COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

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

FRIDAY, 7 FEBRUARY 2003

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Friday, 7 February 2003

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

Members in attendance: Ms Ellis, Ms Hall, Mr Hartsuyker, Mrs May, Mr Mossfield, Mr Tony Smith and Dr Southcott

Terms of reference for the inquiry:

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

WITNESSES

Committee met at 9.02 a.m.

CHAIR—I declare open today's hearing of the House of Representatives Standing Committee on Ageing. Today's public hearing is the first in a series of hearings to inquire into the long-term strategies to address the ageing of the Australian population over the next 40 years. Today we will be taking evidence from several departments, including Health and Ageing, Family and Community Services, Veterans' Affairs, Treasury, and Immigration and Multicultural Affairs, as well as from Professor Peter McDonald and Aged and Community Services Australia. Centrelink is unable to attend today but will have another opportunity to address the committee at a later date. As a result, there has been a minor change to the program this afternoon, with this afternoon's hearing commencing at 1.45 rather than 1.15 as advertised.

It is clear that the ageing of Australia's population will have a profound impact on all facets of social, economic and political activity. In terms of economics, population ageing will have an impact on economic growth, savings, investment and consumption, labour markets, pensions, taxation and intergenerational transfers. In the social policy area, population ageing affects health and health care, family composition and living arrangements, housing and migration. Politically, population ageing may influence voting patterns and representation, which interests the committee, of course. In comparison to other developed countries, Australia is well placed to deal with an ageing population. However, this does not mean we can be complacent. It is critical that public policy is developed that takes into account population ageing. This inquiry is a significant part of the process of laying the strong foundations that can be built on to meet the future needs of all Australians. The committee has received more than 100 submissions to date.

[9.04 a.m.]

BRUEN, Mr Warwick John, Assistant Secretary, Department of Health and Ageing

CULLEN, Dr David John, Executive Director, Aged Care Price Review Taskforce, Department of Health and Ageing

LOPERT, Dr Ruth, Assistant Secretary, Pharmaceutical Benefits Branch, Medical and Pharmaceutical Services Division, Department of Health and Ageing

MERSIADES, Mr Nicolas George, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing

O'DONOUGHUE, Mr Ross, First Assistant Secretary, Population Health, Department of Health and Ageing

THOMANN, Mr Mark, Assistant Secretary, Office for an Ageing Australia, Department of Health and Ageing

CHAIR—Welcome. I remind you that proceedings of the committee are proceedings of the parliament and, as such, misleading the committee is a serious offence. I invite Mr Mersiades to make a brief opening statement.

Mr Mersiades—Thank you. I will make a short one. Given the limited time available and the difficulty of distilling the essence of the wide-ranging submission that we have provided, I will rely a lot on the submission itself. I would like to highlight a certain duality in the submission, that being that a significant section of it deals with the work of the Office for an Ageing Australia and the balance deals with the core business of the department. The office's role is pitched at the level of awareness-raising on the issue of ageing issues, and highlighting the importance of community-wide responses to ageing issues, as you alluded to in your introductory remarks. Hence the section of the submission dealing with the Office for an Ageing Australia is pitched at a broader strategic level. In that regard, I highlight the categorisation by our minister, Minister Andrews, of some of the key strategic priority areas which we think cut across the community at large, all governments and the private sector. Those categories, or policy themes, are financial security and self-provision, work force participation, productivity and prosperity, social inclusion and participation, healthy ageing, and world-class care. In terms of the core business of the department, which I alluded to earlier, it is really the latter which is the focus of our list, though clearly there are interrelationships with the others as well.

I will highlight a couple of themes that come through in the balance of the submission. One theme is the growing importance of good public health programs, including health promotion and disease prevention, to support healthy ageing. Looking way into the future, I think investment in that area is critical. The other thing that comes through, looking into the future, is the growing importance of greater integration and coordination between the acute care, community care, primary care and aged care sectors, recognising that responsibilities in these areas rest across governments. Of course there are important implications there for the various components of the professions in the medical and social community care sectors as well. It is

particularly important, given the expected increase in the number of Australians who will be presenting with chronic and complex conditions. As a society, we need to adapt to that emerging situation. I will leave it at that, other than to say that we look forward to assisting the committee in every way possible in undertaking this important task.

CHAIR—Thank you very much, and thank you for your very comprehensive submission. On the issue of healthy ageing, you mentioned the increasing importance of health promotion. We have seen a number of initiatives in recent times relating to diabetes and nutrition and so on. Looking forward, are there any health promotion areas which you think need more attention?

Mr Mersiades—I will defer to my colleague Ross O'Donoughue.

Mr O'Donoughue—It is an important question. As you indicated in the opening remarks, Australia is relatively well placed. Our history is that we have done rather well in lifting the community away from communicable diseases in particular but, like other developed countries, we face a potential epidemic of chronic disease. The national priority areas that we have identified in our 'Investing in good health' chapter in the submission—cardiovascular health, cancer control, injury prevention and control, mental health, diabetes, arthritis and asthma—account for 70 per cent of the burden of illness and injury, and many of these are amenable to behavioural interventions. In other words, they have some prevention component to them. The World Health Organisation's report released in 2002, *Reducing risks, promoting healthy life*, suggests that, while we do rather well in comparison to other countries in the world, in that we can expect 71.6 years of healthy life from birth—

CHAIR—Is this disability adjusted life expectancy?

Mr O'Donoughue—Yes—they have renamed the indicator HALE or healthy adjusted life years, but it is essentially the number of years that a child at birth could expect to live a healthy life. It is adjusted for illness. We are at 71.6, which is very favourable by comparison with other countries, but they estimate that developed countries like ours could improve that by up to six years of healthy life by addressing some of these behavioural risk factors that would impact on chronic disease. So that would not only have an impact on health care costs but also potentially it could mean that people could lead healthier and more productive lives in their later years.

CHAIR—So I take it that, in the area with risk factors such as smoking, poor nutrition, obesity and so on, we have programs to address them but we perhaps need to do more in those areas. Is that a more fruitful activity than something we have not yet identified or implemented fully—like, for example, colorectal cancer screening?

Mr O'Donoughue—I would say that we need to do both, but certainly the so-called SNAP framework of smoking, nutrition, alcohol and physical activity is definitely a fruitful area for us to make further investments in. In a way, the obesity focus that the minister decided to task AHMAC with last year brings some of those themes together in the sense that obesity itself is a risk factor for any number of those chronic diseases. In addition to those interventions, you rightly point out that early detection of things like colorectal cancer is also an important area for investment. We are exploring bowel screening initiatives for older Australians at the moment.

Ms HALL—What strategies has the department put in place for improving those outcomes?

Mr O'Donoughue—In respect of the SNAP frameworks, for example?

Ms HALL—Yes, that is right.

Mr O'Donoughue—We documented in the submission that there is approximately $36 million in health promotion expenditure, but we are hoping that the government is committed to integrating preventive activity more widely across the health system. An important partner in that exercise would be primary health care. So the SNAP framework is really primarily aimed at general practice and primary health care. Involving those deliverers of health care in more preventive activity is an important part of what we are doing.

Ms HALL—Are you looking at trying to get the community involved at the grassroots level and empowered?

Mr O'Donoughue—Indeed. It has been said that our present environment is an obesogenic environment in that, because of many aspects of our lives—not just in the health delivery sense, but in the way we structure our communities and our reliance on cars and machines to do much of our work—we have to take an intersectoral approach and we very much have to ask people to take some responsibility as well for taking the initiative to have an influence on their own health. So I think you are right in saying that it does need to be a grassroots approach as well as a multisectoral and cross-health approach.

Mr ANTHONY SMITH—Picking up from where Jill left off, there are a couple of points I would like your reaction on. One point is that, if you follow the debate in the media, it seems that in very general terms there has been some success on some issues like smoking. Certainly, the dangers of smoking are now well known and it seems that there have been some real successes in that. But then, obesity seems to be the latest problem. What plans do you have to go about this at that grassroots level with doctors? It seems that the Commonwealth and your department can do so much, but we also have doctors on the ground. Also, the states tend to run their own programs depending on their own priorities. To what extent can we integrate that a bit more over the coming years?

Mr O'Donoughue—Just to give a specific example of an initiative that would relate directly to the general practitioner, the department has funded and developed a so-called lifestyle script on physical activity that will be embedded in the medical software that general practitioners use. So it will be a tool that GPs will be able to use to assess whether their patient has an appropriate level of physical activity and then to give them a prescription which, rather than tell them to take a prescription of a medication, will give them a prescription for a particular course of exercise and also provide them with supportive material. That is a tool that GPs will be able to use directly to deal better with the patient in front of them in a preventive sense.

Through the National Public Health Partnership, which is the main way in which the Commonwealth and the states engage to deliver public health programs, there is a series of nutritional and physical initiatives. The task force that ministers agreed to last year will be an AHMAC task force, so it will effectively engage with both the states and the territories and also with industry and non-government sector players to try to build a collaborative approach and national agenda around obesity. It is a complex issue and it has only really emerged over the last 20 years or so that this problem seems to have got much worse.

Mr ANTHONY SMITH—I just want to take you to one area that gets a lot of media attention with regard to obesity, and that is teenage obesity and obesity even in primary school children. I am wondering, particularly at a state level—and I know this is beyond your direct control—what sort of liaison is going on between state health departments and state education departments. There has been a significant amount of public debate in some states, notably Victoria, about the decline in physical education and what goes on at school. I raise that because obviously doctors have a role and government has a role but, with regard to obesity, the problem happens at home and at school.

Mr O'Donoughue—I think it is a heartening sign that several states have engaged in summits or conferences around the issue of obesity. I believe New South Wales, Victoria and Tasmania have all taken those initiatives. As I said, through the National Public Health Partnership and through this AHMAC task force, we are hoping to mobilise that effort towards a national agenda. The Commonwealth is really trying to support that in a research sense and also in producing materials such as Active Australia, *Getting Australia Active*, *Dietary guidelines for Australians*, *Dietary guidelines for children and adolescents*, infant feeding guidelines and *Eat Well Australia*. I suppose you could say these are all state-of-the-art resources that will underpin the effort at the state level. I think there is a good level of cooperation and the issue is coming to the fore, and hopefully, as this AHMAC task force gathers momentum, we should see some real roll-out of programs at the state level.

Mrs MAY—Tony has actually explored a number of areas I wanted to talk to you about this morning. To take it one step further: we have talked about the cooperation between you and the states. I wonder if that needs to be developed any further. Would you be happy with the level of cooperation there is at the moment in developing new programs? I also wonder about the cooperation between departments. Obviously, Veterans' Affairs are involved. I know I see a lot of my veterans who have problems, whether they be related to smoking or obesity. I wonder how you work with Commonwealth departments. Could you expand a little on that for us, please?

Mr O'Donoughue—You are absolutely right in identifying that it is very much an intersectoral issue. It is not solely within a domain of a health system to deliver the outcomes. I guess there are a number of things; there is a series of emerging national agendas. For example, an early childhood national agenda is emerging, led by FACS, and there is a task force around that. There is a similar youth national agenda emerging, again led by FACS in a task force approach by Commonwealth agencies around that. We envisage that, under the banner of the obesity task force, there would also be a Commonwealth agency task force that would support that effort. I think there is an attempt to increase the link—not just in health but in planning the social service sector and sport and recreation into the mix of the interventions. I think all signs that those connection are being made are encouraging, because everyone does realise that it is an intersectoral issue and it is not something that one particular agency can deliver.

Mr MOSSFIELD—Could you explain what the state of play is through the various stages of aged care accommodation, starting from self-contained units and going through to hostels and nursing homes? I had a practical experience of that with my own mother, who made her own decision to go into a self-contained unit and then to progress to a hostel. But then, when she got quite sick and had to go to hospital, there was no nursing home bed for her. That came as a shock to the family, who thought that she had planned for her retirement. What is the state of play? Are you satisfied that the progression is there and is reasonably extensive?

Mr Mersiades—The Commonwealth's focus in residential aged care is really on high-level and low-level care facilities, which were known as nursing homes and hostels until the reforms in the mid-1990s. Beyond that, there are privately provided independent living units, which sound like what your mother was accommodated in. There is a degree of regulation of them by the state governments, but the Commonwealth has no direct involvement. The process of progression from an independent living situation, whether it is an independent living unit or your own home, is facilitated through aged care assessment teams, which are based in most large hospitals—but not exclusively in hospitals. They undertake assessments. On the basis of that assessment, you can be recommended for high-level or low-level care or even for support in the community.

Mr MOSSFIELD—It was a church-run retirement home, so that was true. I am wondering, for people who do make their own decisions and plan for their own retirement, will everything be available to them even when they have gone beyond the point of making their own decisions?

Mr Mersiades—It depends on the availability of places at the time and on the need for residential accommodation. As far as I am aware, there is no process of pre-booking a place in a residential community. It is a question of as the need arises, it is matched with what is available in the local community.

Mr MOSSFIELD—All right.

Mr HARTSUYKER—I was interested in Mr O'Donoughue's comments that 71.6 years of healthy life can be increased by six years through improved lifestyle factors. Your submission touches on the complex relationship between work and health. Does the department see that, with improving medical technology, there is the prospect for increasing the retirement age by several years? What is the department's view on that? Should we be encouraging that?

Mr O'Donoughue—The focus of the World Health Organisation finding is that we tend to consume most of our health resources in illness in the last years of our lives. It would seem possible, now that we are living longer anyway, that we could be healthier longer. So we could compress that period of illness to a shorter and shorter period of time and thus have healthier years of life. As you say, the interaction between work and health is a complex one. But people argue that it is a chicken and egg situation: it seems that people who are unemployed have a much worse health status than people who are employed. It is hard to know whether it is the work that makes you healthy or your health that makes you enjoy work. There is the prospect, with healthier years of life, that people could retire later. While, maybe a decade ago, people were talking about looking forward to many years of retirement because we are all going to be retiring very early, I think that might have turned around now. People are expecting that we will all be working rather longer as the economy requires more and more productivity. Does that answer your question?

Mr HARTSUYKER—And your view is that that is possible, that we could look at that?

Mr O'Donoughue—Yes. Clearly, for developed countries the World Health Organisation is saying that if we can be successful at turning around some of the challenges of chronic disease we can achieve longer, healthier years of life. There is no reason, therefore, why people cannot

be productive members of society. Whether that is enjoying a fruitful retirement or whether it is spending more productive years at work, they will have the capacity to do that.

CHAIR—On the issue of aged care and community care, what do you see in the future? How do you see the mix of residential aged care compared with community care? I think the Intergenerational Report felt that most of the growth in expenditure would come from community care as opposed to residential care. Both will grow of course but there will be more in community care.

Mr Mersiades—I think the challenge will be to give people a choice rather than try to predict it in any firm way. I think the evidence to date is that more people are seeking the choice to age at home for as long as possible. As a result there have been a number of initiatives which have been put in place to allow that choice, starting with the introduction of the community aged care packages in the mid-1990s, which have seen very significant growth since then. There has been a very significant increase in respite care because, if you are going to have people living at home, there will often be a need to support carers rather than leave them on their own. There is the EACH program, which is even looking at supporting high care in the home. Getting back to independent living units, a new initiative in the budget last time around, there was the extension of community aged care packages into independent living units so that people can stay there as long as possible. The key is to monitor that and to, as much as possible, give people the choice.

Ms HALL—I have a series of questions here. We have touched on the relationship between the states and the Commonwealth and the relationship with the local government and what sorts of initiatives have been put in place to have a whole-of-government approach to this very important issue—and I have thrown that in so that you can deal with this part as well. We have been talking about the three levels of care with regard to housing that are specifically age oriented. Have guidelines been given to local government authorities to look at innovative designs and incentives for housing that meet the needs of older people in areas that are accessible to transport and all the other things that are so vital for them to achieve the quality of life that we would like to see older Australians enjoy?

Mr Thomann—I am just trying to work out what the question is. Is this about the interaction between jurisdictions?

Ms HALL—One is about the interaction between jurisdictions—I probably threw two questions in there together—and the other is: are there any initiatives that the Commonwealth has in place to encourage local government authorities to develop or encourage developers to put in place age-friendly housing? Are there guidelines, state-of-the-art housing projects? There are two things there.

Mr Thomann—In terms of the jurisdictions this was the subject of discussion at the recent COAG meeting, and there was quite a lengthy paper on the subject—I do not know whether you have a copy of that. A term of reference has been given to the Productivity Commission to look at the demographic changes in the Australian population, mostly in terms of the economic drivers but also in terms of the impacts upon state and local government. There is that going on at that level.

In terms of local government authorities, I think this is an underdone area at this stage. We are certainly considering, within the context of the National Strategy for an Ageing Australia, how

we can engage local government. We are starting to receive some swallows, if you like, an indication that the local government is getting interested in this area, and Minister Andrews is very interested now in engaging local government. We have had discussions with the National Office of Local Government, for instance, on how we can go about doing this.

In terms of age-friendly housing design, there are some innovative projects, such as the Delfin Lend Lease project in Adelaide, that you might be interested in. But this is just an indication of a growing interest in the area. We also sponsor the MBA Housing Design Awards to promote interest amongst builders in this area. Obviously, we have a general interest in this area. At the Building Ageing Research Capacity experts forum held in December, it was pretty clear that this particular area, where the research is thematic, is underdone and it is an area that needs a lot more work. We will be seeing how we can do that through those different agencies.

Ms HALL—Thank you for that. I will move now to the more traditional areas of aged care: the hostels, nursing homes and the residential classification index. It has been put to me by a number of people who are involved in the industry that the way the current residential classification index works is designed to award illness as opposed to wellness. There is no incentive built into the classification scheme for improving the wellness of a resident. If the resident becomes healthier then that hostel or nursing home, whether it be a high-care or low-care facility, will receive a lesser payment. If a person's classification changes from a three to a four or five, then the facility will lose some funding. Where they could put in some innovative programs and improve not only a person's quality of life but also their functionality, that incentive is not built into the system.

Mr Mersiades—Yes, that is a feature of the current system, and it reflects the fact that the payment system is based on paying providers according to an estimate of what it would cost for a person presenting with a particular range of disabilities and care needs, so that you pay what you think it is going to cost.

Ms HALL—I understand that.

Mr Mersiades—The consequence of that is, if a person improves and there is a reassessment, then the cost of their maintenance goes down and therefore the payment goes down. There is some perverse arrangement in that, but I think the overriding position for the system is that it looks to pay providers for the costs of care.

Dr Cullen—I have to say that the position which you are reporting is fallacious. To put it very simply, it is true that less funds go to the home; it is also true that they have to spend less on the person because the person is in better health and therefore requires less care. The balance between those two things is by no means clear. It is certainly not the case that funding is cut and they have to provide exactly the same level of care.

Ms HALL—Could I put it in the way that it has been put to me, that a lot of intense resources are going into this person. An activity officer will be working with them, they will be putting a lot of time into improving them through sensory input et cetera, and this cost is ongoing. If you remove those resources, then the person goes back to how they were before. The resident may have been classified as a three instead of a four simply because they were getting that care. Isn't it because the care is available that functionality is improving? Have you thought of building something into the system that accounts for that? I do not want you to

justify the system—I understand how it works—but is there a way that can be taken into account?

Mr Mersiades—There is no doubt that the issue raised is very familiar to us. It is something that a good deal of thought has gone into, but at this point there is no proposal to change the arrangement. It is possible at some point in a broader review of the RCS arrangements that notions like that could be taken on board. There is a lot of currency in the community about that issue. One factor of the way the RCS operates is that through the care planning arrangements there is an incentive for care planners to build in a program of rehabilitation or care and, once that is established in the care plan, that becomes the basis on which the classification is made. So the system does encourage comprehensive planning and a good response to the care needs of the individual. The current paradigm is that we want to pay for what it costs. Therefore, if a sustainable improvement is achieved—and it has got to be sustainable, not just short-term—the price we pay should go down. That is something that could be looked at.

Mr Thomann—The other approach to this is about maintaining independence and function as long as possible. One of the initiatives that we have made is the innovative pool. We are making flexible places available to look at innovative ways of assisting people, especially post discharge from acute care, back to their level of functioning in the community through six to 12 weeks of rehabilitation in these special flexible places. The program recognises that there is an issue about maintaining independence as long as possible, but it is addressing it through other means. This is on page 45 and page 46 of our submission if you want more details.

CHAIR—One thing that has been suggested to us is that in the future there will need to be more focus on the area of neurovascular disease. We are doing quite well with cardiovascular disease. In some areas, we are doing quite well with some cancers, but overall there is no real change. What initiatives does your department have to address the issue of neurovascular disease?

Mr Bruen—More generally?

CHAIR—Yes. Are there any public health programs currently in place? Presumably they would be the programs you have addressing the risk factors at present.

