine and cetirizine which have much lower sedation potential.

There is a new label that has just been introduced this year, Label 1a, which a lot of pharmacists do not have yet but are about to get, and that one is particularly for those sedative products I spoke about:

This preparation is to aid sleep. Drowsiness may continue the following day. If affected, do not drive or operate machinery. Avoid alcohol.

Then there is the question: how do they know if they are still suffering effects of last night’s sleeping tablet? Benzodiazepines I have listed on the right-hand side of the slide with some of the brand names. There is a large number of them, but it is very difficult to say what dose causes impairment, what time was it taken, how long have they taken it, what age is the person, what is their kidney and liver function, and what psychological factors and
what psycho-social factors also enter into this assessment one might do on somebody with benzodiazepine usage. They also act indirectly with alcohol, other medications as well, and if a person has mild cognitive impairment, for them is it the cognitive impairment or is it the benzodiazepine that is causing it?

I was involved at the initiation of a Monash University Accident Research Centre trial where we were trying to put a proposal for more research in this particular field. I attended a meeting towards the end of last year and have not heard further, but I encourage again that funding be considered to find out more about the effect of benzodiazepines on our population.

There is a complicated slide next that shows the bio-transformation pathways of the benzodiazepines. They all just do not go into the body and out of the body, some of them go to other metabolites that stay in the body a longer period, which of course further complicate this issue.

Another slide on the bottom of the page is the elimination of diazepam. It shows the large variation in a person aged 20 compared with somebody of 40 compared with somebody of 80 as to how long diazepam will actually stay in the body. You can see the half life of this particular medication is extended — in this particular case, up to well over 80 hours. There is also a problem if you suddenly say to somebody to stop taking benzodiazepine, and I have listed some of the side-effects that can happen, which would be even more of a problem for somebody contemplating driving.

Label 2 is not quite so complicated. It is a straight red label which states:

Do not take alcohol whilst undergoing treatment with this medicine.

Then we go to Label 2. With Label 2 there are very few medications now that are used for that one, and it is basically an interaction that may make somebody feel quite sick rather than their driving impairment. Label 12 is used for those medications that may affect mental alertness and/or coordination. Again:

If affected do not drive a motor vehicle or operate machinery.

Sometimes symptoms of the medications that have Label 12 will disappear after being on them for quite some time. One could think of examples such as anti-inflammatory medications where somebody who is on a high dose may feel a little dizzy, a little confused, but after having taken them for a while those effects are minimised, so it really is an initial education at the time. The ones that Label 12 might apply to are some of the antidepressants, some medicines for epilepsy, and a few of the medicines for blood pressure control. Generally in the teaching I do I encourage the practitioners to warn consumers that while they are changing over their blood pressure medication they may feel a little bit dizzy and they may need to take care with driving until they are stabilised. Once they are stabilised there should not be a problem.

There is one class of antimicrobial agents that can also cause confusion and dizziness. Sometimes they are used in older people. They are not drugs of first choice; they are often used for urinary tract infections, but they are only used when they are down to about the fourth line when there has been resistance to other medications. You could imagine some of our older people who get a lot of urinary tract infections and if they are put on one of these medications they could be quite dizzy and a little bit confused. That is not really good either. I have mentioned the non-steroidal anti-inflammatories.

The question is: did the drug contribute or not, the ethics of it, to treat or not, to test or not, to drive or not, and who can be the judge? That is an incredibly difficult ethical dilemma. If we start doing roadside testing for people taking medications, what will they do? ‘I won’t take my medication’, then we can end up with somebody whose medical condition is untreated and a worse problem. To me the answer is education. That is what the next slide says: education to the public — general awareness campaigns. We ran a campaign some years ago, if my memory is correct, in 1996 with the TAC in the Herald Sun and the Age that ‘These medications may cause the same effects as 0.05 per cent of blood alcohol in your body’.

That was well evaluated by the consumer organisations and also I evaluated it for Victoria (pharmacists). Reports have been available and tabled of that campaign. It did increase awareness but it was not without its repercussions because some people thought that that advertisement meant that, ‘Oh, I’m going to be tested by the blood alcohol meters and I’m going to show up as being over 0.05 per cent’, instead of the interpretation that it was reactions. We need to tidy up those sorts of campaigns before we run them again.