Mr Bruen—Unfortunately the biggest cause of neurovascular disease is Alzheimer's. As far as I am aware, there are no proven intervention or preventive measures for Alzheimer's, so the focus has been very much on care and management. In community care, we have a number of specific programs that are geared towards funding services for people with dementia and for the family carers of people with dementia. It is clearly, as you say, going to be the big disease problem of ageing over the next 20 or 30 years simply because it is an age related disorder. We do not yet know how to prevent it or even delay it. As there are increasing numbers moving into the old and very old age groups there will be increasing numbers of people with dementia. We have a two-pronged strategy. One approach is to try and ensure that the mainstream community care programs such as the Home and Community Care program and community aged care packages can deal with people with dementia. Another approach is by funding specific programs, particularly dementia respite, carer support, family counselling and programs like that. A lot of this funding is channelled through Alzheimer's Australia.

CHAIR—The committee has also been told that those who will be aged over the next 40 years will differ significantly from the current aged cohort. What will be different about the cohort that will age over the next 40 years compared with their parents who are now aged?

Mr Bruen—Do you mean medically, psychologically, in their social attitudes or in their voting patterns?

CHAIR—I mean both how their health will be different and how their expectations will be different. That is a big area.

Mr Thomann—Do you mean individually or on a population basis?

CHAIR—On a population basis.

Mr Mersiades—Current indications are that, by and large, they will be financially better off. I think their expectations of a healthy and productive retirement will be higher and that they will want to exercise choice as much as possible. I think they will be looking to maintain their independence for as long as possible. I also think that they will be healthier for longer. That probably sums it up pretty well.

CHAIR—Do you see the rising incidence of diabetes and risk factors like obesity affecting that?

Mr O'Donoughue—I think there is a mixed message there. Perhaps the Intergenerational Report is somewhat pessimistic and fatalistic about those outcomes, but they are very much warning signs for us. If we are not able to make a positive impact on those particular threats then, in those respects, we are likely to see less healthy people and declining health prospects for our ageing population. On the basis that they are amenable to behavioural interventions and that there is increasing focus and attention on those things, I think we can be optimistic that we can ameliorate some of those risks.

Mr Mersiades—There is another caveat I would add in relation to our discussions earlier about dementia. The way things are shaping up at the moment, particularly for the older people among the ageing, there will obviously be a huge increase in the proportion of people presenting with dementia problems.

Mrs MAY—We have talked today about people having choice and wanting to stay at home longer rather than going into nursing homes or hospitals. In my electorate I get a lot of concerns raised with me by primary carers. In your submission you have related that 78 per cent of primary carers are of work force age. I often have said to me that the carer feels that they have to do the caring because of an elderly parent who has decided to stay at home but who still needs some level of care, and that respite is really only available on one or two mornings a week. These people find that they cannot live on the social security benefit that is given to them. They would like to go back to work. Do you see that this is becoming a problem? Even though they are choosing to stay at home these people do need a carer in a lot of cases, but your statistics show that those primary carers at the moment are of work force age. Does that mean we need to look at putting in place more community services—and how will that affect the budget—to address the needs of those people who choose to stay at home?

Mr Bruen—I should say that the figures for carers of work force age relate to carers of all people with a disability, including children and young people. The majority of carers of the aged are in fact aged themselves. The most common caring situation is a spouse caring for a spouse. So in about 60 to 65 per cent of cases the carer has retired from the work force anyway.

For the carers who are in the work force there is a range of benefits payable through Centrelink—that is, the carer payment and the carer allowance, which provide income support. But that is not administered by us. It is an issue that we are looking at: on the one hand people's desire and willingness to work longer and on the other hand the fact that our community care system depends very largely on family carers being at home. In fact the Bureau of Statistics estimates that about three-quarters of care provided for frail aged and disabled people is provided not by government programs but by family carers. So it is an issue we are aware of. The interaction of those two policies, trying to encourage people back into the work force and also trying to encourage people to care for their frail aged relatives, is one we will have to work out.

As Mr Mersiades said, over recent years there have been significant increases in respite care funding, in home and community care funding and in community care services generally. People always want more. You mentioned a person who is getting respite care two mornings a week. Ten years ago, two mornings a week would have been seen as a luxury. Hopefully that will expand over the next 10 years. These services are highly valued: when people get them, they always feel it would be nice to have more of them. Somewhere along the line you have to ration them; you need to have a cut-off. At the moment the community care expenditure is expanding faster than the growth in the frail aged population—in fact, almost twice as fast. So I am hopeful that that gap is being closed.

Mr MOSSFIELD—Is there any particular attention given by the department to our Indigenous population, bearing in mind their general isolation because of where they live and also their lower life expectancy? Should they have access to aged care programs and facilities at an earlier age than, say, the general population?

Mr Mersiades—Picking up the last point first, they do have access to aged care at a younger age. I think it is at age 50.

Mr Bruen—That is in terms of planning services. They have access to aged care at any age if they have an age related disorder.

Mr Mersiades—But in terms of planning, allocating the places in regions, we take into account the population over age 50 for the Indigenous community. As well as that, we have particular flexible services and Aboriginal specific services which allow more flexibility in how they are managed and how they respond to the needs as compared with the mainstream services. So we do make attempts to tailor our services to that segment of the community.

Mr HARTSUYKER—Mr Bruen, you mentioned that to date there has been little success in improving the situation with regard to Alzheimer's. I understand there is quite a range of clinical trials going on at the moment. Are those trials showing positive results at this point in time?

Mr Bruen—My colleague here reminded me that two drugs have recently come onto the market.

Dr Lopert—I would like to take up Mr Bruen's point. There are currently three medications for the treatment of mild to moderate Alzheimer's disease funded on the Pharmaceutical Benefits Scheme. I am not aware of any particular clinical trials that have been brought to our attention or other drugs currently under consideration. I would have to take that question on notice.

CHAIR—Thank you very much. If you would, we would appreciate that.

Ms HALL—I am interested in looking at information on what guidelines you use when the department allocates those high-care and low-care beds. What considerations are taken into account to prevent a situation coming about where you have a number of phantom beds, like we do now?

Mr Mersiades—The process for allocating places is focused around a national benchmark of 100 places per thousand people aged over 70. Within that we have a split between low care, high care and community care—you would probably be aware of that—of 50, 40 and 10. That is then linked to population growth in that target group, the 70-plus group. So new places are allocated every year based on a projection of population. Within that we look at the population and provision levels in each region.

We also have state based planning processes which involve members of the community as well as the department and they make recommendations on the allocation of places. Then we have a tender process and an assessment, and the decision making process follows from that. Linked to the issue of provisionals, one of the criteria that are used is a demonstration of how quickly those places can become operational—factors such as whether the land is already owned, whether a development approval has been obtained and whether there are any other perceived impediments to quick implementation.

As a result of the last allocation round, and I do not recall the exact figures, a large proportion of the places to be allocated would be expected to be operational within the two-year period provided for under the legislation as the expected completion time for new places. There is provision for extension in certain circumstances. To help ensure that those expectations are met in terms of how quickly places are built, we have put in place regular monitoring arrangements, which are quarterly, whereby the providers report back to the department against milestones to see how development is progressing.

Mr Thomann—One of the critical issues here is local government planning, which you raised earlier. Certainly the data we have collected indicates that lot of these delays are due to delays in planning. This is another issue that we are interested in engaging with local government on—so it fits with age-friendly guidelines, if you like, as to how those planning guidelines are operating and whether there are disincentives and dysfunctions in the planning process. That also relates to state government. So there are some complex issues that we have to work through to work out why there are these delays.

Ms HALL—That was going to be my linking question.

Mr Thomann—Right. We also have to establish a benchmark as to what a reasonable delay is and as to what is a reasonable time frame in getting planning approval for any business where the residential facility is not a domestic one.

Ms HALL—That was the issue I was chasing.

Dr Cullen—When places are allocated, the algorithm which allocates them does not use that. They are not allocated so that they are required to be online to meet the 100 ratio in the day they are allocated. They are actually allocated so that within the two years they will meet the 100 ratio. That is an important consideration.

CHAIR—Have the new changes—for example, keeping it to a fixed two years and getting updates every six months—had any impact?

Mr Mersiades—That process has only been in place for a relatively short time. We do stocktakes every six months. I think it is starting to have an impact. But that criterion of being established—what was called bed readiness—was really only applied consciously and significantly in the last allocation round. It is something that we have got better at.

Ms HALL—I have another thing. Maybe you could forward this to us in writing. You have mentioned employment. I want to know some of the initiatives that you have looked at as far as trying to facilitate mature age employment. It is all very well identifying that but we actually have to have something put in place that will bring it to fruition. There is another thing as to allocations, but we are running out of time.

Mr Thomann—This is a question that our colleagues in DEWR will be able to answer.

CHAIR—Thank you very much for a very comprehensive submission and your evidence today. I would like to ask you if you would have any objections to the committee writing to you with further questions which may arise.

Mr Mersiades—None.

CHAIR—Okay, thank you very much.

[10.00 a.m.]

DOLAN, Mr Alexander Guy Warwick, Assistant Secretary, Seniors and Means Test Branch, Department of Family and Community Services

FLANAGAN, Ms Kerry, Executive Director, Strategic and Ageing Cluster, Department of Family and Community Services

CHAIR—Welcome. Thank you for your submission to the inquiry. I remind you that these hearings are proceedings of the parliament so misleading the committee would be a contempt of the parliament. I invite you to make an opening statement.

Ms Flanagan—Thank you for the opportunity to be here today and to present to the committee. First of all, I would like to outline some of the key aspects of Australia's demographic outlook, including what we believe to be the economic and budgetary effects of the changing demography. Then I will discuss what we believe are four key areas of action which form the basis of FACS' response to the challenges, risks and opportunities associated with structural ageing.

I think you will see from our submission and from other submissions that we believe Australia is relatively well placed compared with other OECD countries to adjust to long-term demographic change. Nonetheless, spending pressures associated with structural ageing are expected to rise steadily from 2015 onward. The gap between Commonwealth expenditure and revenue is expected to grow to five per cent of GDP by 2041-42, or $87 billion in real terms—that comes from the Intergenerational Report. If these present trends continue, spending on income support payments, which are a key responsibility of FACS, will increase from around 6.8 per cent of GDP in 2001-02 to approximately 7.4 per cent of GDP by 2041-42, an extra $14 billion per annum. Much of this extra spending will be driven by a large increase in the number of working age people over 50 years of age receiving income support and, of course, growth in the numbers of age pensioners. We estimate that the number of working age income support recipients will grow strongly, from 2.9 million recipients in 2001 to around 3.6 million in 2051, and that welfare dependency of the 50 to 64 working age group will show the strongest proportional growth, from 930,000 people in 2001 to approximately 1.6 million in 2051.

Similarly, age and service pension numbers are expected to increase from approximately 2.1 million at present—of those, 1.8 million are age pensioners and 300,000 receive a service pension from the Department of Veterans' Affairs—to 5.1 million in 2051, a growth of 143 per cent. As the superannuation guarantee matures, we expect to see, though, that the proportion of people receiving an age or service pension, which is currently 82 per cent, will drop to 75 per cent. We would also note that, of that proportion receiving the age pension, currently two-thirds receive a full age pension—that is, they do not have enough income to affect their age pension rate—and by 2051, because of other private savings through the superannuation guarantee, only one-third will receive the full age pension. Assuming continuation of current means testing arrangements, we believe the age pension will remain affordable by international standards, even though the proportion of the population of pension age will double between now and 2042.

While much debate is focused on the economic and budgetary impacts of ageing, this submission puts the view that there are also critical social, family and community dimensions that need to be considered. It also argues that we need to consider the impacts of ageing on the young, those of working age, as well as on those increasing numbers who will be retiring. We believe that the impacts of structural ageing can be addressed by four key areas of action, as set out in the submission. They are: increasing participation, consolidating retirement incomes, supporting family stability and resilience and responding to ageing communities. I will now say a short bit on each of those, then we can go to questions.

The growth of the working age population, which has previously been a strong driver of prosperity, will reduce sharply, highlighting the importance of increasing the labour force participation of people of working age. Increasing participation amongst people who currently have relatively low rates of labor force participation can also improve their individual and familial wellbeing and contain future growth in outlays. We believe it also results in higher retirement incomes. Specifically, the submission argues that there is potential for greater participation amongst women and lone parents, mature age people, people with disabilities, where they have the capacity to do so, and jobless families. For example, Australia has internationally high rates of jobless families, with 852,400 children aged under 25 living in jobless families in June 2002.

Some believe that the population ageing will in itself improve participation, including participation among older workers. While the future reduction in the relative supply of younger workers—we have research which shows that they are favoured in recruitment—may lead to older workers being given greater consideration, we do not feel we should be complacent about that. We need to actively monitor what is happening with the employment of older workers. Further welfare reform will address issues of passive income support and inconsistent incentives to take up paid work. Continuing to promote family stability and lifelong learning and build social partnerships with community and business will also assist in increasing participation.

While our retirement income system rates highly by international standards, we believe that it can be consolidated, especially through gains in participation, as I have said, for specific groups. Achieving this will provide further improvements in living standards in retirement by providing greater opportunity to save during working life. Along with private savings, whether encouraged through the superannuation guarantee or through other voluntary savings, you would understand that the critical element of our retirement income system will continue to be the age and service pensions. We project that age and service pensioner numbers will increase from 2.1 million in 2002 to 5.1 million in 2051. However, women, who can face interrupted work force participation, and older people of working age, who may find it difficult to re-enter employment and are vulnerable to incentives and pressures to take early retirement, are particularly at risk of having lower living standards in retirement.

Continued support to promote family and relationship resilience will also be important in conjunction with encouraging household savings and minimising constraints on superannuation savings. Promoting transitional retirement by combining some work force participation with other responsibilities and interests and a gradual transition from full-time work to no paid work could further assist in consolidating retirement incomes. This necessitates attitudinal change, including promoting a greater awareness of the knowledge and skills of older workers and reviewing policy supporting early withdrawal from the labour market.

The third area that we concentrate on is supporting family formation and resilience. Supporting parents' labour force and fertility choices over the coming decades not only will assist economic participation and growth but can also safeguard Australia's relatively slow pace of structural ageing, despite the fact that we see a projected decline in the fertility rate of 1.73 to 1.6 in the next decade. International experience indicates that well developed work and family reconciliation policies support labour force participation, family formation and fertility choices. However, family resilience may be tested by a possible increase in caring responsibilities due to what we call in the submission 'demographic compression', where key life events are further compressed into a shorter space of the overall life cycle. This basically means that a lot of working age people are having children later and therefore are looking after children as well as having ageing parents and having caring responsibilities both for their parents and for their children.

Additionally, the increasing prevalence of disability with age and the growth of older age cohorts could increase demand for services for people with disabilities and their carers. We suggest that a cross-sectoral framework of service provision for people with a disability who are ageing could be one of the things we could develop. Family formation and resilience can also be assisted by a continued focus on achieving better work and family balance and reducing barriers to having and raising children. A focus on capacity building, particularly of children and youth, will further assist adult participation and productivity.

The last element is responding to ageing communities. It is necessary to be mindful that the extent of population varies—ageing varies between states. For example, Tasmania will experience a growth of about 21 per cent in the proportion of people over 65 years of age between 1999 and 2051 compared with an increase of only about seven per cent in the Northern Territory. Where populations are ageing, there is a risk of increasing social isolation amongst older people. There is also an opportunity arising from a potential increase in the number of older volunteers.

Another variation in ageing is found among Indigenous Australians. Indigenous Australian communities have a youthful age structure with rapid growth in the number of young Indigenous people entering work force age occurring in the current decade which raises further challenges for us in economic participation for Indigenous people. Currently health problems impair economic participation and access to retirement savings and that is another aspect of the Indigenous population.

The Department of Family and Community Services is also responsible for housing policy and we have a very high proportion of older people who own housing. For those in the current age cohorts, housing is probably their major form of saving. We also believe that encouraging home ownership reduces recurrent expenses in old age and is an important amelioration of poverty levels in old age.

We have been looking at home ownership because we are concerned about the trends, including a concern that there is lower home ownership at the moment among younger people. However, we believe this might be driven by longer times in education et cetera and, while we will require further monitoring of this, we believe that as people age the home ownership rates of different age cohorts tend to converge.

Older people who wish to move can face obstacles including high transaction costs and a lack of flexibility in planning regulations. On the upside, however, structural ageing may drive change in the housing market to better suit older people. In future, access to adaptable housing, reducing the costs of moving house and cracking the riddle of utilising home equity—that is, the major form of saving that occurs through owning a house—may also offer ways of responding to ageing communities.

In conclusion, I reiterate that Australia in a relative sense is well placed to cope with the effects of an ageing population. The question is whether we want to merely achieve a pass or whether we want to aim for a distinction. We believe that the four key areas for action set out in this submission would help to do that.

CHAIR—Thank you for the submission. I propose to the committee that we work from the four areas that have been identified: increasing participation, consolidating retirement income, supporting family formation and responding to ageing communities. That will give our questions a common thread. We might start with increasing participation. Why does Australia have a lower participation amongst mature men and women over 65 and also amongst men aged 55 to 64?

Ms Flanagan—We would probably have to give you a thesis on why we think that is the case. There is a whole series of complex interactions around that. For example, we have looked at the participation rates of working age women, which are lower than many other OECD countries, and we compared that to the fertility rate to see whether Australia was having more children, as that might be a factor to explain why they are not participating. We have looked at things like the different family arrangements that different countries offer to see whether that might also have an impact on participation. There is a complex range of reasons why there is not as high a participation rate for our older men and for women in particular compared with other OECD countries. We set out some of them in the submission but if you need more detail we can get that to you.

CHAIR—Thank you for that.

Mrs MAY—There appears to be anecdotal evidence that mature age workers are not looked on as having something to offer the work force. There seems to be in my electorate that over-55 man who has been made redundant, who cannot get a job again, whose skills are not recognised or who is not skilled up to today's level of skill. Could you expand a little on what FACS is doing to assist that person and on how we can change the mindset of the employer? There is evidence that it is an employer looking at an older person and not putting them on, perhaps because they feel they have only a limited time left in the work force, yet we are continually talking about working until we are a lot older. How do we change that?

Ms Flanagan—The first answer is that it might change itself, and I have alluded to that. We are starting to see slight turnarounds in participation rates in some of these older age groups. The story is different for men and women, because women's participation rates in those older age groups is increasing markedly, admittedly from a low base. Again, the answer is always relatively complex. DEWR might be better to help here, but having regard to the changing nature of the labour market we know that some of these older age groups have low skills and therefore are less adaptable to changing labour market conditions. We have done some attitudinal surveys and found that men continue to look for full-time jobs, because that is

traditionally what they have been used to, but the labour market is much more fluid than that and they find it difficult to adjust to a much more flexible labour market with part-time and casual work. There is a whole range of factors.

You alluded to what we might do with business. Certainly through the department—again, there are other departments with policy responsibility for this—we are trying to drive attitudinal change to the view of older workers and how valuable they are as a resource, through things like the Community Business Partnership that is chaired by the Prime Minister. Through the Stronger Families and Community Strategy there is a lot of work going on to try to change business attitudes to older workers. I do not know whether we give the examples in the submission but there are some forward-looking companies. Even McDonald's and a UK firm like BBC Hardware have a policy of employing older workers. Some people are taking a proactive attitude to this. One of the things we should do is use these as examples.

Mrs MAY—That would be a great idea.

Mr ANTHONY SMITH—Any further information you could give us on that would be good. It is something that a number of us pick up in a situation similar to Margaret's. You will find examples where obviously there is a skills shortage, but sometimes it really does seem attitudinal. Delving a bit further, I notice you mentioned in your submission some research conducted by Drake. Is it at all possible for us to get a bit more information on that? It looks very interesting—it does not look like an incredible state secret—and it caught my eye when I read the submission. It is on page 11 and it refers to a survey of employees and employers with no employers reporting that they preferred people over 50. It struck me that zero per cent is pretty bad. If we cannot get a copy of the research, could we get a briefing on it?

Ms Flanagan—We can certainly give you a fuller briefing on that.

Mr ANTHONY SMITH—That would be great.

Ms Flanagan—I think it reinforces other studies that are in the public domain about attitudes to older workers.

CHAIR—Just on that, evidence has been provided to the committee that in the decade of the 2020s there will be only 125,000 new entrants into the work force. Do you expect that, as the number of new entrants to the work force shrinks, businesses will out of necessity find that they have to value the skills that they have in older workers?

Ms Flanagan—That is a point that we are interested in monitoring because, as you say, a shrinking number of new entrants would suggest that in order to keep up economic growth they are going to have to find the workers somewhere, and we believe that mature age workers will be a natural place to look. The other thing that we all know is that people are living longer—they are usually healthier—so there is a real capacity there. Very often we just focus on those that get to age pension age. We are also interested in ensuring that the age pension age does not become a soft barrier to retirement as well and that if people wish to continue to work for as long as they are able then we can provide the incentive to do that and again change attitudes. But we do believe that the market will respond; it is just a matter of how quickly and how well it will respond to that change.