The next slide is increased education of health professionals to choose the optimum medication for an older person particularly, and to test to make sure that they are safe to be out on the road. We have the ability to affect
behavioural change of consumers, and I think awareness is the important thing. There was a campaign that was initiated by VicRoads — I think Mike Hull was the originator — the Safe Drive campaign, and I had the pleasure of being involved in that. It was run in a number of centres around Victoria. We made a video and had groups of consumers who came along. We talked about driving skills, eye problems, medication, and a number of other health professionals were involved. That was highly evaluated again, and that might be something we could do.

Another slide is minimising risks, driving and medication. We have listed the medications. It somebody has hay fever then they should be taking what we call the second generation antihistamines which have less likelihood of driving impairment. With the antidepressants, the new generation ones have less problems than the older ones. There are options for antihypertensives and for sedatives that have a shorter half life, or preferably to look at sleep hygiene rather than just relying on medication. There are a number of cough mixtures that can cause problems. The classical one is perhaps the Benadryl cough mixture which contains an ingredient called diphenhydramine which is an antihistamine, and while it is an excellent cough mixture for somebody who is troubled at night, it would not be the best for somebody who is driving on the road to take. We at the Pharmaceutical Society have made an active effort to educate not only the pharmacists but the pharmacy assistants so that they will screen consumers to check if they are planning to drive before they select some of these particular medications that are available without prescription.

Mr LANGDON — Does that particular cough medicine have a clear label?

Dr GOWAN — It does, but it depends on your eyesight, how good your eyesight is. In some of the interviews I have done with consumers in their homes looking at the labels on their medication, they cannot read them, so it does need to be highlighted. That is a very valid point.

Pharmacists need to counsel the patient on all occasions about the possible adverse effects with it. The pharmacy assistants under our pharmacist-only and pharmacy-only protocols are required to check with the consumer, to check who the medicine is for, what are the symptoms, and are they taking any other medication. If they are, they are advised to consult with the pharmacist before they actually sell a product. That might be a cough and cold product or it might be a simple pain reliever, such as a paracetamol and codeine combination. The doses of codeine in products such as Panadeine, Panamax Co and Dymadon Co if taken on a regular basis have the potential to impair driving.

The CHAIRMAN — Do you think pharmacists have a social responsibility and an obligation to notify VicRoads whether the patient should be driving or not?

Dr GOWAN — That question on face value would appear to be yes, but because of the privacy restrictions the answer has to be no. I think it has to be driven by the consumer to the doctor. We could not even ring the doctor to say, ‘Mr Brideson we felt perhaps needed to have a driving test’, without that consumer’s permission.

The CHAIRMAN — Is that a fault in the privacy act, because we have the capacity to legislate these things?

Dr GOWAN — I think it is something that needs to respect the consumer, and it is a difficult one. I would not like to give an answer on that one.

The CHAIRMAN — Do you have a private view?

Dr GOWAN — A private view would be that I would request a medication review be undertaken for that person with their permission, which is driven by the doctor. I would then sit down with that person in their home, look at their medications and do a report. That would go back to the doctor. It would be discussed with the doctor and the consumer, and it would then be up to the doctor to follow the next step for perhaps looking at occupational therapists who can assess driving skills, make some modifications. Perhaps if the person was driving a geared car they may be able to manage better with an automatic car. It might be as simple as that because of their cognitive functioning, but I think we do need to respect the consumer; but we must also respect the other road users, so it is a difficult dilemma.

In summary, we have a number of initiatives that we try to give to consumers. I think there needs to be more consumer education through the senior citizens clubs, the bowling clubs and the over-50s clubs. Shopping centre testing of reaction times, Safe Drive programs and certainly this initiative of the home medicine review offer an ideal opportunity for somebody to come to the decision themselves that perhaps they should not be driving at night.
They might only drive during a certain time of the day to get their provisions. Looking at the quality of life as well, then we need to have initiatives such as half-price taxi schemes so that they can use those alternatives when they are driving outside their immediate area and want to go to functions or arrange something with family members. I think if the person makes a decision then it is a far more happy situation.

I have seen many consumers who have been absolutely devastated after an having an adverse hospitalisation when they have been unable to drive and who have fought to get back on the road. It has meant that some of these people have not been able to live in their own homes and have had to go into assisted care accommodation. The repercussions are huge.

Mr SPRY — When does a medicine become a drug?