Ms HALL—I worked in this area for a very long period and I know that there have been a lot of initiatives, particularly in the area of employment of older people and people with disabilities. From reading the submission, I think things have probably declined since I was doing that work, which was a few years back. A zero preference is something that did not exist in those days. It was always very difficult to encourage employers to employ people over the age of 50, but there seems to be even greater resistance to it now. In attachment E, which looks at programs et cetera to try to get people involved, I notice that A Fair Go For Mature Age Workers is the program cited. I suspect that you need to have in place a few incentives for employers to employ older people, rather than just looking at the language, literacy and numeracy programs. I have worked with older people who are, for example, engineers and who just cannot get employment. So it is about turning around this stereotyping. At the same time you need to put in place some incentives to encourage them. My question is: what incentives does the department have in mind for trying to improve this participation and turn around what is happening?

Ms Flanagan—It depends what you mean by incentives—incentives to business?

Ms HALL—I mean incentives to business, to employers. Even the public sector, I see, has changed its attitude a bit in this area.

Ms Flanagan—I would like to boast for a minute and point out that we do have a mature age employment strategy in our certified agreement—

Ms HALL—That is excellent.

Ms Flanagan—because many of us are getting to the stage where we are interested in having a strategy in place. I think that so far the response has been rather to try and do it on the business side—and DEWR will be better able to speak to that. We are more interested in reskilling people and ensuring that the income support system is designed in such a way that it does not lock people in. Many of the initiatives that have been taken recently, such as the personal support program, are more about assisting people, reskilling them and finding them employment rather than about providing incentives for business and/or mandates about business employing certain proportions of people.

Ms HALL—Has any study been done to look at the structural reforms within the economy, the changing occupations and how this relates to mature age unemployment? If so, could we have a copy of it?

Ms Flanagan—Yes. We have certainly done a little bit but I think, again, DEWR has also looked at—

Ms HALL—I am asking DEWR type questions, sorry.

Ms Flanagan—That is right; but it is something we have been very interested in as well. We will see what we can dig out and we will also contact our colleagues in DEWR to see what we can get for you.

Ms HALL—Thank you very much.

CHAIR—Could we have a copy of the department's mature employment strategy?

Ms Flanagan—Yes.

CHAIR—Thank you. I would now like to ask about consolidating retirement incomes now in relation to international comparisons. A number of submissions have mentioned that the three-pillar structure Australia has is seen as a successful model. Would you like to comment on that?

Ms Flanagan—A number of international organisations that we hold in high repute, such as the World Bank and the OECD, hold the Australian system up as one of the better designed systems in the world to cope with the effects of ageing. The reason is that—unlike most other systems in the world, which are what we call social insurance systems, where people contribute and then are payed a pension that relates to their previous income—we have a flat rate, means-tested pension. That is why our system is one of the most affordable in the world.

We then have the second pillar, which we call the superannuation guarantee. In effect, the advantage here is that the risk to government is protected by just providing a means-tested age pension and by people being encouraged to save through the superannuation guarantee. The government does not bear that risk but puts in place mandated responsibilities for people to contribute. Over and above that, people can have other forms of savings; people are still participating in civil service and parliamentary pension schemes et cetera.

Mr MOSSFIELD—What impact has the falling value of superannuation savings had on retirement income? Have you looked at that in the longer term? There has been a considerable drop in recent times, as we all know.

Ms Flanagan—Yes, there has been. The thing about superannuation savings and new savings invested in the private market is that over time they still earn a relatively good rate of return. First of all, what I would say about the superannuation guarantee at the moment is, because it is a relatively immature system, many people coming on to the age pension do not necessarily have big lump sums; they are quite small sums. We are interested in the impact on the age pension itself. The other advantage, I suppose, of having a floor of a means-tested age pension is that, if people's superannuation savings go down, it will in effect be picked up through an increased age pension to try and balance that out in some way. We try and encourage people to get the best rate of return they can, but if that is not possible there is the social protection that occurs through the age pension.

Mr MOSSFIELD—From a government point of view, do you think there would be any value in relaxing taxation arrangements on superannuation, which would mean that people could then rely on superannuation and not have to fall back to the age pension? Would that be of economic value to the government?

Ms Flanagan—You would need to ask that of Treasury, but I point out that superannuation is very concessionally taxed compared to many other forms of taxation at the moment.

Mrs MAY—You refer in your submission to a decline in household savings and you refer to disincentives for saving. Our savings have really fallen quite low. Do you think people are thinking, 'I've got superannuation; I have to pay that anyway. Why should I be saving? I've got the family home, and that'll pay for everything in the future'? Can you expand on what you

think are the disincentives for saving? Why are we thinking this way? Is it just anecdotal information?

Ms Flanagan—We can actually observe what has happened to the private savings rate, and there is a concern that it has declined. But the superannuation guarantee, because it is a mandated form of saving, has in fact kept that rate up somewhat. Again, there is anecdotal evidence that our parents' generation were much better savers than we were, and there would probably be a range of factors about people wanting to consume in the current period rather than putting it away for a rainy day et cetera.

Mrs MAY—Even though we know we are living longer and we are going to be around for a lot longer, it would be nice to know that there was that little nest egg.

Ms Flanagan—Yes. I think there was a campaign a number of years ago, and I think it was called 'a superannuation nest egg' or 'money doesn't grow on trees'—I cannot remember exactly. But the key message was—and we actually did some analysis of this—is that people do not understand—

Mr ANTHONY SMITH—I think that was the problem actually; I think it was that they did have money growing on trees.

Ms Flanagan—We certainly have done case studies where we have asked people—and financial advisers do this all the time—'How much do you think you're going to need in retirement, assuming that you will live to the average life expectancy?' People very often think that what they are currently putting away—as you say, through the superannuation guarantee and saving in housing—will be fine. Then when you actually do the calculation and look at it you find that it is not going to last very long at all.

Mrs MAY—Particularly if you want to maintain the same standard that you are living at now.

Ms Flanagan—That is right. Again, in a cultural and attitudinal sense we need to work on explaining that to people. One of the examples you can give is that you can be as long in retirement as you have been working if you work to age 55 and retire. So within that 30-year working period you have got to save enough for another 30 years. That sum becomes quite scary when you think of it in that way.

CHAIR—Are there any more questions on retirement income?

Ms HALL—I have a small comment, which I would like you to comment on. I have done an overlay within my electorate of where the concentration of aged population is and where the concentration of poverty is, and I am sure you would know that they correspond. This reinforces the fact that maybe the income support and what we have in place at the moment are not working.

Ms Flanagan—We have done many overlays where we look at hardship on a regional basis, because we are interested in providing services into those areas and so on. But it does not usually correlate with age.

Ms HALL—It did in my electorate.

Ms Flanagan—It might have 10 years ago.

Ms HALL—It did in my electorate, and that was done using the last census figures.

Ms Flanagan—We find that there are higher pockets of poverty and when we look at the most vulnerable groups they might have been the aged 10 years ago but we do not see that as much now.

CHAIR—Thank you for that. I would like to move on to talk about families. Could you outline briefly the significant differences in the structure of Australian families now compared with 40 years ago and the implications that these changes have had on care for older Australians?

Ms Flanagan—We know many of the statistics and we can give you some fact sheets on this. Our minister is particularly interested in this so we have got a lot of data looking at what family structures looked like a long time ago. The major changes are for women. We know that women are staying in education for longer; therefore, they are having children later. Back in the late 1940s most children used to be born to mothers aged between 25 and 29; now most children are born to mothers aged between 30 and 35. The number of women working and combining work and family has changed significantly—you can think of the reasons for that, such as equal pay for equal work, married women being allowed to work and the cultural changes in attitudes to families. Because of the changes in the labour market, such as a lot more part-time and casual work, it is easier to combine work and family. The other very significant change that has occurred is to the number of sole parents. In the late 1940s, seven per cent of families were sole parent ones, whereas now the number of sole parent families in our population is 23 per cent.

CHAIR—In your submission, in the section on families towards the end headed 'Care for people with disabilities', you mentioned that sometimes there are people who do not fit the disability sector or the aged care sector and so on. You said that an innovative policy and service approach is needed. Does this happen at the moment?

Ms Flanagan—We are looking at it. Things continue to change and now many women of working age are in the work force. You were talking earlier to Health about what is happening with the informal care arrangements. We are certainly monitoring that and it is changing. We believe that we need to respond to it.

CHAIR—Thank you. We will move onto the last section, which is about responding to ageing communities. The information in this submission and the one we will deal with later with the Department of Immigration and Multicultural and Indigenous Affairs is broken down by state, looking at the differences that occur. Obviously, Tasmania, South Australia, the ACT and, to some extent, Victoria will be ageing a little bit faster over the next 50 years than the other states. Within those states, which regions are ageing the fastest?

Ms Flanagan—We can get you maps of that very easily, but you can imagine where ageing might be occurring. Even though we are not necessarily seeing any issue with ageing in Queensland or New South Wales, we know that there are issues with the coastal belt. We are really interested in seeing where those changes occur, because it means that there are different

services provisions needed and different issues. One of the big areas where ageing may be of concern is in rural areas.

CHAIR—Certainly. Would you like to comment on potential future directions in adaptable housing? Do you see adaptable housing increasing in the future?

Ms Flanagan—We believe that the housing sector is very good at responding to what is required and that we will perhaps see a lot more dual occupancies. There is a lot of urban infill, because services and transport networks are there and people very often want to stay in their own communities. We expect that there will be a push to have smaller land subdivisions within existing suburbs. That would be one of the ways that you would go with adaptable housing. Housing also needs to be adapted for cases where there is frailty or a need for increased care. Locating housing close to aged care facilities, access to services and so on is another issue—and Health would be better able to talk about that.

CHAIR—Another potential future direction is utilising home equity, which I understand has been controversial in the past. Do you see a way around that?

Ms Flanagan—We have been trying home equity and sale lease-back and many schemes for many years, because we have been very concerned very often when we observe people with quite large housing assets who have no other income at all. There still seems to be an attitude, with the current generation in particular, that they have saved all their lives for a house and finally paid it off and they are reluctant to remortgage it or re-encumber it. Also, in these instruments there is a design issue in that we found very few financial institutions prepared to pay for, or bear the risk of, longevity. Most of the schemes are based on somebody staying in a house until they die. If you lend someone some money, they are not paying it back; it is only paid back when they actually die. If they live in the house for another 30 years the bank loses the money, basically. So there is a real design issue there for them too.

Mrs MAY—I want to touch on social isolation, which I find is a huge problem in my electorate. I have quite an ageing population and, with my electorate being in Queensland, I have people migrating from down south. These people have often lost a partner and they have no backup—there is no family here—and they are just not aware of community programs that they can access. Carelink has been a wonderful initiative that allows them to ring up and get some information. Can we improve the way we get that information out into the community? How can we find these people? Often with social isolation, health problems begin—people are not talking to other people and they are unaware of what they can access to help them with health problems. Are there any plans to somehow get that information to these people or to get the community based organisations involved more with these people who are socially isolated?

Ms Flanagan—Within the portfolio we have a range of things that we do. The production of *Age Pension News*, which goes to everybody that receives an age or service pension, is a great vehicle. We get very good feedback and people read it. That is one way of doing it.

Mrs MAY—How often is that publication sent out?

Ms Flanagan—It is either three or four times a year. The other thing, of course, is having Centrelink as our major service delivery agency. We have what we call financial information service officers who, even though they are there for financial information, are also there to

provide information on, for example, what community groups are available to help. The issue there, as you say, is that the person actually has to come to them, has to know that they are there. There is not an outreach structure. We can probably get you some information on what Centrelink does, because I think that they do do outreach services. I know that in southern Queensland there used to be a sort of a retirement office that had vets' affairs plus tax—

Mrs MAY—We do have one of those, yes.

Ms Flanagan—and they hold seminars on home security et cetera.

Mr MOSSFIELD—We see here in your presentation the value of volunteering. I think we can all appreciate that for retired people this would be a great outlet to avoid social isolation. Do you have any proactive volunteering programs that get out to the community what they can do or that encourage people to participate in volunteering schemes?

Ms Flanagan—We have a number of things that we can do within the portfolio. The year 2001 was the International Year of the Volunteer, and our portfolio had policy responsibility for implementing that. A range of activities occurred there. We also fund volunteering organisations to do placements, linking people that want to volunteer with those that are looking for volunteers. In effect, we fund outside organisations that are themselves based in the volunteer sector to assist them to do that. Again through *Age Pension News* and other articles like this we encourage volunteering, because not only are we interested in economic participation but we also know the value of social participation and minimising social isolation for the wellbeing of people.

Mrs MAY—Are you saying that the department actually funds volunteer organisations?

Ms Flanagan—Yes.

Mrs MAY—Can we get some information on that?

Ms Flanagan—Yes.

CHAIR—Thank you very much. Thank you for your submission and also for giving evidence to the committee. We have asked for a number of things, so we appreciate your cooperation with that as well. Do you have any objection to the committee writing to you with any further questions which may arise?

Ms Flanagan—No.

CHAIR—Once again, thank you very much.

[10.47 a.m.]

EDGAR, Mr Arthur, Branch Head, New Compensation Scheme, Department of Veterans' Affairs

KILHAM, Mr Wes, Branch Head, Younger Veterans, and Vietnam Veterans' Counselling Service, Department of Veterans' Affairs

TELFORD, Mr Barry, Branch Head, Housing and Aged Care, Department of Veterans' Affairs

CHAIR—Good morning. Welcome to this hearing of the House of Representatives Standing Committee on Ageing. Thank you for your submission to our inquiry looking into the long-term strategies to cater for the ageing of our population. I invite you to make a brief opening statement. I should remind you that proceedings of the committee are proceedings of parliament and, as such, misleading the committee is a contempt of the parliament. Would you please proceed.

Mr Telford—I have nothing particular to add to what we have in our submission. We are happy just to respond to questions.

CHAIR—Thank you. How many veterans does the Department of Veterans' Affairs have from more recent conflicts—for example, from the Vietnam War?

Mr Kilham—There are 50,000 from the Vietnam War. From the Gulf War, I think there are about 1,700.

Mr Edgar—There are 1,840.

Mr Kilham—From service in East Timor there are people who would qualify as veterans but who may have no entitlement or no accepted disability with the department. We think approximately 18,000 people have cycled through East Timor. They are the major conflicts.

CHAIR—Eighteen thousand?

Mr Kilham—Yes.

CHAIR—Would that include their dependants as well?

Mr Kilham—No, it does not include their dependants.

CHAIR—I notice that you have looked forward as far as 2007. As we get to the stage where World War II veterans start to pass away, how has DVA thought about restructuring the department? Presumably the number of veterans that you will be looking after will be much smaller.

Mr Kilham—One of the obvious things we have done is to strengthen our relationship with Defence. There is what is known as the Defence Links Project. We are certainly looking to run programs jointly with Defence. Some services that were previously housed within Defence—for example, the military compensation and rehab scheme—are now administered by DVA.

Mr Edgar—We took over control and administration of the Military Compensation Scheme in December 1999. We are currently working on developing a new single scheme to cover both training and work in Australia as well as deployment overseas.

Mr Telford—An important point to make is that the tail is quite long. There is a general belief in the community that it goes along and then drops off a cliff in terms of the chart, but that does not actually happen. The main reason for that is that, of the World War II veterans that die, a large number are replaced by war widows. So what we are seeing is a change in the gender balance, which in itself is creating some structural issues to do with not only designing appropriate health care services and aged care services for women but also the increasing number of people who are living alone. In relation to the previous question, social isolation is of major concern to us as a significant number of our people are living alone. We are talking about 2020 before we see some very significant drop off in numbers. That said, while the numbers are decreasing, the workload of the department is not necessarily going down because the support services required for the 'old, old', which we have referred to in our submission, are increasing the called upon health services that we would normally expect to see drop off.

CHAIR—Do you find it easier now that you are not running the hospitals yourself, though, now that they have been transferred to the states?

Mr Telford—I think the move to a purchaser-provider model has been one of the most significant shifts we have had. I would not characterise it as easier. I would characterise it as different in that we are now contract managers as opposed to direct service providers, with the exception of what Wes mentioned in terms of the VVCS, which is the only remaining direct service delivery program we have in the department. So it is not easier, it is just different. With that, it brings a whole range of greater capacities to analyse and research what is going on. Our requirements for data and accountability mean that we have an extremely rich database on which to do an enormous amount of research. We have got significant details going back for a very long time on the 340,000 card holders we now have.

Mr MOSSFIELD—What is a card holder?

Mr Telford—There are two main sorts of cards we issue: a gold card and a white card. A gold card is for all conditions and a white card is for specific conditions—that is a very broad description of the difference in the cards.

Ms HALL—You have an orange card too.

Mr Telford—An orange card is for pharmaceuticals for particular groups.

Mr MOSSFIELD—We have quite a few people come to see us about their eligibility for gold cards. One more recent visit was about the fact that the person concerned had been in a war zone for something like 27 days and to qualify they had to be in the battle zone for 30 days, so they missed out by a couple of days. I have also had visits from some Second World War people

who joined up late and did not actually get into the war zone. They are missing out too. Yet these people are getting older and their need for medical attention is growing. Does the department have any view about relaxing the conditions governing entitlements to these health cards?

Mr Edgar—The government put the whole question of veterans' eligibility to Mr Justice Clarke and his review team. A major volume on eligibility will be released by the minister on Tuesday.

Ms HALL—That was the question I was going to ask. Seeing that we are talking about the gold card—and I know that any member here who has any significant number of veterans in their community would have lots of questions about the gold card—I have a question relating to the fact that we are starting to see that a number of GPs and specialists are failing to accept the gold card and are charging veterans when they go to see them. I think it is probably even more predominant among specialists. What strategies does the department have in place to deal with this, both in the short and the long term? Basically, what should I go back and say to my veteran community? This is a big issue.

Mr Telford—We had a memorandum of understanding with the AMA which expired late last year.

Ms HALL—On 13 December.

Mr Telford—We have now entered into negotiations with them on the fees and structures for both LMOs—GPs—and specialists. That is also the subject of some discussion with government, obviously, about the way forward. What we did do, though, so as to give both sides adequate time to research, analyse and see the situation that was developing in terms of cost structures and so on, was seek from our providers, both LMOs and specialists, an extension of our current arrangements until the middle of this year to give time for that consideration to take place. We wrote to all of those people late last year and we followed that up a month or so after that. To date, a very large number have re-signed and have actually agreed to continue with the existing arrangements until such time as the government, the AMA and we have had time to consider how we move forward with these new payment arrangements.

I think that the press around this has focused on the very small number of difficulties that we have had. The information from our state offices and from the various advisory groups we have is that, in the vast majority of cases, doctors and specialists are continuing to treat veterans under the current arrangements and are waiting until such time as the government makes a decision in relation to the new arrangements for the new MOU and so forth, which will happen toward the end of the current financial year.

Ms HALL—I understand that something in excess of 1,200 GPs have not signed.

Mr Telford—That is not correct—

Ms HALL—That was from the AMA.

Mr Telford—I cannot give you the actual number. The difficulty is that about 16 per cent of doctors have not re-signed. That figure overstates the number for a couple of reasons, the main

one being that the way we have communicated with and records we keep on our doctors relate to provider numbers. Doctors can be registered in a number of places. Indeed, a lot of them have locums—they are registered in a locum and they may go there only once or twice a year or something like that.

Mr ANTHONY SMITH—So you are saying that the numbers can be multiplied?

Mr Telford—That is right. The 16 per cent probably does not represent anything near that.

Mr ANTHONY SMITH—It may be three, four or five registrations?

Mr Telford—Indeed. Then you have multiple practices and so forth involved. At the moment our state offices are trawling through the lists of people who have not replied to us to try and eliminate the duplication—the number of locums or the people who are on the system twice or three times or whatever. That said, though, while we understand the concerns which have been raised, the number of individual approaches to us by people who are saying that they have been denied services is relatively small. We are saying that, if anyone is in that situation, they should contact the department. If it is a situation where there genuinely is a doctor who has decided not to participate in the scheme then our state office people can arrange alternative treatment for that individual veteran.

Mrs MAY—Firstly, I would like to see the community grants programs that are run through Veterans' Affairs continue, because I think they play a hugely valuable role in the community. In fact, last week we opened a social club for veterans in my electorate, and this is where we talk about social isolation. There are around 11,000 vets on the Gold Coast, so we need to look after them.

I would like to move on to the health promotion. Vets are also becoming more and more aware of their health problems and, yes, they have access to health care. Talking to a lot of them, they are into preventative health. One of the most successful programs you have run is the Heart Safe program. I have seen a lot of vets being involved in that and every year we seem to go through the fear that it will be stopped and it will not run any longer. Some of the vets in my electorate do not realise that they are in the program for only a certain amount of time and then it is up to them. It is giving them the tools to continue a healthy lifestyle themselves. Is it something that the department continually looks at for health promotion, preventative health and educating veterans on what they can do for themselves as far as a healthy lifestyle goes? I truly think that is important. Rather than just giving them the gold card or the white card and, yes, they have health treatment, how about a bit of responsibility? But they need some direction and to know that those programs are out there for them.

Mr Telford—Absolutely. One of the major thrusts over the last year or two has been their health promotion activities. We have a five-year strategic plan, with seven health priorities, which runs us through until 2005. In that particular document we have a lot of emphasis on particularly self-management of chronic diseases—diabetes, prostate cancer and those sorts of issues.

Mrs MAY—Smoking is a big one, too, with veterans.

Mr Telford—Indeed. There is a whole raft of material which we put out in terms of encouraging people to understand that they are not too old now to make a difference to their lifestyle by introducing some form of walking, balance and so forth. Certainly, balance and strengthening are an increasing focus. You are right in terms of the role that the community grants play in that area.

Mrs MAY—It is huge.

Mr Telford—We are shifting our focus as much as we can with our community development people to make sure that that is the focus of where we go. All of that being said, the big difficulty we are finding is that you can get people in for a little while and then they drop off. So it is the sustainability of the programs which is really the thing that has now become the issue. We are doing a lot of work on trying to find what are the buttons which we have to push to keep that interest going. There are some successful things that we run, such as Men's Sheds, where the blokes will get together and do whatever they do. Importantly, a lot of them now are moving into areas where they actually do some home and garden maintenance for veterans and so forth. Give them a reason and an activity which involves almost by stealth some form of fitness and health promotion activity, but at the same time we are trying to make sure that we do not create an atmosphere of dependence. That is the hard bit. An example is that it is a matter of making sure that we kick-start any program we are doing and then try to find ways to maintain the sustainability of it, which is not necessarily pouring money at it.

Mrs MAY—No.

Mr Telford—Men, as you would be aware, are the more difficult group to deal with, because they are not joiners. Our social isolation studies have shown that 15 per cent of male Vietnam veterans are socially isolated, whereas it is only five per cent of widows. You can see the difference in cultural issues to do with the way women get together and operate as opposed to the way that men do.

Mrs MAY—I find that a lot of veterans in my area do not join the local RSL club, so they do not have that social interaction with other people. But through your grants program we run 'Connect the vet'. It was actually the wife of a Vietnam vet who set this up. It is a little bit like an outreach program in trying to bring these people together. The wives have formed a social interaction club, and that then tends to bring along the guys. They have good barbies; I have been to a few of their barbies. Keep up that program and please do not cut any funding there.

Mr Telford—Okay.

Mr Kilham—There is sometimes confusion about that. The Heart Health Program is funded for 12 months for individual groups. When that funding ends, people think the program as a whole is ending, but in fact it is not; it is continuing to grow. We are just about to complete a national evaluation of the program.

Mr Telford—I would like to make one more point which I think is important. Choose Health, which is our health promotion strategic plan, is one of the few around which focuses on health promotion strategies for old people. I think that a lot of the health promotion activities are directed at the general community, whereas I think of older people themselves as being not part of the lycra gym set, and they need to be educated that walking and that sort of level of exercise

is just as beneficial as going and working out at a gym and lifting weights three times a week or something. So that is a really important part of what we are trying to do—putting it into an aged care perspective as opposed to a general one.

Mr HARTSUYKER—With regard to Veterans' Home Care, my electorate has a lot of World War II vets who are now well into their 80s. There seems to be pretty much exponential growth in the need for home care. It is my understanding that when a vet, if he is not a POW, goes from living in his own home to residential care, he goes out of your budget into that of the department of health. I understand that your budget, with regard to home care, would probably be getting pretty stressed as the demand for that service rises. Has the department been discussing with Health any cross-subsidisation in regard to home care and keeping people out of residential care and therefore saving the Health budget a substantial amount of money?

Mr Telford—I would like to clarify a few points. We actually fund the residential care component as well. When they—putting aside ex-POWs—do move into residential care, we then pick up the government subsidy for the daily fee associated with that, and it is paid through the Department of Health and Ageing on our behalf. But we actually control the funds associated with that. There is no funding relationship between Veterans' Home Care and residential care. They are totally separate buckets of money. We monitor that in a totally different sort of way—it depends on whether it is low care or high care and the services you can get in low care differ from those you get in high care.

So there is no relationship between those two buckets of money. If the costs of residential care go up, that does not affect Veterans' Home Care dollars at all. It is not a balancing act in that way. Veterans' Home Care is a funds-limited program, however, in the same way that the HACC—the Home and Community Care program run through the states and the Department of Health and Ageing—is. Because it is a limited program, there are obviously very strict criteria and boundaries around that.

The government decision was to move people from HACC across to Veterans' Home Care if they wished to move. We did that, and we guaranteed to maintain their existing level of service. What we have discovered is that there have been some very significant levels of services provided under HACC, which has really cut into our budget. In our professional assessment, some of those levels of service are far too high. They are creating levels of dependency which are deleterious to the health promotion outcomes that we would like to see. We do not want to have veterans just sitting in a chair doing nothing all day. Some form of gentle mowing of their lawn or what have you can be very good for them. So that has caused some tensions and difficulties. At the same time, there has been, in certain areas, more domestic assistance—this is a good example—approved by some of our assessors than would be seen to be in the need of the veteran at the time. Some of those things have been changed, and I am sure you would have heard about some of the reductions in services which have necessitated the introduction so that we can actually bring on some new veterans as time progresses.

The other thing, which is good news but which is causing some strain on the program, is that the evaluation has shown that the death rates of veterans in Veterans' Home Care is lower than it is in the general community and in the non-Veterans' Home Care population. Once they get into Veterans' Home Care they are living longer, so it means that now we have people who are on the program for—this is our current information—nearly 14 months. That is a far longer period of time than one would have anticipated. But because the levels of service are there, because the

support is there and because they are not visiting their doctors and so forth, there are significant benefits to the individual. The other role that the assessment agency has is linking the veteran to support services and other programs which are funded in that particular region. So there is a nice linkage occurring now. But I just want to clarify that there is no relationship between those two buckets of money.

Ms HALL—In relation to the Veterans' Home Care program, can you tell me the criteria that are used to assess whether or not a person is eligible for a service. What determines the provision of those services? Also, this program is obviously very popular and has had wonderful outcomes, so do you project that the budget for it will grow or do you see it staying much of a muchness? Are the budget allocations regional?

Mr Telford—Yes—'ish'. It is actually quite—

Ms HALL—Just wait there. Linked to that: do they get moved from one area to another? Can they be moved from one region to another?

Mr Telford—Yes, they can. I will just take your questions in order. The criterion is that anybody who had a gold or a white card is eligible for assessment.

Ms HALL—No, I do not mean that. I mean what you were talking about before.

Mr Telford—My point, though, is that there is no difference in this program, which is unlike other Veterans' Affairs programs, between a gold and a white card holder. Under this they get access to all services.

Ms HALL—I am sorry; you misunderstood what I was asking. I was not asking whether or not it was the gold or the white card but, rather, what you look at when you are allocating the level of service they are entitled to.

Mr Telford—It is all done via a telephone assessment. There is a proforma, a set of questions, and I can make those available to you. It is a screening tool which has certain points in it where we say if the person is blind or in a wheelchair then stop the telephone assessment and do an in-home assessment. There is one set of questions which apply across Australia; unlike HACC, where there are about 340 assessment forms, we have one.

Ms HALL—That is a strength.

Mr Telford—Indeed it is, and it provides equity. It also means that if a person moves from one region to another they will take the services they are currently getting but they will be assessed in their new region on exactly the same criteria as they were in the region they have moved from. The agencies arrange for that transfer of services from one area to the other. I can certainly provide you with that—it is about four pages.

Ms HALL—That would be really useful, thank you.

Mr Telford—It is based on a scale of independent living—acts of daily living and independent living scales—which has been validated internationally. The budget is set; I cannot

give you the figure now, but it is around $60 million a year and it will just be inflated in the normal way. It relates to the number of veterans in the treatment population—that is, the number of gold and white card holders—so the budget will gradually decline as the number of veterans declines. We have a certain formula which allows us to work out how much money goes nationally and then how much money goes to each region based upon the population of veterans in that particular area, and that is based on the 70-plus population.

Ms HALL—Thank you so much for that. I must say, too, that the book and video you have on prostate cancer is excellent. I wrote a note for myself to mention that that is an outstanding publication.

Mr Telford—It has been well received. It is now being used by the College of Urologists as part of their national training program.

Ms HALL—I also wanted to know about the relationship between Veterans' Affairs and the states and between you and the contractors in the delivery of services—things like the interface, the difficulties you have, and things that could be done to streamline it and make it better for you and, as a consequence, the veteran population. I am happy for you to give that to us later.

Mr Telford—It is a fairly straightforward answer, in that our relationships with all of our providers are contractual ones. With the contracts we have we are able to determine the levels of service, the levels of quality assurance, data collection and so forth. All of that is reasonably straightforward. We referred in our submission to the department's information service, DMIS. That data warehouse allows us to compare the outcomes associated with different sets of providers across the country, so we can actually look at what outcomes we are achieving, what costs we are getting, what QA is associated with it and so forth, and compare those against best practice. We then talk to the provider, if need be, and say that we think they could change things here or there.

An example of that would be our prescriber feedback, where we monitor the number of medications a veteran is on by looking at the claims that are made. We run a sample through those which may involve up to 10,000 or 15,000 veterans. We get our pharmacist to look at that. If we find some contraindications between the various medications a veteran is on, we write to the doctor and suggest that a medication review needs to take place. In some cases we have seen a halving of the medications these people have been taking.

Ms HALL—That is excellent.

Mr Telford—That is an example of how we try to continue to move forward using our data to improve the service. It is not an overservicing issue; it is just a misunderstanding between the various providers about what is going into the veteran's medicine chest.

Ms HALL—My final question is about research. What research do you think needs to be done in this area?

Mr Telford—Do you mean across the board?

Ms HALL—Yes, across the board and in the delivery of service to veterans. Remembering our long terms of reference, what do you think we should consider?

Mr Telford—I think Arthur could talk about a whole range of health studies.

Ms HALL—That would be great.

Mr Telford—We have a research budget and a research committee which has a forward agenda. We do a whole stack of research, and I could provide you with a list of the research that is currently on the books.

Ms HALL—That would be very good.

Mr Telford—Arthur can talk about the health study side of things, but the research relates to a range of issues. For example, we carried out a big research project on social isolation. We did some work on trying to find out what impact the gender shift in our population would have. I think the health studies are one of our biggest areas.

Mr Edgar—We have quite a large population research activity going on at the moment where we are doing some epidemiological studies. The Gulf War veterans health study has been finished and is at the printers. It will be published within the next couple of weeks. During the nineties we did the Vietnam veterans studies, which Wes can brief you on. We are in the first stages of developing a follow-up to the mortality study that was completed a couple of years ago with Vietnam veterans. We are doing a study of Korean veterans. That group felt that everyone else had been studied so they should be studied too. We have done a pilot study on the telephone and we are about to look at the prospect of a wider health survey of Korean veterans. A cancer and mortality study of Korean veterans has been going on for a little while and the results of that are due out this year. Even though atomic test veterans are not currently a recognised category under the Veterans' Entitlements Act, we have been cooperating with civil agencies, Defence and so on, looking at the impact on the people who participated in the atomic tests during the fifties and sixties.

Ms HALL—Where is that study up to?

Mr Edgar—It is still at the working stage. I think we are a little way away from a report. The complexities there include getting it on a roll to a stage where people are truly happy with it and matching up the activity. We are doing some symmetry studies separate from the broader population study. We are trying to get some experts on board for that. We also have a smaller study on the people involved in aircraft maintenance, particularly the people in the re-seal, de-seal process of the F-111s.

CHAIR—On that, you mentioned before that you expect a much greater proportion of war widows within the veterans population. How do you expect the future veterans population to be different from the current population? Do you expect differing incidences of certain illnesses?

Mr Kilham—I think one of the major differences is the increased focus on mental health issues, particularly since the 1980s. Since the acceptance of the diagnosis of post-traumatic stress disorder, there has been a far greater focus on psychological illness or psychological problems. In my branch in particular we are at the implementation end of all those studies. We have developed a DVA mental health strategy. The Department of Defence has followed suit, and that was released by the minister just last year. So we are trying to work at all ends, if you

like—at the early intervention, prevention and health promotion ends but also at the active treatment end for people with severe war related or deployment related trauma.

Mr Telford—We are also working on dementia and Alzheimer's, which are the other side of that and, I think, important. We have done a lot of work in the health promotion area to develop a stepped approach to understanding of dementia and Alzheimer's and the various stages that people go through. Rather than waiting till the end stage, we educate carers and the individual about management of early onset dementia or Alzheimer's. I think that the number of people with dementia and Alzheimer's in the general population is going to be very significant, and that is a major focus we have—and depression, of course.

Ms HALL—Do the studies that you are conducting at the moment in the area of Alzheimer's show any difference between the veteran population and the general population?

Mr Telford—We are not actually doing a separate detailed study on veterans, but the data that I have looked at does not necessarily show any great difference.

CHAIR—Thank you very much for coming to give evidence to the committee today. Do you have any objections to the committee writing to you if any matters arise which we wish to get more information on?

Mr Telford—Not at all.

CHAIR—Thank you very much.

Proceedings suspended from 11.22 a.m. to 11.40 a.m.

GALLAGHER, Mr Phillip Francis, Manager, Retirement and Income Modelling Unit, Department of Treasury

THOMAS, Mr Trevor John, Manager, Superannuation, Retirement and Savings Division, Department of Treasury

TUNE, Mr David, General Manager, Fiscal and Social Policy Division, Department of Treasury

CHAIR—I welcome witnesses from Treasury. We welcome back Phil Gallagher, who gave us a briefing on the Intergenerational Report. Thank you very much for your submission. As you can see, the inquiry is very broad ranging. The minister determined the terms of reference and made it over 40 years so as not to duplicate any of the work that had been done in the Intergenerational Report and look at the same time frame. It is a very broad-ranging report. The idea of inquiring into long-term strategy is not completely new for parliamentary committees. Ten years ago, there was a committee for long-term strategies, which was chaired by Barry Jones. That committee did a number of reports, including one on the ageing of the population. Thank you for your submission and for coming to appear before the committee. I invite you to make a brief opening statement.

Mr Tune—We will not be making a formal opening statement, but I will draw attention to the nature of the submission. Given the terms of reference of the committee, which are, as you said, very broad ranging and looking forward over the next 40 years, we thought that the most appropriate thing we could do was not get into the nitty-gritty detail of programs and all those sorts of things but to give a bit of an economic overview of where we think things are going and basically building a bit on the IGR. You have had a briefing on the IGR so you know the basic content of it. We want to take that a step further and think through some of the policy issues that may result from the IGR at a very broad level. So that is where we have tried to pitch the submission. We are happy to take questions on that and we are also happy to take questions on broader and more detailed issues around programs. I cannot promise that the three of us will be able to answer every question about a particular program. We are not experts in all programs but between the three of us we do cover a fair field within the Treasury and we will do our best.

CHAIR—Thank you very much. I found your submission very valuable in terms of how you have broken down the GDP per capita growth and also anticipated where we can expect growth. As you pointed out, we cannot rely on the share of population growth to be making a contribution and so, once again, the contribution is going to have to come from labour productivity. What are your assumptions there? Are we going to see productivity growth as in the 1990s or is it going to be more like the long-run trend of, say, the last 30 years?

Mr Tune—We have basically put the long-term trend into the numbers. The 1990s was probably an exceptional period. We had very high levels of productivity growth through the nineties for a variety of reasons, some of which we have intimated in our submission. Rather than take the last 10 years, we thought that, if we were going forward 40 years, we probably should go back about 40. So we have taken that long-term trend.

Mr Gallagher—Essentially, as I explained in my last appearance before the committee, for the productivity growth assumption we went back 30 years, and 1.75 is also the number used by the OECD in its international study comparing the fiscal effects of population ageing. In addition to it actually being the number we got out of the data, it has international standing as the number used in general comparisons.

Mr HARTSUYKER—In your modelling, have you looked at the increase in the age pension age? We heard earlier that we can expect 71.6 years of healthy life with an additional potential six years through lifestyle changes. What is the impact on changes to the age of eligibility for the age pension?

Mr Gallagher—The age pension age for women used to be 60 but is going up to 65. It is 62 at the moment. We have built that increase into the modelling of the age pension. In terms of the Intergenerational Report, we have built that into the projections for the disability support pension because a number of women who are currently receiving disability support pension no longer transfer to age pension at the age they used to in the past, so the actual numbers of disability support pensioners are rising in step with the movement of age pension age. So that is built into the projections in those two areas.

Mr HARTSUYKER—What about the male age pension age?

Mr Gallagher—It is staying at 65. Current policy remains at 65, therefore no change has been factored into the projections.

CHAIR—You have identified four areas which are important to increase. Australia has quite a low rate, compared with other comparable OECD countries, of people over 45 participating in the work force—I think that is right.

Mr Gallagher—The attachment to the submission looks at that issue. One of the interesting features of the attachment is it shows that that lower participation rate is more for women than for men. That is something that we did try to cut off because of the focus in this submission on participation and productivity issues.

Mr Tune—We have not actually gone age specific yet. The attachment shows labour force participation rates across all those of work force age. I think you are correct, Chair, that we do have lower rates of participation by over 45s than many other countries. If you would like us to get that information, we would be more than happy to do so.

CHAIR—We have had similar information in other submissions, but if you could forward that to us. It says here that labour force participation rates of females across most age groups, and also for both male and female mature age people, are relatively low—and that has been the pattern. Another problem on the horizon is that in the decade of the 2020s it is anticipated that there will only be 125,000 new entrants into the work force.

Mr Tune—Net.

CHAIR—Net. So the work force will only grow by 125,000 over the whole decade. If that is the case, can we expect to see changes in labour force participation by those aged over 55 and so on?

Mr Tune—It is an interesting issue, because you might expect that the market would adjust to some extent if that were the case. If we are going to end up, for example, in the 2020s with some sorts of labour shortages, you would think that the market would adjust and there would be some demand for people who are outside the work force. You may even see changes in wage relativities to reflect that. There will be some adjustment. We are saying that may or may not occur. It is a bit difficult to know, particularly when we are in such a globalised economy. The wage rates may not be able to adjust to attract people back into the work force. We need to try to boost participation through a whole series of measures. Older people are one group where we think there is great potential to improve participation. We also see opportunities for increasing women's participation—that is a strong area to focus on as well. They are the sorts of areas we are thinking about.

Some of those people are on income support at the moment or they gravitate to income support—sole parent pension, mature age allowance, disability support pension or whatever—and maybe some of the structures around those payments need to be looked at as well so that we ensure there are adequate incentives for work force participation. It is a mix of market mechanisms adjusting. We will have to wait and see. If the market works as Treasury predicts it may, there will be some impact, but there are also some policy changes that we think need to be thought about.

Mr Gallagher—As shown in chart 16 of the Intergenerational Report, we have assumed in the base projections that there will be a slight rise in labour force participation rates for all those aged 15 to 64. But it is also true that, given that slowdown, you would expect that the market would react in the 2020s. With the baby boomers having retired before then, one of the issues is whether the market will react before then.

Mr MOSSFIELD—On the question of mature age employment, is any research being done on the need to provide, say, education leave for mature age people if they anticipate needing to change their skills to adapt to another occupation? Bearing in mind that the people we are talking about would have a fair amount of financial responsibility, being in that age group that still has kids at school, a mortgage and all that. Do you have any thoughts on that sort of thing?

Mr Tune—I am not aware of anything specific happening; I know there is a lot of interest in the issue. There has been work done in the OECD—for example, their concepts of lifelong learning, which are somewhat similar to what you are alluding to, whereby there is a desire for people to continually adapt, upgrade their skills and retrain, if necessary, throughout their life rather than just focus on education during the early years of life. We think about education and training as a lifelong event. Those sorts of things are relevant, I think, for that sort of issue. I do not know the details but there are a number of programs around and perhaps you would be better off talking to the Department of Employment and Workplace Relations and even the Department of Education, Science and Training about some of programs that are around to assist mature age people with these retraining issues. I am sorry, I am not on top of the details but I am aware there is something happening within government. This concept of lifelong learning is probably one that needs to be examined further.

CHAIR—On the issue of sound and sustainable retirement income policies—Australia's three-pillar model is often mentioned quite favourably—are you concerned about the decline in the level of voluntary private household saving? Do you have any initiatives to address it?

Mr Tune—I defer to my colleagues who are more expert on retirement incomes than I am.

Mr Gallagher—It depends what you mean by voluntary saving. I would prefer to look at the ABS series on wealth rather than at the household savings ratio. The ABS series on wealth shows rising household wealth and liabilities—the ratio of household debts to household wealth—being at sustainable levels. Treasury is always concerned about the movement in the household savings ratio. Overall we are seeing households borrowing more, but the value of their housing, their superannuation and their shares is rising quite considerably. One interpretation of the trends is that people are increasingly borrowing against their increased housing wealth. If you look at the advertisements on television about 'equity mate' or whatever, there is certainly enough in the community to suggest that that may well be a driver of the trends we are observing.