Dr GOWAN — It depends on the definition. I would have to go to the World Health Organisation definitions, which I do not have off the top of my head. Any medicine has the potential to assist people but to also impair people.

Mr SPRY — The line I am going down is that pharmacies fill out prescriptions, which are presumably written for the patient by a doctor, but if a pharmacist sees that there is an abuse of the medicine so that it does become a drug, what then is the pharmacist’s reaction? Where does their social conscience lie?

Dr GOWAN — Under section 34 the pharmacist has the responsibility to notify the doctor, and then to notify the department, of a person who is suffering from drug dependency. If somebody is misusing a medication and a prescriber is ordering it more frequently than what is normally expected, then the Drugs and Poisons division needs to be contacted.

Mr SPRY — There are probably not too many cases where older drivers in particular need stimulation, unless they are on the road trying to drive around Australia in a big harrier, or something like that. I suppose there is an occasional instance of an older driver wanting to keep awake for whatever reason. Have you ever come across an instance like that, or what are the protocols in that case for such an instance?

Dr GOWAN — To advise them to always travel with another person, and the usual VicRoads initiatives of stopping and having a break every hour or hour and a half and of having a cup of coffee or cup of tea as provided by the Lions Club down the road, but certainly not to take an stimulant. Also to use schemes such as putting their car on a train if they are going to Queensland, which has a lot going for it for an older person for their quality of life as well. A lot of it is that older people are taking their medications excessively almost inadvertently because they are suffering from pain and their pain management programs need reassessing. We need to look at some non-drug treatments and a whole spectrum of treatments rather than just relying solely on medication. Somebody taking an excess amount of paracetamol and codeine because of pain is at great risk of driving from the medication but also because of their pain threshold. There are a number of factors.

I also circulated the Self-Care card ‘Medicines and driving’, which is available in about a third of pharmacies in Victoria. It was funded by VicRoads under the initiative, when we were doing the campaign before, for it to be available in other places other than pharmacies to assist people. We need to get to them to assess what is happening.

The CHAIRMAN — You mentioned in your submission that more funding needs to be provided for these. What sort of funding are you looking at — what dollar amounts?

Dr GOWAN — Just providing the leaflets by themselves will not achieve as much as if we have education sessions run out of each division of general practice or out of each road safety authority, where we increase driver awareness when people come along and in a non-judgmental manner we test their reaction times, look at some current road rules they might have become a bit confused with and also include the medicines and driving impairment.

The presentation that I gave to you was a slightly more complicated presentation than I would give to consumers, but something along that line could be available to be done in a number of regional centres to assist people. There is always great interest when we do these presentations.

The CHAIRMAN — I can see no reason why this sort of literature cannot be sent out when a registration or licence renewal process is occurring.
Dr GOWAN — There is a small brochure that has been put out. In the older drivers handbook there is a section in it from where a lot of that has been taken. It has the labels in there as well, but whether they read it is of concern and whether they actually apply it to themselves is also of concern.

Mr LANGDON — Is there a label saying, ‘Do not take with any other form of medication’? For example, if you are on one of the tablets to do with whatever, and you have a cold and a sore throat, would that be affected by having a cold tablet and a cough medicine? Is there any label saying you should not mix them?

Dr GOWAN — Yes, there is. Label 5 is used with certain medications that have particular dangers, and they are the medications that have a very small area where they are effective and they can proceed into toxic areas or with additive effects.

Mr LANGDON — Have you found a lot of people do not think of that when they are taking, say, cough medicine?

Dr GOWAN — With the screening done by assistants I would see that a pharmacy would be negligent if it let a consumer go out of a pharmacy without that screening. I have had the privilege of going around Australia for a number of the banner groups training their pharmacy assistants in that screening process, so if you had picked up a cold and flu preparation you would be asked, ‘Are you on other medications? Hold on a moment, I will just check with the pharmacist to make sure it is safe’. I would like to believe that that would happen in the majority of pharmacies. Of course, we cannot get them all, but we are trying very hard with our education.

The CHAIRMAN — Do you foresee it happening, or would it be possible for community pharmacists to administer simple cognitive assessment tests?

Dr GOWAN — It would be possible, yes. We certainly do blood pressure testing and peak-flow testing. I would not advocate the bone density test because I do not believe the equipment is sensitive enough. It (screening) certainly would be possible. That is an interesting point.