Mr ANTHONY SMITH—Andrew's question and your response lead to the point that I was going to raise. If you believe the anecdotal evidence that is around in the newspapers and current affairs shows, you could be forgiven for believing that some of the laws of macroeconomics have been altered and that saving is no longer a function of income. As income goes up it is spent, and some. It is part of an innate desire for consumption. Do you have any response to that? To the extent that there are strains of truth in it, it does have implications for the baby boomer generation who might end up with incredibly good houses with gigantic kitchens and garages but not much else. Your job, I know, is to sift through public assertions to find the underlying truth.

Mr Gallagher—It is certainly the case that households are borrowing more, probably as a consequence of both financial deregulation and the lowering of interest rates. Obviously, interest rates have declined dramatically and that has an impact on the amount of borrowing. Economically, the price of borrowing has declined substantially and financial deregulation has meant that people can borrow against their house and other assets in ways that were more difficult in the past. The trends observed are those that we might have expected in that policy environment. One of the issues for us is always what the link is to superannuation. I suppose that is still a fairly open question for people in any situation anticipating superannuation payouts. They appear to be borrowing young and, because of preservation, they cannot get their superannuation until they are at least 55, so it is not a full substitute.

Mr ANTHONY SMITH—If they are young, it is older than that now, isn't it?

Mr Gallagher—There is a range of ages. I would have thought that, in the law of economics, the amount of borrowing would have been a function of both income and wealth, and that is probably what we are seeing.

Mr ANTHONY SMITH—Would you say that some of the analysis at times can be a bit one-sided? Once people bought a house and stayed in it. Now another part of this recent trend is flexibility. People borrow a lot on a house when they have a big family and, through their own choice and planning, they may decide that is something they will have for 10 or 15 years but then might realise some equity and move to a—

Mr Thomas—That is certainly what is happening and that will continue to happen as the population ages. If people have a significant proportion of their assets tied up in the family

home, there will come a point where they want a smaller house. They want to realise some of those assets and that will go to supplement how they live later on in life.

Mr ANTHONY SMITH—They will diversify their personal portfolio.

Mr Thomas—Exactly.

Mr Tune—Certain loan products now enable you to depend on your equity in your house. I am not sure what happens post retirement though. I am going back a few years in experience here, but in past times when governments have tried to induce retired people to run down or gain access to the equity they hold in their houses, they have always been very unsuccessful, whether it has been done through the private market or via a government subsidy. There seems to be something that is perhaps different pre retirement from post retirement. Perhaps the issue of security comes to the fore more as people age. I am not quite sure. I do not have any firm data on it but I do know that at times when there were attempts to subsidise things the demand was just not there. People did not want to do it.

Mr ANTHONY SMITH—But even not taking that aside, the thing that surprises me about some of the analysis is that on the one hand in the economic pages of the paper you will see how people are borrowing so much to buy a big house and you turn to the real estate pages and you see why people sell big houses—out of choice. They say that they want to, that it does not suit them anymore and that they are moving to a place with two bedrooms. The only thing that upsets the theory is when the kids decide stay home till they are 30.

Mr Gallagher—Look at retired people and consider the wealth that is tied up in houses. People in Australia often move to the coast. Look anywhere down the South Coast and look at the houses that are being built on the coast in Australia. Clearly, people have sold their houses in Sydney or wherever and moved out. When they are deciding to move, when decisions are being made about going into hostels or nursing homes—that is another point—it could be seen that their housing could provide some longevity insurance for Australians, giving them an asset they can draw on if they live longer than they expected to, perhaps giving them financial flexibility in terms of their movement. That is one of the issues with the older people in the community—how they utilise their housing assets.

Ms HALL—I have a couple of questions. The first question relates to the PBS and the fact that there has been strong argument put to us for increasing costs in that area. To what extent have you factored into the cost the increase in hospital care? Is it because hospitals are provided by the state and not Commonwealth that it is not factored in? Is it because it will not be an increase to the Commonwealth or is that in some way factored in? My research shows that $1 spent on pharmaceuticals would save something like $3 in other health care costs.

Mr Gallagher—We have used historical growth rates to assess health because the policy is one of constant renewal of technologies and ways of doing things. These are often small increments, and we wanted to capture the evolutionary nature of health policy. The growth rates we are using for Commonwealth funding of public hospitals are in the order of one per cent. State public hospital expenditure growth is of the same order. In fact, state public hospital expenditure over the 20- to 30-year time frame that we looked at was growing at a lower rate. So, in as much as it has influenced the 30-year trends—and that substitution is in the 30-year trends—it is already happening in the way we have projected it.

When we did the estimates for the Pharmaceutical Benefits Scheme in the Intergenerational Report we found that the growth rate per capita real, age adjusted, if you went to the end of the forward estimates period, was 5.64 per cent per capita real. If we had not gone to the forward end of the estimates period and assumed that the budget measures would have their impact, the growth rate would have been 6.55 per cent per capita real, which means that the underlying growth rate is over 10 per cent nominal per year. I think, the year before last, the Pharmaceutical Benefits Scheme grew by 20 per cent in one year. There is obviously a very high demand for pharmaceuticals, and that has been reflected in a very long-term growth rate. That is what we have done in terms of projecting it forwards. We are saying that this is the trend and, if the trend continues, this is what it will look like. But in saying that, the whole idea, as we say in our submission, is to look at what challenges the future has for us and what will be the policy response or what other events may transpire which would address the issue. I think that is one of the challenges posed by the Intergenerational Report.

Ms HALL—I remember that, from the Intergenerational Report and from your previous presentation to the committee, when we looked at the area where the increase in health costs was the greatest, it was related to changes in technology.

Mr Gallagher—Yes, it is largely due to changes in technology and associated changes in demand. I made the point when I appeared before the committee last time that there has been and continues to be an increasing efficiency in the health sector. Things like diagnostic imaging, pathology testing and day surgery have all dramatically improved the throughput of our health system. Despite that—

Ms HALL—There is an associated increase in costs.

Mr Gallagher—Yes. The increase in costs is still there, despite the increasing efficiency.

Mr Tune—There are two things driving it: those things plus the demographics to some extent as well. We make the point that the former is predominant, but ageing is not helping.

Ms HALL—Unfortunately, that is something we are all doing.

Mr Gallagher—If you look at the Pharmaceutical Benefits Scheme, you will see that the average subsidy cost for prescriptions for males aged 25 to 29 is about $30 per year but the average prescription cost for someone aged over 85 would be of the order of $700. There is a very marked age gradient in that program. I might have given you a slide on that in the last presentation. The very marked age gradient impacts heavily—that is, if you apply the growth and you have a very marked gradient, there is a very marked ageing effect in the PBS projection as well.

Ms HALL—I want to raise a question in relation to the Intergenerational Report, your baby. The Intergenerational Report seems to assume that there will be no innovation, by implying that the community is not willing to fund this area. It also talks about community preference in the allocation of tax dollars, the structure of federal-state allocations and responsibilities and the saving in transaction cost overlays of health expenditure, such as administrative efficiency. How would significant innovation assist in moderating the trends identified in the Intergenerational Report? In which areas should innovation be seen as a priority?

Mr Tune—There is a whole series of things there.

Ms HALL—There is, isn't there.

Mr Tune—I will probably not get through all of them without being reminded. I will start with innovation.

Ms HALL—It is all about innovation, actually. It is about innovation and how everything interrelates.

Mr Tune—The economy is innovating, adapting. Technological change is taking place all the time, as it has in the past and will in the future. I guess the issue is the pace at which that occurs. That should be reflected in productivity. The figures we used before you came in—we were just talking about the assumptions that are in there around productivity—were figures for the last 30 years. So we looked at that. Then there was a big growth in the 1990s, which we think had something to do with micro-economic reform and various other changes to markets. For the future, we have taken that long-term trend and adjusted that forward. So we are saying that the rate of innovation pretty much continues the long-term trend. So that would reflect a high degree of innovation occurring in the economy into the future. In essence, it is implicit in the productivity assumption. So there is innovation going on. If there was a higher rate of innovation and that led to a higher level of productivity then you would have to adjust these numbers in some way. But at this point in time we do not see any evidence for that occurring. There is innovation built into it.

Ms HALL—How do you see that relating across state and federal responsibilities and policies? That is always an area of great concern to us.

Mr Tune—We have focused on impacts on the Commonwealth budget. I know that at least one state has commissioned an outside consultant to look at their own statement of the implications for that. Our view is that there were certainly some implications for state governments as a result of ageing—that is reasonably obvious if you look at health and education spending and so forth. The quantity of that is probably a bit indeterminable. We have not done the work on that, I must admit. If there was a change in Commonwealth-state responsibilities, you may say that the impacts of ageing and so forth on one level of government vis-a-vis another will change, but the quantum would not. The quantum of impact on Australia per se will remain the same unless, by changing the relative responsibilities, you are improving efficiency in some way. So we might change whether the impact is on the Commonwealth or on the states; nonetheless, it is going to be there.

Ms HALL—Do you think there is an argument for a whole-of-government approach?

Mr Tune—Yes. The Council of Australian Governments is looking at that issue at the moment.

Mr Gallagher—One issue here is the extent to which the particular health service is demand responsive or supply constrained. It may well be the case that things such as hospitals and health services, where decisions are made more centrally, have been somewhat supply constrained, whereas the decisions about the giving of a pharmaceutical script or participation in a medical benefits system are made by doctors and patients in decentralised offices all over the

suburbs and those more decentralised decision making systems are the ones in which we have seen the fastest growth. That does interact with the nature of the level of government, because the Commonwealth has the things which have more decentralised decision making by doctors and the states have things which perhaps have more centralised decision making. That is perhaps one factor among many that underlie the trends that we have seen. The trend has been that the Commonwealth's growth rates for health have been far higher than the states' growth rates for health.

Mr MOSSFIELD—With those various services, particularly at the Commonwealth and state level, we have been told that there has been a fair amount of duplication. Have you done any modelling on that?

Mr Gallagher—No, we have not looked at those issues at a micro level.

Mr MOSSFIELD—Do you anticipate that there could be some duplication, or is it not evident?

Mr Gallagher—It depends. One of the objectives of the Home and Community Care program, which is one of the areas where there was a duplication between the states, was to remove that level of duplication. I think that in that area there has been some sorting out. In the area of pharmaceuticals, one of the things that we have seen is that increasingly the state hospitals, if we look at a long-time series, have dispensed fewer drugs and the Commonwealth has perhaps dispensed more. So I think there has been less duplication in those areas in terms of where the weight of pharmaceutical spending has been.

CHAIR—What can be done to stimulate the labour force participation rate of groups, particularly mature age workers?

Mr Tune—I must admit that we are looking at this issue at this very moment; it is a large policy issue. I alluded to a couple of things earlier on where we would see the targets as being, in a very broad sense—I do not think I can get into detailed policy options or anything like that at the moment, but let us talk in the broad. I mentioned lifelong learning earlier on, which we see as possible means of addressing some of these issues—maybe not immediately, but if we are looking out into the future, we see that as a good policy option to explore. There are issues around what we are calling 'healthy ageing'. People may be living longer, but are they living healthier? We think there are some things that may be able to be looked that there so that people, rather than retiring early, are leading healthier lives so that they can remain in the work force. There might be some issues around that that are worth exploring.

There are issues around the structure of the income support system. There may be issues around the structure of the retirement income system and how it interacts with the tax system that are worth exploring. In those areas, I am particularly talking about incentives to leave the work force and whether we have evolved into a system where we are actually providing a way out for people. That is an issue that needs to be thought through. They are the four key ones that we have at the back of our minds as being worth exploring. As to what the specific policy options are in each of those, we are at an early stage, I must admit.

CHAIR—What was the fourth one?

Mr Tune—The fourth one is around the retirement income system. There is an income support system and then there is the retirement income system.

CHAIR—I have 'lifelong learning', 'healthy ageing', 'income support system' and—

Mr Tune—'Retirement income system'—some of the elements of the retirement income system.

Mr ANTHONY SMITH—It is not strictly your area, but we heard some earlier evidence on mature age unemployment about business attitudes being one aspect and skills being another. There was some evidence that part of this problem, over the medium to longer term, would self-correct because of labour market demand. Can you give us your views on that and also on the business attitudes, particularly whether for some of these businesses it would not be the first time they had overshot the mark through recent years thinking that anyone over the age of 50 might not have the skills set but they might be making a bit of a correction themselves?

Mr Tune—In terms of your question on employer attitudes, a little bit of evidence I have seen suggests that there are negative employer attitudes—a state of mind, almost—and perhaps that does need to be addressed. How you do that is very difficult. Almost constantly talking about it is one of the key issues—getting it out there amongst people and in the minds of employers that once you are over 50 it is not the end of your labour market career.

Mr ANTHONY SMITH—We have evidence that some employers are starting to have a pro over-50s attitude and that needs to be encouraged.

Mr Tune—One thing that may influence it is that there will be more of us over 50. So there may be advantages in, rather than focusing your employment on serving kids and kids markets, having product markets that are catering more for older people. Older people will be actually selling those products and will have a better appreciation of the sale of those products to their fellow older people. That may influence things. In terms of the way the market adjusts, it is very difficult to know. I mentioned earlier that we think the market will probably adjust to some extent.

If there were a shortage of labour at some point in time—I do not know if we are saying that, but there is going to be reducing growth in the work force, almost going down to zero, over the 40-year period we are projecting—you could expect some wage adjustment. Wages might get pushed up. Whether or not that is possible will depend very much on where we as a country are vis-a-vis the rest of the world. If we are talking about product markets that are extremely competitive on the world stage, it would be very difficult for us to increase wages as a response. All it might mean is that we might not have the jobs here anymore per se because they will drift overseas because we have become uncompetitive. All of that needs to play itself out. At the moment we do not know where that is going to end up. We are thinking of commissioning some work on this particular issue, because we think it is an important one. We will probably get some expert assistance on that. I hope that within 12 months we will have a decent body of research that we can bring to bear on the issue.

CHAIR—As there are no further questions, I thank you very much for coming to address the committee. If any other issues or further questions arise, are you happy for the committee to write to you asking for a response?

Mr Tune—Yes.

Proceedings suspended from 12.16 p.m. to 1.48 p.m.

COOPER, Ms Claire, Assistant Director, Economic and Environment Section, Migration Branch, Department of Immigration and Multicultural and Indigenous Affairs

DOHERTY, Mr David, Assistant Secretary, Citizenship and Language Services Branch, Department of Immigration and Multicultural and Indigenous Affairs

LESTER, Mr Ian, Policy Adviser, Service Delivery and Performance Section, OATSIA, Department of Immigration and Multicultural and Indigenous Affairs

RIZVI, Mr Abul, First Assistant Secretary, Migration and Temporary Entry Division, Department of Immigration and Multicultural and Indigenous Affairs

SMITH, Mr Chris, Assistant Secretary, Migration Branch, Department of Immigration and Multicultural and Indigenous Affairs

CHAIR—Good afternoon and welcome to the House of Representatives Standing Committee on Ageing and our inquiry into long-term strategies to cater for the ageing of the population over the next 40 years. Thank you for your submission to our inquiry and for appearing before the committee. I will begin by asking you to identify yourselves and your sections for the purposes of *Hansard*. I remind you that committee proceedings are proceedings of the parliament and as such any attempt to mislead the committee is a contempt of the parliament. I would now ask your spokesperson to make an opening statement.

Mr Rizvi—Thank you for the opportunity to make some introductory remarks. I will say a few things. Like most developed nations, Australia is facing the prospect of an ageing population and a gradual slowing in the growth rate of the number of persons of work force age. The demographic shift to an ageing population and work force is almost inevitable, irrespective of any plausible levels of net overseas migration or fertility gains we might achieve over the next three decades. Based on plausible assumptions of our fertility and net overseas migration rates, Australia's population may reach between 25 million and 27 million over the next 50 to 75 years and then possibly stabilise in size and age at around that level. Natural increase may fall below zero around the mid-2030s. After that, only net overseas migration will keep Australia's population growing. The proportion of our population aged 65 and over is likely to double in the next 50 years. Whereas it is around 12 per cent now, by 2050 it will have increased to around 24 per cent. Migration has a positive role to play in assisting Australia to manage the transition to an older population. The current migration program, being on average younger than the Australian resident population, can help slow the ageing of the work force to a small degree. The median age for the Australian population is 35 years, compared to 32 years for principal applicants in the migration program.

A well-targeted and well-managed migration program can help produce a highly educated and technologically and scientifically literate work force. Today's migration program is highly skills focused, employing rigorous selection criteria to ensure that those coming to Australia under the skills stream are young, English-proficient migrants, with skills that are fully recognised in Australia, who are able to very quickly make a positive contribution to the economy. The current focus in the migration program on skills and English proficiency should see that, as

migrants themselves age, several decades from now they will be more affluent, healthier and better able to utilise mainstream aged care and health services than would otherwise be the case.

Migration should not, however, be considered the Holy Grail. Work by Professor Peter McDonald has shown that the first 80,000 net migrants per year make a reasonable contribution to the reduction of the ageing population. However, net migration above that level brings diminishing returns. This is because migrants themselves age. Ever-increasing numbers of migrants would be needed each year just to stabilise the rate of population ageing. Theoretically, to maintain the current proportion of the population that is aged would imply a net overseas migration of around 200,000 per annum within the next five years, growing to 1.7 million per annum by 2050. This would result in a population of around 75 million by 2050, one growing very rapidly indeed.

The reality is that changes in our fertility rate will have a far greater impact on the age structure and size of our population than changes in migration levels. It is important to note, however, that there are likely to be differing population outcomes which might give rise to specific further policy needs for some sectors of the Australian community. For example, population growth rates in regional Australia compared to metropolitan Australia are quite different. The demography of the Indigenous community is significantly different from that of the wider population: it is younger, has significantly higher fertility rates and is growing more quickly. Finally, there are the specific needs of ageing ethnic communities that must be considered. We would be happy to elaborate on any of the above.

CHAIR—Thank you very much for that. You have said that the population of Australia is projected to be 25 million to 27 million by mid-century. What percentage will have English as a second language? Have you looked at that?

Mr Rizvi—We make the projections in a number of ways. We look at them in terms of categories of entry. We certainly look at them geographically. We do not tend to look at them by nationality or ethnicity, and I think Professor Charles Price has done some work on ethnicity. Having said that, we would note that the migrants of non-English-speaking background who are coming to Australia today have significantly different English language characteristics to the non-English-speaking background migrants who were entering Australia 20 or 30 years ago. The vast majority of non-English-speaking background migrants who enter Australia today have quite good English language skills.

CHAIR—Perhaps I can ask that in another way: how do you expect the current migration intake, who over the next 40 years will become aged migrants, to differ from the cohort of aged migrants we have in Australia today?

Mr Rizvi—I think there are probably three major differences between the aged migrants we have today, who predominantly entered during the fifties, sixties and seventies, and the aged migrants who we may have in 20 or 30 years time. They will be different, firstly, in that they will be significantly more skilled. Their qualification levels will be substantially higher. The overwhelming majority of those migrants will have entered through the skilled stream and therefore will have tertiary qualifications which are recognised in Australia. The vast majority of migrants who entered Australia in the fifties and sixties would not have had tertiary skills. Secondly, the migrants entering today have a younger age profile than the migrants who were entering Australia in the fifties, sixties and seventies, and therefore will have a longer period in

Australia to become more integrated in the population than those who entered in that earlier period. Finally, they will enter with English language skills that have been tested and are of a much higher level than those of the migrants who entered in the fifties and sixties.

CHAIR—So it is going to require a change in established thinking in how we understand the population group of those not born in Australia?

Mr Rizvi—Yes.

Ms HALL—I would like to concentrate a little bit on the issues of ageing and the Indigenous population in Australia—I know that is your area, Mr Lester. Do you see that ageing is a big issue within Indigenous communities? Are there adequate support mechanisms, services and resources being allocated? If not, what needs to be allocated? What initiatives would you like to see in that area?

Mr Lester—The ageing of the Australian population as a whole will continue to accelerate away from the rate at which the Indigenous population is ageing. In relation to services, there are two issues that arise from a change in the age profile of the Australian population relative to the Indigenous population. One is that Indigenous people may be poorly located for existing aged care services, and as the number of aged Indigenous people continues to increase, as it will—although we do not have very good projections of what the Indigenous population will be—

Ms HALL—May I interrupt you. Given that the mortality and morbidity rate for the Indigenous population is pretty horrendous in comparison to the rest of the Australian population, should we consider a person living in an Indigenous community as aged at a younger age than we would do for the rest of the population? Can you incorporate that into the answer you are giving.

Mr Lester—By all means, yes. There are three issues. The first issue is where Indigenous people live in relation to where services are and how services might be delivered to aged people. There are cultural preferences to be considered. Indigenous people would prefer solutions that are home or community based rather than institution based. That is shown by trends in access to the community aged care package and to HACC services at the moment, where there is an increased rate of access to community based care and a decrease in institution based care as community based care becomes more available.

The second issue is the remote issue generally. The third issue is the early ageing phenomenon, and there are two issues related to that. The first is that the government is putting a lot of effort into doing something about Indigenous health, so there is a possibility that things will change. If they do then the numbers of older Indigenous people may well increase. They will still, however—except in remote areas where there is a service access problem anyway—be a very small proportion of the overall population in absolute terms.

The early ageing problem is taken into account currently in Commonwealth aged care programs, such as HACC and CACP, in that Indigenous people have access at the age of 50, while the access age for the general population is 70. As long as that is maintained then, all other things being equal, it should be adequate to meet the needs of Indigenous people, who age earlier. It is not fixed in stone that Indigenous people have to be middle-aged at 30 and die at

50; it is something that can and may very well change, in which case programs will differ in that context. The reverse side of the issue is that an ageing non-Indigenous population may very well remove itself from remote areas of Australia, which has implications for maintenance of services to the rest of the population, because almost everywhere in Australia non-Indigenous people predominate.

The second issue under the early ageing phenomenon is that in areas where mainstream services are marginal and the Indigenous population continues to be a relatively young population far into the future—by 'far' I mean in the next 40 years—then maintenance of the services for younger people will become an issue if the location of the non-Indigenous population changes. Simply put, if at present 75 per cent of the kids in the school are non-Indigenous but in 20 years time the population changes to the extent that you have doubled the number of Indigenous kids but halved the number of non-Indigenous kids, then you are going to have in absolute terms a marginal reason for providing services to that population in the same way that you did previously. Does that answer your questions? I might have missed one of the points that you mentioned.

Ms ELLIS—When you talk about the potential for changes in the health status of the Indigenous community, do you agree that we need to talk in generational terms?

Mr Lester—I am glad you asked me that! The early ageing phenomenon—

Ms ELLIS—To see the sorts of changes that you are saying will have an impact on expectation of services and changes in provision and so on, do we agree that we are talking about a generation of change—in generational age terms?

Mr Lester—Yes. We are talking across generations because it is thought that a considerable effect on early ageing is birth weight.

Ms ELLIS—Yes, lightweight babies.

Mr Lester—The statistics on low birth weight Indigenous babies are encouraging but not fantastic. If that trend continues and improves, you will have a population that starts off with a predisposition to better health. Currently the 25- to 44-year-old age group is experiencing very poor health. Part of that is due to them being babies that would not have survived in a previous generation. So there is that sort of generational effect in any case. As with the rest of the population, a lot of health effects are generational. Health transitions across the generations are increasingly becoming the emphasis within Indigenous policy to try to work out what is going on there and to concentrate on that area.

Ms ELLIS—So when we talk about the changes that we would like to see happen, there are some things that any government could do in relation to the provision of health services for the Indigenous community that could have an effect within 12 months; some things that could have an effect within five or 10 years and some things that could have an effect in 20 to 30 years. I am talking about the 20- to 30-year period, and we agree that the lightweight baby birth or other inherent health issues that remain long-standing in communities involve a range of issues which, over a couple of decades, will start to have an impact. If we agree on that, given that you have explained the age cut-off for the provision of aged services to our Indigenous community—and I am sorry if this has been covered in earlier evidence—can you outline for us

what role your department has in liaising with the departments that administer HACC, CACP and whatever else is entailed to ensure that those service provisions have a good and thorough understanding of the cultural, distance, geographic and health issues that are relative to Indigenous people? What arrangements, if any, are there between your department and those service departments to ensure that all those issues are considered in relation to the delivery of those services within the Indigenous community? Is there a relationship?

Mr Lester—Yes.

Ms ELLIS—If there is, could you outline it? I assume Mr Lester is the person to address that question to.

Mr Lester—Let me first explain where we are within the department, which is somewhat isolated from the mainstream activities. The Office of Aboriginal and Torres Strait Islander Affairs is a policy office.

Ms ELLIS—I understand that.

Mr Lester—We do not have responsibility for any specific programs. There are of course programs operated through the portfolio through ATSIC. It is our role to take that Indigenous affairs policy focus rather than the functional areas and to advocate or encourage coalition, coordination or collaboration between Commonwealth agencies or governments in order to facilitate a more effective way of dealing with what needs to be dealt with within the context of what other people are doing. It is our job, in collaboration with the Office for Aboriginal and Torres Strait Islander Health within the Department of Health and Ageing, to engage aged care services to ensure that those things are done. More that that, overall you could say that we take an approach to Indigenous health status that looks at health services, other forms of health intervention, the role of education and so on and how they impact on health. It is a bit unkind to the health sector when it is stated that the life expectancy gap between Indigenous and other Australians is 18 or 19 years and therefore our health programs are not working. It would be as valid to say that education programs or community services programs are not working because we do not know what the relative attribution should be.

Mr MOSSFIELD—Leaving aside the Indigenous involvement, in very general terms what part does our ageing population play in the department's immigration policy? Do you try to seek a balance with our ageing population? Is there a deliberate move to bring more younger migrants into Australia so that it balances the older population? Is that a consideration? I am anxious to know in general terms.

Mr Rizvi—I think the age structure of the migration intake is almost independent of the age structure of the Australian population. Irrespective of the age structure of the Australian population, all the research and analysis suggests that a younger age structure in the migration program is a good thing. It is a good thing economically and socially, hence governments have consistently over the last 15 or so years emphasised and indeed given greater weight to having a younger migration intake.

Mr MOSSFIELD—But it is not a conscious policy, the fact that we have an ageing population. You do not try to balance that. There are many other reasons for a younger migration intake.

Mr Rizvi—That is the point I am making: irrespective of your age structure, you would want a young intake.

Ms ELLIS—Mr Lester, as you may have realised, the reason for asking these questions—we need to fess up—Ms Hall and I were on the inquiry into the status of Aboriginal health which produced the report entitled *Health is life: report on the inquiry into Indigenous health*, which was tabled three or four years ago. Until that point we had a pretty close feeling for the issues we are talking about here. If we are talking about the ageing of Australians, we obviously agree that we need to talk about the ageing of Indigenous people as well. If there is a part of government that is the source of information and expert advice on how best to formulate policy for the Indigenous community in Australia, where is it? In your department are there experts on health, ageing, education and employment? Throughout that inquiry the committee were very strongly of the view that there needed to be a whole of government approach to this issue, not a silo mentality, as has historically been the case.

I am trying to understand to what degree the department, given that it is the ministry of Indigenous affairs, along with other things, has a relationship with the departments that provide those services? I fully understand and accept that you do not do them, but there surely has to be a strong flow of influence, information or understanding. How does it all come together? Or does Health, FACS or whatever the department might be just say, 'Our Indigenous unit tells us this, so this is what we will do'? To what degree is there collaboration? Is there an interdepartmental committee? What allows it all to happen well, particularly with the ageing of the Indigenous population? During that inquiry, which was a few short years back, we saw a fairly mixed bag of success—I am not being critical of any one party here—in understanding the needs of the ageing end of the Indigenous population. If they are going to go out and do HACC and CACP programs for Indigenous folk in the remote and semi-remote parts of this country, who is telling them what they need?

Mr Lester—It may be in the form of an interdepartmental committee or ad hoc or informal meetings between the parties who have a role. In the Indigenous perspective in those policy areas, the minister has access to two avenues: ATSIC and the Office of Aboriginal and Torres Strait Islander Affairs. There is obviously a fairly reasonable working relationship between ATSIC and our office but they sometimes have different perspectives or things to add to the policy debate, but in general terms both of those entities are used as resources in Indigenous input into policy discussions, whether the area be aged care services or whatever. Occasionally silos happen.

Ms ELLIS—I understand that.

Mr Lester—Things may not be fleshed out in that context or people may think they have enough information. In general, I think the process works well and our advocacy role in looking at the way policy affects Indigenous people is increasingly being accepted. We are a fairly young entity in terms of where we sit in the public sector now. The office itself has been independent of PM&C for only about 2½ years, so the role is different and that role is developing. The role is as I have outlined it.

Ms ELLIS—Chair, I suggest it might be useful if we attempt to get a flow chart for the committee to understand the delivery of Indigenous services for the ageing population as it relates to the structure of the public sector.

CHAIR—Certainly. You could ask for that.

Ms ELLIS—If someone could provide that, that would be a great idea—just to show who is in the loop and where it all knits in from the aged care provision.

Mr Lester—By all means.

Ms ELLIS—Is that possible? I do not want to create a great task, with weeks of putting some diagram together, but just a simple flow chart or whatever you think you can put together to show us where the stakeholders are within the public sector.

Mr Lester—We can do that and it is not a terribly onerous task.

Ms ELLIS—Good.

CHAIR—Does the department have any view on whether the shift to the coast is something that is going to continue in the future—seeing growth in the coastal regions and decline in the inland regional parts of Australia?

Mr Rizvi—Certainly that shift has been taking place, as you say, Chair, for quite some time. The extent to which that shift is going to continue, I really could not comment. What I can say is that increasingly we as a department are looking to the development of mechanisms that will in particular help regional Australia. Regional Australia, of course, will at times include coastal Australia, but very much we are also looking at areas such as Wagga, Dubbo, Parkes and other inland areas throughout Australia and at how we can work with communities in those areas to enable them to attract a higher level of both permanent skilled and business migrants. You may be aware of further regulation changes to that effect that are, in fact, to be introduced in the parliament shortly. As well, we are looking at how we can assist those areas in terms of key industries that we are linked with, and that in particular relates to tourism and overseas students. How can we make, for example, our tertiary institutions in places such as Wagga, Dubbo and Ballarat more competitive in attracting overseas students, relative to the already very attractive institutions in Sydney and Melbourne?

Mr Rizvi—To a degree, at the end of the day economic forces have their way. But there are things governments can do and I think that pursuing these things is inevitably a matter of partnership between Commonwealth, state and regional authorities. That is essentially the approach that we have tried to pursue. It is certainly true that, for example, the South Australian state government is very active in trying to attract more skilled and business migrants. They have had some modest success to date. Clearly, they are looking to have greater success in the future and we are looking to work with them to develop the mechanisms that might help in that regard.

Ms HALL—I will have to ask you one question that is probably a little more contentious. Do you have an issue with people in detention centres who may have need of aged care services?

CHAIR—Is this really related to the inquiry topic?

Ms HALL—Yes, it is.

Mr Rizvi—I am not an expert in detention centres, but I can make some general comments and if there are some more specific questions, we could take them on notice and see if we can get back to you.

Ms HALL—Yes. It is not going to be anything more specific than this.

Mr Rizvi—Certainly, we try to maintain medical services in detention centres at a high level of quality. The provision of medical services within detention centres is certainly a challenge. It is not an easy thing to do. We certainly try to tailor the services to the needs of the individual populations that we have. The challenges are probably more in trauma and so on, including the sorts of issues that arise from the backgrounds of individuals concerned. As a general rule, the populations of detention centres are not particularly aged. They tend to be quite young. Hence, I cannot recall the question of what services are provided to aged detainees. But we could examine it a bit further and get back to you.

Ms HALL—That is why I asked. I thought it would be more an exception, but there would probably be a few people who fell into that category. Therefore, I am wondering what sorts of resources you have to deal with them.

Mr Rizvi—I can take that on notice.

Ms HALL—That is fine. I want to ask about the relationship between the states and the Commonwealth. I notice that you have mentioned in here that cost-shifting between the states and the Commonwealth is one issue. I should imagine that there are areas where there is crossover and duplication of services, too. What things do you believe are needed to be put in place to overcome this and gear the services better towards the people that need them?

Mr Rizvi—I might provide a general answer and then I might ask Mr Doherty to comment on the specific issue of settlement services. In immigration matters generally, leaving out the issue of settlement services, the delineation between the responsibilities of the states and the Commonwealth is reasonably clear. Hence, we do not encounter that difficulty to the same degree that other portfolios do. It exists, certainly, but not perhaps to the same degree as in other places.

In terms of immigration outcomes, we do try to work very closely with state and territory governments in getting the distribution and dispersal of business and skilled migrants that those individual states are after and I would like to think that we try to pursue a collegiate and partnership approach. I am not aware of any cost-shifting issues that have come up in that regard. In the settlement services area it becomes more unclear. Hence, those issues do tend to arise. I might ask Mr Doherty to comment on those.

Mr Doherty—Perhaps I will start by talking about the range of settlement services we actually provide. They are fundamentally targeted at the most recent arrivals. For most recently arrived people we provide the Adult Migrant English Program. We provide community grants, the Integrated Humanitarian Settlement Scheme, the Translating and Interpreting Service, migrant resource centres, et cetera. Those are targeted at the most recently arrived. Our ultimate objective is for the department to pay attention to that group of people and to gradually have mainstream service providers take responsibility for services to all of their clients, whether they are Australian born or newly arrived or recently arrived migrants. We have a process of trying to

get mainstream organisations, whether they are Commonwealth, state or local government, to take those responsibilities on.

In terms of English language, for example, we are providing the Adult Migrant English Program, the first 510 hours of intensive English language. When people have completed that, we find pathways for them either into other Commonwealth employment preparation type programs or into state provided English language programs. That is one example. In the community grants area, our grants are focused on the newly arrived, making sure that we get them settled and connected properly and then we focus our attention down on newly arrived and emerging communities. We try to withdraw—

Ms HALL—And put it to the states—

Mr Doherty—and put either to states or the Commonwealth, depending on the nature of the product that is required to be delivered.

Ms HALL—My final question relates to the provision of aged care services and the need for culturally appropriate services. I notice that you mentioned there is a change in the people migrating to Australia. With the older migrant population that is already here, do you believe that we are currently meeting their needs? What needs to be put in place to meet the needs of people who are newly arrived to Australia?

Mr Doherty—In terms of people who are aged migrants already here we are making pretty good progress in having mainstream agencies respond to their particular needs. We are still trying to make progress in the area of some of our community grants to communities that have been here for perhaps many years. We still find we are providing, for example, services to some people in the aged ethnic communities in the areas of aged health care and related needs when really we should be focusing our attention back on newly arrived communities coming out of Africa rather than people from Greek, Italian, Spanish and Portuguese background. We are still caught, if you like, in filling that aged provision gap.

Ms HALL—One of the phenomena of people with dementia is that they sometimes lose their English and revert to their first language. That will probably be something that is a constant, and it needs to be taken into account as well. Could you incorporate that into your answer, please?

Mr Doherty—Yes. That is a quite well-known phenomenon. Again, it is a case of our doing two things: we certainly have interpreting and translating services available, and the health systems are some of the biggest users of TIS, our translating and interpreting service. In addition to that, ultimately we have to rely on the second generation. In other words, they play a critically important part in helping their parents to negotiate the range of services needed. Our experience has been that in the early stages of migration we are providing a translating and interpreting service to meet that generation of need, but over time we are relying more and more on family structures, if you like, to provide that communication device in the case of a loss of English language.

Ms HALL—More so than in the general community.

Mr Doherty—I think they are slightly different sets of communication devices. We all have aged parents at some time and we all negotiate those sorts of things on behalf of them; it is just

that those who are from a non-English-speaking background probably spend a little more time in that interpreting—

Ms HALL—Correct me if I am wrong, but are you saying that it is acceptable for us as a community to have people who are migrants rely more on family to ensure they get the services they need whereas Australians from an English speaking background can access those services without the necessity to rely on family to that degree? Are we transferring the costs to the family as opposed to the community as a whole? If that is what we are doing that would concern me.

Mr Doherty—I am not sure that I would characterise it as a deliberate policy. I think the reality is that we are involving a range of people in the provision of services to the elderly, and that includes specific agencies with grants like HACC funding, other specific arrangements for the aged in ethnic communities, the funding that we provide through community grants and the family and mainstream agencies using interpreting and translating services.

CHAIR—You have mentioned different scenarios for fertility and for net overseas migration and from that I take the point you have stated that increases in fertility have more effect in retarding the ageing of the population. You also said in your opening comments that there is an annual NOM of 80,000 to 100,000 and that that does help to retard the population ageing. Are there any other conclusions we should draw from these different scenarios?

Mr Rizvi—Those are the two main points. I think initial levels of net overseas migration do have a valuable impact on retarding ageing. As you keep increasing net overseas migration, the incremental increases have less effect.

CHAIR—Yes. You have to keep front-loading.

Mr Rizvi—That is right, and eventually you would just catch up. I think Professor Peter McDonald has shown fairly clearly that it is the fertility rate that really determines the extent to which your population will have more or fewer aged over the long term.

CHAIR—These are things we can change, whereas life expectancy is something we anticipate should continue to increase as technology and as our lifestyles change.

Mr Rizvi—That is exactly right. All of the models that we have shown here assume that life expectancy for both males and females will increase at the rate of approximately one year in every decade. That is actually a fairly conservative assumption; it is probably improving at a faster rate than that.

CHAIR—Thank you.

Ms ELLIS—Where is the population department in government? Is there a population branch in DIMIA?

Mr Rizvi—Certainly, we have areas—

Ms ELLIS—I do not mean migration driven, just population.

Mr Rizvi—We certainly look at broad population issues quite extensively, as do a number of departments. For example, there is a population area within the Department of Employment and Workplace Relations. There is an area within the Department of Family and Community Services that looks very closely at population issues. In the context of the speech that he made to CEDA last year, the Prime Minister has set up some fairly broad-ranging mechanisms to look at issues of demographics and ageing, and a range of interdepartmental working parties are looking at those issues. The bulk of those working parties are chaired either by the Prime Minister's department or the Treasurer's department.

CHAIR—If there are no more questions, we will look at the model and how it changes. If the committee does have any matters that arise, are you happy for it to send written questions to you?

Mr Rizvi—Very much so.

CHAIR—Thank you very much for coming and for giving evidence to us.

Mr Rizvi—Thank you.

An audiovisual presentation was then given—

Ms Cooper—This model was developed by Professor Peter McDonald, who I think is appearing next.

CHAIR—Yes.

Ms Cooper—It is a fairly basic model, but it gives an overview of the sorts of demographic changes that you could expect a hundred years from now in terms of people of labour force age and the population as a whole, and the age structure of the population. The two variables are the total fertility rate and the net overseas migration rate each year. At the moment we have set the fertility rate at 1.65, which is a little lower than the current fertility rate. The annual net overseas migration rate is set at 100,000. Do you have any suggestions as to what you might like to see for net overseas migration, or NOM?

Mr Rizvi—Run through what happens over the years. Drive the model a bit and see what happens. You can see the age structure, which is the pyramid, changing over the years.

Ms Cooper—By 2040, for example, with a fertility rate of 1.65 remaining constant over that period and an annual net overseas migration of 100,000, we would have a population of 25.5 million. There would be 61.3 per cent or 15.6 million people of labour force age. The population aged over 65 years would be 23.5 per cent.

Mr Rizvi—That is approximately double the current rate.

Ms Cooper—Yes.

CHAIR—What has the long-run average been? Has it been about 90,000?

Mr Rizvi—Over the last decade, average net overseas migration has been around 90,000. Over the last two or three years, it has been well over 100,000.

CHAIR—What was it during the fifties and sixties and so on?

Mr Rizvi—During the fifties and sixties there would have been periods when it averaged higher than 90,000. There would have been periods when it got up to 110,000 or 120,000, those sorts of numbers. But looking over the whole of the last 50 years, about 80,000 to 90,000 is the average.

CHAIR—I suppose what is happening is that, as a proportion of a population, the numbers from the NOM are going down.

Mr C. Smith—The fertility rate in the fifties was about 3.6, which is more than double what it is now and what it is projected to be, so that has a significant effect.

Mr Rizvi—The really big change, if you look back at the last 50 years, is that natural increase is contributing far more to population increase than net overseas migration. If you look at the next 50 years, the situation is reversed.

CHAIR—It is the migration.

Mr Rizvi—The migration program is the dominant driver, not natural increase.

Mr C. Smith—Such that, by 2030 or 2040, depending on how the variables go, the only contribution to population growth will be from net migration. You can show that.

CHAIR—That is positing a fertility rate of 1.65?

Mr Rizvi—Yes.

Ms Cooper—I have just put a total fertility rate of 1.3 into the model—which has happened in some developed countries. If we were to drop to 1.3 but we maintained our net overseas migration rate, by 2040 we would have a lower population. About 25.5 per cent of our population would still be aged over 65.

Ms HALL—Do we get to a stage where we have negative population growth?

Mr Rizvi—We would only if you assume a lower level of fertility. At the moment we have assumed net overseas migration at 100,000 per annum and a fertility rate of 1.65. At that that level, eventually you reach stabilisation. If you assume a lower level of net overseas migration or a lower level of fertility, eventually the curve turns over and goes down. It might be worthwhile actually running net overseas migration as zero. Net overseas migration as zero shows a dramatic contrast.

Ms Cooper—And with a fertility rate of 1.65?

Mr Rizvi—Leave 1.65 as the fertility rate.

Ms HALL—That is serious.

Mr C. Smith—It is about 20 now, so 2000—

Ms HALL—So if you dropped it to 1.3 plus—

Ms Cooper—We would get to 2040 and have a population of just over 20 million and 27 per cent of the population would be aged over 65.