Mr SPRY — Is there a recognised test?

Dr GOWAN — Some tests have been trialled, yes, but that depends on the time of the day and on so many other variables. I doubt whether our members would be prepared to undergo that possibility of litigation. I think it needs to be done as a separate entity, perhaps from the doctor and then referred to a centre such as the centre at La Trobe University. I am familiar with the occupational therapists and there is certainly something there to address. I believe that our biggest role is in education in warning people about possibilities and then taking other precautions when necessary.

Mr LANGDON — Over the years pharmacies have had more and more things in them; they are selling more and more products to make ends meet. When you go into them there is a whole range of stuff you can buy. Are they getting too busy to start policing all these things?

Dr GOWAN — I believe that pharmacy is now refocusing on the provision of information for the consumer rather than purely a supply of a product. The initiative of the home medication review, where we get paid $140 per review, is one instance of that. This is the first time that we have actually been paid for a cognitive service rather than being paid for a product. I can assure you from my own experiences it is a privilege to go out and sit down with somebody, go slowly through their medications and talk about the problems that they may be causing them, such as perhaps they are not able to react as fast with their driving, what other options they may have considered and allowing the consumer to make their choice and look at what they can do, such as getting a ride at night if they are going out at night and those sorts of things.

I believe pharmacy is focusing how back on to the care of people because there is remuneration. In other states there is initiative called the medication advisory service, which is a 20-minute consultation. I forget the fee, but that is something where people are taken to a semi-private area and sat down if they have a new device to go through it right in the pharmacy. That is something which could be done under that and which is reimbursed currently by the health funds.

Mr LANGDON — Have we got anything in Victoria?

Dr GOWAN — We have not because it is on MBF (Medical Benefits Fund), which is here only in a very small percentage. It has come to New South Wales, so that is something that we could consider. Again, that goes to
the people who have the private health insurance — they get reimbursed over that — and it does not come to a lot of our people who cannot afford to be in private health insurance.

Mr LANGDON — You have explained one rebate and there is one in New South Wales?

Dr GOWAN — This is a new one that is just starting to come in, yes. I think it is about a $40 dollar fee for an at-length consultation. So if somebody has new medicine and they need more counselling you can actually sit down and talk to that person for 20 minutes instead of the 2 or 3 minutes while other people are jangling their car keys and wanting their antibiotic prescriptions in a hurry.

Mr LANGDON — Would all pharmacies have those individual rooms?

Dr GOWAN — They have to have a semi-private area where they can withdraw people so that other consumers cannot hear. That will start to come in in the future, so we can look forward to some new initiatives. That is the sort of thing you could discuss: the impact of medication on driving. We could run campaigns.

Mr SPRY — What role do you think the pharmaceutical industry has in producing drugs that actually improve driving capacity?

Dr GOWAN — I would not like to say ‘improve driving capacity’, but I would like to say that they do not impair driving capacity. I think they have a major role, and it needs to be a major marketing thrust. That has actually happened with, say, the new antihistamines for people with hay fever and other allergic conditions. It has also occurred with people suffering from depression. The older antidepressant medications had a very high sedation potential, whereas the newer ones do not have nearly as high a sedation.

Mr SPRY — There are instances, and I think we have received evidence of it today, where people with hypertension and who might be too nervous to drive can be sedated a little bit to make them better drivers. Do you have any comment to make about that?

Dr GOWAN — I would not be using the effect of the antihypertensive medication to achieve that end. The potential for sedation depends on the medical condition; it becomes a fairly complex matter as to the choice of the antihypertensives. There are so many variables.

Mr SPRY — To put it in the vernacular, I have heard people say at the bowser, ‘I am no good driving until I have a couple of grogs in me and then I am pretty right’. Are you suggesting that sort of approach?

Dr GOWAN — There is a saying that perception is reality, but perception is reality when they have an adverse event.

Mr LANGDON — Can you again elaborate to me and the rest of the committee about the way the pharmacies are now taking people aside and the way they are getting funded to do this from New South Wales and the federal government?

Dr GOWAN — It is not from the federal government; it is under an initiative from the health funds.

Mr LANGDON — From the health funds themselves?