CHAIR—So a country like Japan has the problem of low fertility and very low net overseas migration as well.

Mr Rizvi—The point that Peter McDonald has made on that is that if you do move to a scenario of very low fertility and net overseas migration which is fairly small, you eventually get onto a very steep slippery slop where you just cannot recover.

Mr C. Smith—You can see the point that Mr Rizvi is making about that scenario. With 1.3 versus 1.65, which was on there before, by 2040 there is a two million difference.

CHAIR—The poor taxpayer!

Mr C. Smith—Where are they—on the bottom?

Ms Cooper—Yes.

CHAIR—They are being squashed!

Ms Cooper—Back to 2040, it is 18.6, and a substantially smaller population as well.

Ms ELLIS—Yes, smaller than now.

Ms Cooper—Yes, and that is within a relatively short period of time for demographic change.

CHAIR—There is a guy from the Brookings Institute who was at the Melbourne Institute conference in April, and he was saying that although there will be a much greater proportion of aged people in the working population—there are often couples working—he was arguing that it is not such a big deal because the dependency ratio is about the same. He said that in the 1950s it was one breadwinner and maybe five or six children to support and now there are two people earning an income—

Mr C. Smith—Yes, disposable income has increased significantly. That is why arguments about the quality of the labour force and all that change all the traditional ways of thinking about it.

Mr Rizvi—He may well be right. It may well be true that, increasingly, older people will remain in the work force longer and all the problems will be solved.

CHAIR—It has not been happening to date, however.

Mr Rizvi—That is right. The questions is: can you afford to be complacent about it?

CHAIR—Yes. That is very interesting.

Ms HALL—Yes, it is.

Mr C. Smith—1.7 million in net migration—

Mr Rizvi—That was the level of migration you would have to assume in order to maintain the ageing of the population at current levels.

Ms HALL—Really.

Mr Rizvi—You would have to be bringing in 1.7 million net overseas migration per annum.

Mr C. Smith—The population aged 65 and over is 11 per cent on that, 10 per cent in 2004.

Ms HALL—And that is assuming that birth rate.

Mr Rizvi—That is assuming 1.65. That maintains the age structure as it is now.

Ms ELLIS—If you go to 2040, which is what we have been measuring all of them—

Ms Cooper—It is 109 million population.

Mr C. Smith—About 4.8 versus 12.4 per cent.

Ms Cooper—It keeps the percentage of the population over age 65 fairly constant.

CHAIR—By contrast, what fertility rate do you need then with a NOM of 100,000?

Mr C. Smith—Change it to three per cent.

Ms ELLIS—I was going to go for three; let us be provocative!

Mr C. Smith—3.6 is provocative.

Ms ELLIS—That would be outrageous.

Mr Rizvi—We had three in the early sixties. It was not that long ago.

Ms ELLIS—100,000, three per cent.

CHAIR—It is still an increase in people aged over 65.

Ms Cooper—It is pretty inevitable over the next few decades. There is nothing that could be done.

Mr Rizvi—With the extra babies, you would still have to wait 60 years before they become part of the aged population.

CHAIR—As you go further out, it starts to drop, although it does not really change that much I suppose. Is the United States' fertility rate about 2.1?

Ms Cooper—It is about 2.1.

Mr C. Smith—A lot of European countries are around 1.4 or 1.5.

CHAIR—I saw that.

Ms ELLIS—I am no statistician but if you turn that fertility rate around to three per cent, that would be terrific, but at some point they are all going to get old.

Ms Cooper—Exactly.

CHAIR—Amongst the OECD countries, we are in the top 30 for fertility. This figure is taken from the FACS submission and it is taken from some OECD stuff looking at the proportion of women employed versus fertility rates. Thank you very much for that and also for the presentation. If we have anything else that arises, we will get in touch by writing.

[2.54 p.m.]

McDONALD, Professor Peter Francis, Professor and Head, School of Demography and Sociology, RSSS, Australian National University

CHAIR—Welcome, Professor McDonald. Thank you for coming to speak to the committee about our inquiry. I remind you that proceedings of the committee are proceedings of parliament and, as such, misleading the committee is a contempt of the parliament. Do you wish to make an opening statement?

Prof. McDonald—I do not have any particular opening statement to make. I am here more to answer any questions that you might have. Broadly, over the last six or seven years since I have been back at the Australian National University, I have been heavily involved in looking at Australian population futures. On a more international level, I have been looking at international trends in fertility rates—what influences them and what policies appear to work. I think I would be regarded as an international expert in that area.

CHAIR—Yes, we are very honoured to have you come and address us—we do appreciate that. At the moment there is a lot of public debate in Australia about how to raise the fertility rate. What sorts of things, in your view, would work in Australia? I understand France has been able to reverse a decline in its fertility rate, but many other countries have tried other things which have not succeeded.

Prof. McDonald—To begin with the premises of the question, I do not think we should be trying too hard to increase the fertility rate. Australia's fertility rate at the moment is around 1.75. Because we are a migrant country, we are able to compensate quite comfortably through migration for the population decline that would eventually occur with that kind of fertility rate. A migration of something like 80,000 people a year, which we have had for the last 50 years, would ensure that the population did not drop in the long term. A combination of a fertility rate of 1.65 and 80,000 migrants keeps Australia's population going—at least, at zero population growth; then it depends on how much growth you want. The way that I argue it is that Australia's fertility rate is falling and we want to stop the fall, rather than arguing that we need to increase fertility to 2.1 or whatever to the replacement level. In some ways it is the same question: what works?

A lot of overseas research where the conclusion is that it does not work is because the expectations are too high. They are expecting to increase fertility from, say, 1.7 to 2.1. We need to be concerned about fertility more at the margin. If the fertility rate drops down to 1.65, that is still not such a drop. A fertility rate of 1.7 is the number I use on an international level as a rate that countries should aim for, and 1.5 and below is the danger zone. The difference between 1.7 and 1.5 is 20 per cent of women having one child. You have to keep that in mind. You are operating at the margin. You are not trying to dramatically change society but you are trying to provide conditions so that we do not get into a position where 20 per cent of women have one fewer child than they are having now.

Leaving out the United States, which is a very special case, the situation is that, in general, it is in the English speaking part of the world where fertility is falling. Fertility is very low in a lot

of European countries and in East Asian countries, too, such as Japan, Singapore and Korea et cetera. They have bottomed out, but at a very low level—a dangerously low level—for their future labour supplies, in particular. But it is the English speaking countries—Canada, Australia and the United Kingdom—that stand out at the moment as being on the way down. Canada has already hit 1.5 and the UK is around 1.6. Scotland, for example, is under 1.5—even though it is part of the UK. Interestingly, the UK is held up by London for ethnic type reasons. The highest regional fertility rate in the UK is in London. We, too, are not terribly far from that situation with Sydney.

The questions are: what is different in the English speaking countries that is pushing the fertility rate down? In what ways are they like the countries where the fertility rate is already at a very low level? How do they differ from the countries that are going in the other direction—countries like the Netherlands, France and the Nordic countries which look like having longer term sustainable fertility rates? That is what is different about English speaking countries. This gets you into a grand theory, I suppose, but what I have argued is that the countries that have very low fertility rates are countries that have accepted the new economy, the new capitalism. Their economies have been deregulated, they accept women's employment, and women's employment has risen. That is essentially the case in every country where this has happened. But they are countries that, on the private side, want to maintain the old model of family: the male breadwinner model. Their policy on the private side supports a male breadwinner model of the family, while at the same time they are offering women, through the economy, as individuals, all the opportunities of young men. That creates a clash. The countries that stand out there are the southern European countries and countries like Japan and South Korea as well as Germany and Austria. There is still what you would call a maintenance of old tradition about family but it is not in keeping with the modern new economy and women being involved in the work force.

The countries that are doing well in these areas, like France and the Nordic countries, are countries that are socially liberal in a sense, in that they have allowed a lot of change in women's lives and they have had the same kinds of catalyst changes in the labour force, but they have seen that there is a need to compensate for that. Compensation, at least in those kinds of countries, needs to be done through government. It cannot really be done in any coordinated way through the market.

Ms HALL—Would that be with initiatives like paid maternity leave?

Prof. McDonald—Yes. There are a lot of initiatives. When you get down to actual policy—I will come to the policy in a minute—the end point is that the English-speaking countries have not done that, and that is why they are still heading down. They do not score very well on policies which support work and family, essentially. I believe that it is a pretty comprehensive approach. It is not any single policy: it is not paid maternity leave; it is not child care; it is not financial assistance. It is a comprehensive approach to it. I am on record as saying that Australia should have an independent review, because it is hard to shift the enormous structure we have of family payments and so on without some kind of independent review.

Ms HALL—What would you like to see included in the independent review?

Prof. McDonald—It would be a review of work and family. I think that is the focus more than fertility, because there are good reasons to do this aside from the fertility rate.

Ms HALL—Definitely.

Prof. McDonald—You get a kind of marginal effect on the fertility rate which is helpful, but it is good for the society and children. I would see that it had the brief to look at Australian arrangements for family payments, industrial relations issues related to work and family and early childhood education in that context—not so much its content but how it can fit into that model—in supporting both parents in families to combine work with family. That is the kind of agenda. I have not actually written out an agenda, but that is the idea. I am presenting next week at the Australian Institute of Family Studies conference, and for the final discussion there I have a 16-point plan.

Ms HALL—Would you be happy to send the committee a copy of the 16-point plan?

Prof. McDonald—Sure. I have not brought it with me, unfortunately.

Ms HALL—We would be very interested in that.

Prof. McDonald—Essentially it consists of looking at how Australian families operate at present and designing a system which is related to that. At present in the vast majority of Australian families when they have an infant under the age of one, one or the other parent—usually the mother—is not working. I think you need a scheme which takes that kind of thing into account. After the youngest child there is a gradual return into the labour force part-time et cetera as the child ages. By the time the youngest child is three or four the labour force participation rates are quite high—heading up to 60 or 70 per cent. Looking at that kind of structure, I would provide through the social security system a large cash payment which is attached to the child—not so much to the parent—probably income tested at a very high level like family tax A, maybe up around $100,000 or something. So they would get that in the first year of life of the child. To take into account maternity leave it would be conditional on the mother staying out of the labour force for three or four months—whatever is considered to be the best—and maybe even throw in a couple of weeks for the father as well.

In the second and third year of life there would be a similar kind of arrangement: a large cash payment. The payment in the second year of life can be made conditional upon immunisation, as with the immunisation payment. Then parents can use that money for child care or as an income supplement if they are out of the labour force. Once the child is three years old—and the money is attached to the child—what we should be looking at is early childhood education. Again, I am on record as saying this: Australia should have a good early childhood education system for three- and four-year-olds, maybe 20 hours a week, depending on what the early childhood educators say—something like that.

Ms HALL—Uniform across states?

Prof. McDonald—As uniform as possible across states. States are the big problem in doing this, and also the structure of child-care centres these days. It would bring the child-care system into the early childhood education system; it would integrate them. The rest of child care—that is hours outside of those hours or for younger children—would hang off that. This is essentially the French system I am describing. By providing a base to the child-care industry with that 20 hours a week for three- and four-year-olds, it makes it a much more stable enterprise than it has

been—it has been very up and down, with places going bankrupt, corporate takeovers and all that kind of thing, which is not very edifying.

I did some calculations based on wiping out a lot of existing payments. What I came up with is that without spending any additional dollars, just wiping out some things that are there at the moment, you could have about $6,500 per child per year in the first year of life that you could allocate to what I am talking about. You could provide that in a cash payment form in the first three years of life of the child, and then take about $4,000 of it when they are three and four to put into an early childhood education system. The remaining $2,500 or so would again be a cash payment that they could use for additional child care or additional time out of work. The child-care system would be probably 50-50 with the states, something along those lines, so it would have to be negotiated.

I think you could get a pretty good system with $6,500 per child. It wipes out the child-care benefit and family tax B. The only substantial losers in the system that I put together are those receiving family tax B for children aged five and over, but I have my doubts about whether it is a good idea to be paying a completely universal payment in that kind of circumstance. If there are problems there then they are vertical equity problems—they are problems of people who are poor—so you can use the upper level of family tax A to deal with that situation. I do not have a great problem with wiping out family tax B above age five. But these are all political questions. That is the scheme, essentially, along with some industrial relations changes.

Ms HALL—Such as?

Prof. McDonald—The most important one is a right to part-time work. The countries of northern Europe and France provide parents with a child under the age of 10 or so with a right to part-time work—say, 80 per cent—in their own job, not in some other job that they do not really want. That is a right to both father and mother. So if they want to work 80 per cent, that is 1.6, two days a week one of the parents is available for the child or children. That is probably the most important change. Part-time work has gone a long way in Australia, a lot of people work part time, and I think a lot of parents would be interested in that kind of approach. I have spoken to big employers about it, the Business Council and so on, and they do not seem to be too worried about that kind of approach, but maybe smaller employers would have problems.

Ms HALL—Have you spoken to small business?

Prof. McDonald—I have not spoken to small business about it, but a lot of small business works with part-time workers anyway so I do not think it is necessarily going to be all that problematic, although generally business objects to everything if it is changes of this nature. I would also think about extending the unpaid leave after the birth of a child from 12 months to 18 months. That might be useful.

Ms HALL—Why?

Prof. McDonald—There is a gradual return. Some people do not return quite that fast. It does not mean that they have to stay out for that long. Some people are returning later. If there is 18 months each for both parents, that is three years—if fathers actually do it. It is a cultural change which will take time. But at least if you provide the opportunity for it, I think cultural changes will take place. In terms of attitudes like that, I think the post-1970s generation is

different in that there is a much greater level of gender equity thinking among young people under the age of 30, so that fathers in the future might be a little different from people like me.

CHAIR—In the first paper that you have given us, *Low fertility: unifying theory and demography*, you said:

> What is required is no less than a new social contract asserting that children are a social good and not merely a private, optional pleasure.

Has this occurred in the northern European countries and France? What sorts of things are going to lead to a change in social contract? Could just the fact that we are having this debate in Australia be helpful?

Prof. McDonald—I certainly think it is helpful. I think of a work like the Intergenerational Report, which shows longer term impacts and in particular an emphasis on what is happening in countries like Japan with their labour supply in future. Those kinds of things can convince people that there might be a need for change. There are vocal people who put the private argument that children are a private responsibility and that if you have them you pay for them. 'I should not have to pay for other people's children'—you do get that kind of argument. But I think it is very much a minority argument even among childless people. This is anecdotal but speaking to people who are committed to being childless, they say, 'But I would still support children in this society'. So I do not think it is all that hard to achieve. I think there would be pretty strong support for it.

I do not think there is this intergenerational problem that older people would be looking after their own pockets compared to the younger people, because most of them have children and most of them want to have grandchildren. I think you would get fairly broad community support but you would have to start making the points and putting it out there. Yes, countries like France and Sweden and Norway are child friendly—there are all kinds of institutional arrangements where children are welcome. That is not often the case in Australia.

CHAIR—On the impact of immigration, we have had a little bit of a look at the models. The previous witnesses from the department of immigration said that a net overseas migration of 80,000 to 100,000 did have a beneficial impact on retarding the ageing of the population but after that the changes were much smaller. Would you care to expand on that?

Prof. McDonald—Yes, I agree with that. I guess their views were based on a paper done by me for them.

CHAIR—I am sure they were.

Prof. McDonald—I am not sure that I can show it on a diagram. But suppose the average age of the population looks something like this line. At about this point, say, 38 is the average age of the population, and the average age of migrants is, say, a bit younger, about 35. In that kind of circumstance, migration is having only a fairly marginal impact on the ageing of the population, because there is not much difference in the average ages of the two groups. But if the fertility rate drops, that line goes up—maybe to age 45 or something like that. It is then that migration starts to have an impact because the difference between the average ages is quite large. As migration has its impact, the line indicating the average age of the population comes back down

again. Migration no longer has much impact even though you increase migration hugely. In simple terms that is essentially how it works.

CHAIR—I can understand that.

Prof. McDonald—So when fertility rates are very low, the population is very old and migration makes a difference.

Ms HALL—I find this absolutely fascinating.

Ms ELLIS—Yes, it is extremely interesting.

Ms HALL—This is a very important part of any policy that we have in the area of ageing. It is really about planning and looking towards the future, reacting earlier.

Ms ELLIS—Yes. It is not just about standing up and telling women to go and have babies.

Prof. McDonald—No, it certainly is not. That is completely counterproductive.

Ms ELLIS—Exactly.

CHAIR—It is much better to discuss it in a value neutral way.

Prof. McDonald—I do not think it is value neutral. As I was arguing before: you do say that children are very valuable to the society but you do not point the finger at any particular woman.

Ms ELLIS—Or group of women and say, 'Come on, do your bit.'

Prof. McDonald—Yes. My view is—and again I will draw a simple diagram for you.

Ms ELLIS—You are good on these diagrams.

Prof. McDonald—Yes. This line is the fertility rate and this line is the education of women, or human capital or something. What you generally find is that the fertility line falls as the education line rises. Some people say that the fertility line is the group of women who have the children, let us focus policy on them—this is a bit like the Catherine Hackham Line. We are not very far apart, despite the way that people portray us—and others say that the education line is the group of terrible women who are not having children, let us hit them. My view is that you raise that.

CHAIR—You just raise the whole line.

Prof. McDonald—You don't worry about the fact that there are differences between women. What you are trying to do is improve the situation for all women, essentially.

Ms HALL—Yes. You accept the fact that there will be differences and that those differences can relate to income and education, but what you try to do is get an increase at both ends of the spectrum.

Prof. McDonald—Yes.

Ms ELLIS—We have countries not far from here where all the massive effort in the last, say, decade has been put into people's wish to—and people assisting them—retard their fertility rates, for very good reason. At the same time we have countries like Australia, Canada and the others you have named being very thoughtful about what we need to do to consider the decline in our fertility rate. It is a fascinating global picture, isn't it?

Prof. McDonald—Yes, it is. We have countries very close to us, like Papua New Guinea and the Solomon Islands, where the population growth is out of control.

Ms HALL—There is a correlation between poverty and population growth, too, isn't there?

Prof. McDonald—Yes, generally.

Ms HALL—I am talking globally, and even domestically.

Prof. McDonald—There is a big debate in demography about that. There was a big debate in the 1970s about development being the best contraceptive. But the fertility rates have fallen in a lot of places where development has not advanced all that much, and then development has come about on the basis of the fact that you do not have to support huge numbers of children.

Ms HALL—And there are cultural and religious influences as well, aren't there?

Prof. McDonald—Yes. But fertility rates are falling pretty much everywhere now. As my sideline I work on Iran, and fertility rates in Iran fell from seven per cent to two per cent in 15 years.

CHAIR—What time period was that over?

Prof. McDonald—From 1985 until now.

Ms ELLIS—Good heavens.

Ms HALL—That is incredible.

Prof. McDonald—That is my other little line—explaining that one.

Ms ELLIS—Thailand is another good case study.

Prof. McDonald—Thailand's rate is very low. Thailand's rate is below Australia's now. Thailand is 1.6 per cent or 1.5 per cent.

Ms ELLIS—They have brought it right down. That has been an absolutely concerted program to try and do that.

Prof. McDonald—It means that in the long term you need the fertility rate to be around two per cent or something. It could be a bit below; it could be a bit above. With big populations, such as India, a fertility rate of even 2.5 per cent produces a huge number of kids.

Ms HALL—It is incredible.

CHAIR—What is the current fertility rate in India?

Prof. McDonald—It is about three per cent I think.

CHAIR—It has come down from about six per cent, I think.

Prof. McDonald—I have one comment about the long-term nature. We are talking about very long term here, and that is a message which is hard to get across. Ageing in Australia, as things stand now, is going to be big between 2020 and 2040. Why does that happen? Primarily it is because of the difference between the number of births in the 1930s and the 1940s compared to the 1950s and 1960s. That is a hundred-year time frame that we are talking about. Ageing is a very long-term issue. If the question is, 'Do we care about people in Australia in a hundred years time?' it is hard to make that case. In the Intergenerational Report you would have noticed that fertility in the next 40 years makes no difference to what they were talking about, and that is true. Indeed, if you were looking at government expenditure, not having any children for the next 25 years would reduce government expenditure.

Ms HALL—If no-one ever had any children, it would eventually end up getting rid of all government—

CHAIR—But it would surely drastically affect the economy and the tax base.

Ms HALL—We would not need it.

Prof. McDonald—I have not sent the paper to you, but we did some projection work of labour forces for 16 developed countries, and some of the results are quite shocking—that a country such as Japan is facing a fall in its labour supply over the next 40 years of 20 million workers.

CHAIR—Is there anything Japan can do now?

Prof. McDonald—No, Japan is in real trouble, I think.

CHAIR—And they have had no real tradition of migration.

Prof. McDonald—Yes. I have just received a newsletter from Japan and there is a little box celebrating the fact that there are 200,000 foreign workers in Japan, which is almost nothing.