Dr GOWAN — From the private health funds. The particular one was MBF. There is the federal government initiative that I have spoken about with the medication reviews which happen in a consumer’s house, a doctor’s surgery or a pharmacy. By choice it is the consumer’s home, because we are looking at how they are managing to take their medications. Are they doubling up and taking double their medications in a day, or are they forgetting to take them? There are those issues. That is $140. Just to complicate matters, there is another one which comes out of a different lot of funding which is for the residential aged care facilities — hostels and nursing homes. Would you believe that some people in hostels are still driving? I was really surprised the other week. I interviewed a 91-year-old woman and she said, ‘I still play golf, you know’. I said, ‘How do you get to golf?’ She said, ‘I have my car here’. I had concerns, and we did address them.

Then we have this other new initiative. Those two are federal-government funded. This third initiative is a private health funding initiative, and that might be something that we could look at with in-depth consultations to assess how the medicines may possibly impact on driving skills.

Mr LANGDON — How do people access it, or is it just through the health cover they have got?
Dr GOWAN — At present it is only if you have private health cover. If we had a Medicare-type rebate that could be something that — —

Mr LANGDON — And the others? How do they know about the others?

Dr GOWAN — The other initiatives are publicised on the television, the radio, seniors magazines and pharmacies, and there are notices in doctors’ surgeries. We also identify people at risk. Mr Brideson raised a question of how I would assess someone and whether I would contact VicRoads. I would assess that person and say, ‘Hey, I am concerned about their driving. If we do a medication review we can look at their total picture and then discuss it and let them have an input’.

Mr LANGDON — Thank you.

Dr GOWAN — There are lots of new initiatives.

The CHAIRMAN — That certainly has given us something to think about.

Dr GOWAN — I am sorry; it is a very complex area and not an easy one on which to come up with any recommendations. It is something I am passionate about and helping people with, but to me the only solution is basically more education. I look at New Zealand. You have probably picked up the accent. People usually laugh about it.

The CHAIRMAN — Sean understands you very well!

Dr GOWAN — I look at what my father had to do before he passed away at 91 or 92 — he had to go up and do his driving test — and at my mother, who is now 78. They undergo regular driving skills testing and try and get the best ‘traffic cops’, they call them over there, to test them. To me, the testing is a positive thing. I also look at what happens to them if they cannot drive and cannot toddle up and get their milk, bread and meat. That is also a concern.

The CHAIRMAN — That is a major concern actually.

Dr GOWAN — I guess my own personal point of view is that we could have these people drive in a limited area of time, perhaps between 10 and 2, so that they miss the school traffic. Where my mother drives, once the schoolchildren are out it is chaotic on the road, but she would be quite happy to be able to toddle up, go to the bank, pick up her meat, fish or whatever, and come back home again. To have to ask someone to do this really takes away their dignity. They are usually driving at particularly low speeds in the area she comes from, where there is an older population.

The CHAIRMAN — Is she in a metropolitan or rural area?

Dr GOWAN — It is Paraparaumu, which is a place a bit like Rosebud. Do you know that one?

The CHAIRMAN — I know the one.

Dr GOWAN — The oldies are just out there. They would not miss going to safe-driver education. You hear them talking: ‘You mustn’t miss that, Mabel. You must go’. They are trying to encourage their friends to take responsibility. That is very healthy.

Mr LANGDON — Just one other question. One of the things we have picked up is that what we call ‘golf buggies’ are becoming far more prevalent these days, more and more people use them. If those people are on medications which say on the label ‘Do not drink or drive’ or ‘Do not use and drive’, I do not think people are necessarily relating them back to those golf buggies.

Dr GOWAN — I think you are right. There does need to be increased awareness. We only need think of older people walking across the road and accidents, so I have included such things as cycling and walking, and I should include Fisher and Paykel scooters, which are the New-Zealand-made ones!

Mr LANGDON — Free advertising! Thank you.

The CHAIRMAN — Thank you, Dr Gowan, for your presentation to us. It has been most informative. It has certainly given us some food for thought.
Dr GOWAN — It is not an easy one!

The CHAIRMAN — You will receive questions from Hansard reporters before you go, but in the event you do not meet with them, I am sure you will be looking forward to receiving your transcript of today’s hearings.

Dr GOWAN — I remember doing this one other time when some poor reporter had to struggle on some of the drug names that I quoted. I try to use generic names rather than brand names for this purpose. That can make it a bit more complicated.

Committee adjourned.