Ms ELLIS—What is Japan's population?

Prof. McDonald—It is 120 million.

Ms ELLIS—They have significant problems with ageing, and they are dealing with—

Prof. McDonald—It is not just in migration; it is also in fertility, because of the nature of Japanese society, the conservative nature of women, work, and the fact that it is very difficult to shift. They have had inquiries. Interestingly, the one that I really like about Japan is a government inquiry that concluded that the pill should be made available in Japan, and now it has been. The reason for that is that it is a female method that puts the power in the hands of women. They felt more willing to have children if the power not to have children was in their hands. That is an interesting dimension. That was a Japanese government inquiry that came to that conclusion.

Ms HALL—I had someone give me the solution to the ageing problem, which is that the pill and any form of contraception should be taken off the market. That was their answer to solving the problem.

Prof. McDonald—It works for a year! Fertility rates in Australia in the 1930s were very low and they did not have all the contraceptive technology in those days. Indeed, in the European countries, the fall in fertility from high levels down to relatively low levels was done very largely with the withdrawal method—very simple methods.

CHAIR—Are there any more questions?

Ms HALL—No. Thank you for a very thought provoking submission and presentation.

CHAIR—If anything arises—and I am sure we will think of things that we may want to put to you—could we write to you?

Prof. McDonald—Most certainly. I have a couple of other papers I should send to you.

CHAIR—Please do. We will have them as exhibits for our inquiry.

Prof. McDonald—I have one coming out in a book fairly soon, which is a discussion of population policy, so I will send that to you as well.

CHAIR—Great. Thank you very much.

[3.34 p.m.]

MUNDY, Mr Gregory Philip, Chief Executive Officer, Aged and Community Services Australia

CHAIR—Welcome. Thank you to your organisation for making a submission to the inquiry. I remind you that proceedings of the committee are proceedings of the parliament and, as such, any attempt to mislead the committee is a contempt of the parliament. Would you like to make a brief statement?

Mr Mundy—I might speak very briefly to the submission, which I deliberately kept brief for the committee because 40 years is a long period of time. It struck me that a high-level overview rather than detail about things that might need to be done in the next six months was really more appropriate.

CHAIR—That is right; thank you.

Mr Mundy—I will start by re-emphasising the importance of aged care in the context of the broader ageing debate, because sometimes people say, 'Well, only seven per cent of older people are in residential care and only 20 per cent of people use care of any sort.' But if you look at the chances of an individual using care, in the case of women it is over 50 per cent at some point in their life. So it is a more significant feature than people sometimes give it credit for. We do it quite well, but we made the point in the submission that we did not get to the point of doing it well by being complacent about how we do it now. I think we need to be vigilant and not satisfied about the way things are going and to raise the issues, identify the rough corners and address them progressively.

In our view, probably the biggest issue from a public point of view in aged care is access to appropriate services. We have identified a number of dimensions to that, many of which are on people's agendas, and we are reinforcing them to the extent that they are and highlighting them to the extent that they are not. Firstly, I think that there is a lot of agreement that there are too many seams in the system. There are too many barriers that arise for other extrinsic reasons that actually get in the way of our members as service providers doing the best they can and certainly get in the way of consumers accessing appropriate services. There are some things the industry can do to address that itself. We are developing an agenda jointly with the Australian Medical Association and the Australian Society of Geriatric Medicine, identifying the list of issues which irritate both sets of members and working out where the common ground is and what things we can do collectively to address it. That will also identify things that governments, both federal and state, also need to do.

The root cause of most of those is actually the Constitution and the division of labour between the Commonwealth and the states. We would never put all our eggs into that basket and say, 'If you fix that, everything else will be fixed,' because that it is not true and it might not happen. You only have to look at the media stories about the health care agreements in the last couple of weeks to see evidence that that friction underlies a lot of the rough edges in the system.

It also gives rise to some gaps in the array of care services that are available for older people. I think the principal one that we would highlight is the area at the very high end of residential care, above the level of nursing home care that was contemplated five years ago, and between that and hospital forms of care. It is done differently in every jurisdiction. The availability of services is extremely patchy. If you live in one area, you can get them; they are just not available in another. This is almost speculative, I suppose, but in my view it arises from the fact that it sits squarely between the responsibilities of the Commonwealth and states.

Nonetheless, regardless of its genesis, it is an area where there is some current focus. It is possible to fill those gaps. I give the example of the Adelaide project. People are doing good work in filling them. There needs to be more of that type of work to fill that gap. In our view, that has the potential to actually improve the overall efficiency of the system. A strategic investment in that area might well be a genuine demand management strategy. To the extent to which you can rehabilitate people and send them home or send them to lower levels of care, you are actually taking a resource pressure off the entire system.

We also think—and we know this as a challenge that both we as providers have to respond to and probably government as a purchaser of services has to—that we will need a more diverse range of services for older people in the future. I am sure many of the groups that appear before this committee—the consumer groups and so on—will touch on that in some way, shape or form. People talk about the baby boomers being a more demanding generation, but even if you do not necessarily want to subscribe to that argument, the very fact that there will more older people means that there will be a more diverse group. It just follows.

We currently spend $4.5 billion on, basically, one set of products—institutional care in a congregate setting. If you put it that way and ask the question, 'Is that likely to be sufficient for the future?', it becomes a rhetorical question. We think it will not be. Our members are certainly interested in developing new and perhaps more flexible and innovative ways of meeting people's needs. I think that will be a demand that is placed on us and, to the extent that governments are funders, it is a demand that is placed on governments too.

Lastly, there are some questions about the quantity of service that is available in the system. We have argued in our submission that changing the mix might be more efficient. But probably the real pressure point, apart from the one I have mentioned between hospitals and aged care, would be on the community care side. Everyone agrees that there is a trend towards community care, consistent with what older people want. It is consistent with government policy, but we probably need to recognise that there will be a need for a greater level of investment in that area in the future. Having said that, we also argue that there is quite a lot of work that needs to be done to the community care system if it is going to be capable of picking up that role to a significant extent in the future.

Quality of care is obviously very important both to us and to consumers. There is some work currently going on around price. I would say at this early stage in the current pricing review that it looks as though the major problematic areas in terms of price for residential aged care would be around capital and around indexation to make sure people are not continually falling behind. Our own assessment of the risk to quality of care is that the technical quality of care interventions is holding up to date, but what in our view has tended to suffer over the last period, starting progressively, are some of the human touch type services in residential care—the ability of staff to spend a bit of unstructured time with residents, to read to them, to do all

those sorts of things that probably make a more important difference to their quality of life than some of the things that we actually measure and count. That sort of area—because it is soft, because it is not measured and because you can get away with not doing it—is vulnerable to cost pressures in a quality sense.

We also make a case in our submission that there is a need for investment in the future of the system in terms of research, developing the work force and so on, which I see is very consistent with the thrust of the inquiry. There is an initiative which I did not catch in this submission which is relevant, that is, that there is a committee looking at trying to consolidate the research effort in aged care which we are a member of. It goes by the lovely acronym of BARC—building ageing research capacity. So there is work going on in that area that we certainly think is important to participate in.

We devote a bit of attention in our submission to older people with special needs, which I think is important. It is a particular, though not exclusive, focus of the not-for-profit and charitable sector. Other people do do work in that area, but it is probably fair to say that the lion's share of that sort of work is done by charities. We have talked about the number of different groups. It is important to make the point—it relates to the earlier one I made about diversity—that not all older people in the coming generations will be affluent. Many of them will be more affluent than the current generation but many will not be. Sometimes when people talk in broad terms about the coming generation of older people, they actually forget that, even though three-quarters of older people might be better off, there is a quarter that will not be and we ought not to forget that. I am sure the committee would never do that anyway, but we must be careful that we do not forget about those people and come up with a model that ignores the fact that they will still be there.

One of the issues that is probably worth highlighting—and I am sure people will be making far more detailed submissions on this—is the non-English speaking population. That is going to hit some very impressive peaks quite soon. The work that the Myer Foundation did in developing their vision for aged care includes figures that indicate that by 2011, which is only nine years away, 40 per cent of the population in care in Melbourne is going to be from a non-English speaking background. That makes it mainstream; you have to think of it in a different way. The figures for other capital cities are in the high 30s. It will pass but during that 40-year time frame it is going to be a major challenge. There are others better qualified than I am to say that one of the things that happens with older people whose first language is not English is that they lose their English capacity once they leave the work force. It is an enormous challenge to come up with appropriate ways of meeting those people's needs.

CHAIR—So for an organisation like yours, your members are already facing an ageing work force, but presumably you will be requiring people with those language skills as well?

Mr Mundy—Yes, we are. There is probably an unresolved set of policy settings currently. About five or six years ago we were setting up ethnospecific services. There are some tricky issues for government in doing that, because the peak demand for each particular community tends to be very short lived. Some of the groups that came to Australia as displaced persons in the late forties have already peaked in terms of their age structure. They have reached their maximum and will steadily decline. So when you are building things with bricks and mortar, like nursing homes, there are some challenges but they are not going to go away; they will get more significant in the next decade in particular. We have issues like finding people with the

language skills. For example, we have one organisation in Victoria that caters for elderly Dutch people. They have the double challenge of finding skilled nurses who can speak Dutch. Everyone has difficulty finding sufficient nurses, but to add a criterion like that it is a particular challenge. They have responded to it very well, I might say. They have worked out how they can manage with fewer nurses, which I think is very clever.

Rural and remote care is an issue that we will certainly be prosecuting in the short term in the context of the pricing review. Our view is that in order to provide access in rural areas of Australia it will be necessary to pay a premium for that service. There may be scope for efficiencies, but at the end of the day it will cost more to provide localised access to aged care in rural areas. I think that is a bullet that we need to bite, to use the colloquial expression.

CHAIR—Regarding the model of collocation with a district or community hospital, you are saying that as the community hospitals are closing then you may not have a purpose-built facility.

Mr Mundy—That is right. You may not need a hospital, but you will need the aged care, unless you are going to ship people an hour's drive away for the last three years of their lives, which is a cruel thing to do. I think it will cost money to avoid doing that in some places. The other thing that is worth noting about rural areas is that we will go through a period in the next 15 years where the growth in the number of older people in rural areas will be higher than in metropolitan areas. This is because the younger people have left and there are more babies being born in cities. Rural areas become the areas with the highest concentration of older people for about a 10-year period, which is completely different from what we have had to date where the concentration has been in inner cities and so on. Again, it is an issue that is not going to go away. I have already said what needs to be said about financially disadvantaged and homeless people. We should not forget about those who are most disadvantaged. Providing services to that group is a challenge. It is done excellently well by many organisations and it is really a question of keeping those people on the agenda.

Lastly—and I guess this is the closest thing in our submission to pure self-interest from a provider perspective—we think it is very important to maintain capability in the provider sector. The innovation that we have today came from providers interacting with their clients, identifying needs and developing solutions. It tended to get overlooked in some of the approaches to funding in the last decade, where people looked at buying a product and purchasing services. The notion that you might want to purchase something different in a year's time, and that someone has to work out what that is and develop it and so on, might be overlooked. I have to say I have been encouraged to date by the work that the pricing review have done. They have explicitly identified that as one of the things that they want people to make submissions on. It is possibly not an accident that they have done that. But it is important to think, particularly with a long, 40-year time frame, about the aged care of the next 10 years and who is going to invent and develop the models. We need to invest in the industry if it is going to grow. That is basically a brief summary of our submission. I am happy to answer any questions.

Ms ELLIS—Is the Acute Transition Alliance in Adelaide a pilot? From the way you have worded it here, it sounds like it may be.

Mr Mundy—It is new. It has a combination of funding sources. It has some funding from the state health department, it has some aged care funding from the innovative pool and it has some other sources of funds.

Ms ELLIS—Do you know where we would be able to get some detail on how that is progressing and what it comprises?

Mr Mundy—The best person to contact would be Mike Rungie at the Aged Care and Housing Group in Adelaide.

Ms ELLIS—Could the committee do that, Mr Chair?

CHAIR—Sure.

Mr Mundy—I can certainly provide his contact details.

Ms ELLIS—It would be terrific if we could get that information.

Mr Mundy—The work they are doing is really interesting. It is new and they are learning as they go along, but one of the things that Mike was telling me last year was that, from the people they had selected, something like three-quarters of them were able to be diverted to some less intensive form of care than might otherwise have been the case. Of course, they were selecting people for whom the program would work, but it is exciting stuff.

Ms ELLIS—Is it an ongoing program? That is the point I was trying to discover.

Mr Mundy—Yes, very much so. It is very interesting. They are not the only people doing it, but it is probably a good example with a very articulate spokesperson.

Ms ELLIS—Maybe when we go to Adelaide we should visit it.

Mr Mundy—They are doing other things too. That is part of a whole set of initiatives that the aged care industry and the health care industry are taking in Adelaide. There are examples in Newcastle, for example—Pacific Care, I think it is called—and in Wollongong, but they tend to be isolated examples; they are not a standard part of a whole array of services available everywhere. That is the point we should aspire to get to.

Ms ELLIS—That is why I think it is worth looking at. Could you expand a bit on the comments you make in your submission about the planning arrangements and the current ratios for Commonwealth funded places? We are all aware of the formula that is currently in place. I have some views on that and I know a lot of other people do. Could you expand for us a bit more on what you think about that?

Mr Mundy—I think it is about time we had a proper review of those arrangements. They do not produce what you might think they produce. The interesting thing is that, since the government developed the Ageing in Place strategy, whereby people in low care can move up to higher care, I think it is showing us that we need more high care and less low care, because we do not have 40 per 1,000 people in high care; we have 50 something.

Ms ELLIS—I think 50 to 40 to 10 is the way they do it at the moment.

Mr Mundy—The current ratio is 40 high care, 50 low care and 10 of the packages, but Ageing in Place has actually taken the high-care figure up to above 50, so there is more demand for high-care places than the formula says, and we probably should recognise that. We would argue that it is worth investigating whether an investment level just slightly higher than for nursing home care into areas like rehabilitation and so on might actually meet people's needs better and reduce the overall level of demand. We would certainly argue that we need to look at the whole array of aged care services rather than narrowly at the ones the Commonwealth funds. Where that comes out most sharply is in community care, where they very carefully plan the 10 CACP places. That is what they have control over and that is what you expect, but that is a figure of less than a quarter of the total community care effort. Most of it is in the HACC program, which of course the states run, and it does not really make sense to spend a lot of time carefully planning the CACPs when the bulk of the system is done separately. It should be looked at slightly more broadly.

Ms ELLIS—Am I right in suggesting that the difference is that the CACP person is ACAT assessed and the HACC program person is not?

Mr Mundy—That is correct.

Ms ELLIS—So there is a distinct difference there.

Mr Mundy—They are different but, if you look at the people using the two services, it would be hard to distinguish between them.

Ms ELLIS—I understand that, but you cannot get into one without ACAT and you can—

Mr Mundy—You have to have an assessment usually for a HACC service, but it is not that sort of statutory assessment under the Aged Care Act.

Ms ELLIS—No, it is a different regime.

Mr Mundy—There are all sorts of interface issues there, which we have hinted at in our community care paper. There is quite a bit of work that needs to be done to sort that out.

Ms ELLIS—The reason I am asking this is that there is quite a discussion, or a thought going around, about just how future planning should be when we talk about high-level and low-level care. The majority view is that we are not putting enough attention to high-level care. At the other end of the spectrum, to what degree are we really fully and properly utilising the CACP process?

Mr Mundy—Both of those are very good questions. I think that prima facie we could do a lot better in both areas. I do not subscribe to the extreme view that says low-level care will disappear.

Ms ELLIS—No, I don't, either.

Mr Mundy—I think it will reduce, but I do not think it will disappear. One of the reasons I say that is that we know that one of the things that will happen during this 40-year time frame is that there will be a relative shortage of family carers, because there will be fewer children to do it. In Australia, spouses and children provide that care. So one of the corollaries of the age pyramids that your previous witness talked about is that there will be fewer voluntary carers. The first thing that will impact upon is people's ability to remain living in the community, because carers make that possible. I think that is actually going to prop up the demand for hostel care, as we used to call it. It is one of the reasons why people seek hostel care.

Ms ELLIS—Does it also illustrate, on the other hand, the need for any government to be far more serious than to use—for the sake of this discussion, I will just use the critical word 'rhetoric', although it is not all rhetoric—the rhetoric that everyone wants to stay in their own homes, so the government is going to allow that to happen and is going to support that as the best outcome? Of course, it is the best outcome for those for whom it is possible, who wish to and whose circumstances allow it to happen. But it will not work successfully unless it is properly, fully and adequately supported and resourced in a really cohesive way, so that it is in fact a viable, true option.

Mr Mundy—I think we would agree with that. Certainly, we have identified the need for reform in community care. The Myer Foundation paper—I had a bit to do with putting that together—really has the premise in it that, if we are going to place this great reliance on community care, we have to fix it so that it is capable of sustaining that burden. I think that both of those things are true. I also think that there are probably limits to the extent to which people can be supported in the community practically, safely and also, being realistic, economically.

Ms ELLIS—Do you have a view about those people who are not physically frail, who are actually ambulatory but who have a dementia problem? Where do you see those people fitting into this new approach? If we agree that high-level needs are there, that CACP community needs are there and are paramount and that that level sits there in the middle and needs to be catered for, where do you see dementia fitting in?

Mr Mundy—I do not think that we are in a position in this country, really, to answer that properly. I think we need to do some work about distinguishing levels of need for care for dementia. We had an interesting discussion with the Department of Health and Ageing last year about that. They showed us a typology of different levels of dementia care. I think that is an important tool that we need to be able to answer that question. At the very top end you are talking about people who need psychiatric services—their needs are so extreme that they need very specialised attention.

Ms ELLIS—That is almost at a psychogeriatric level?

Mr Mundy—Yes, or even the acute psychiatric level in some cases. At the other end, people might need a little assistance in the early stages of, let's say, Alzheimers. They might need a little assistance to help them with memory things. You can go a long way with memory aids and those sorts of things. There are all sorts of technologies that people are experimenting with that are clever at finding simple ways of helping people with early memory problems. I have seen a web site that had a talking tap which shouts at you if you leave it turned on. It is those sorts of little things sometimes that actually make a lot of difference. One of the reasons people seek residential care early is that they have lost the confidence to remain living at home. Sometimes

a few of those things that actually support them by filling in little gaps—we probably all need reminders about things like that—are well worth exploring. That is the sort of research agenda that I think is quite exciting and needs to be pursued.

If you are interested in that particular example, it is called the Gloucester Smart House and it is on the University of Bath web site. I am pretty sure that is correct. I was looking for something else when I saw 'talking taps' and I thought, 'That's quite clever.' There are also visible signs if you have left the stove on and there are time delay switches. When people have very early memory loss conditions, there are all sorts of people much more expert than I who can support them and preserve their independence for as long as possible. But, as you go up the spectrum, it becomes progressively more difficult. We have had a lot of success amongst our members with dementia hostels where, if you design the environment carefully and specifically for that purpose, you can maximise the degree of freedom and autonomy that people have. If you take the hazards out of the environment then you do not have to have more restrictive forms of care. The specialised dementia program has stalled currently. There was provision for it as a ratio as people were saying, 'Yes, we must build more dementia hostels,' but I am not aware of a systematic plan for how many we should have or whether that is the right way to go. There was a debate about whether every aged care facility should do it or if some should specialise, and that has never really been resolved.

Ms ELLIS—That comes back to the basic law of the planning—

Mr Mundy—Yes.

Ms ELLIS—which is what we are all about.

Mr Mundy—We ought to make a considered decision about how we deal with that in the planning context. Because dementia is so prevalent, possibly saying it is a generic problem is correct. But then we need to make sure we are getting enough of purpose-built facilities for that middle range of the seven levels of dementia to cater for them, because the ones that work, work very well.

CHAIR—How do you see the mix between residential care and community care in the future? What do your organisations anticipate in the future?

Mr Mundy—I think that is the right language to use because I do not think any of us can be definitive. We anticipate that a larger share of aged care in the future will be in the community, particularly if it is supplemented by more carefully designed housing that meets the needs of older people. I think the growth is such that our members' livelihoods in residential care are not at risk but, in terms of growth, we anticipate that more of it will be in community care relative to in the past. It is one of the reasons we changed our name as an organisation and put 'community services' in the title. It is one of the reasons we are happy to invest in working in community care. Our members do see that as a more significant part of the future than it has been up to this point.

CHAIR—So they see a probable area of growth as being involved in the delivery of services in the community.

Mr Mundy—Yes, I think so. There is no question really. Everyone thinks so. That is what their consumers tell them, it is what government tells them and they see that that is the way of the future.

CHAIR—Does your organisation have any views on adaptable housing?

Mr Mundy—We do. It is an area where we have not done a huge amount of work ourselves, but we certainly see it as being a necessary complement to the community care strategy. Ideas such as doing something about the Australian standard on adaptable housing, which I think we put in the Myer Foundation recommendations, would be worth doing. I am told that building a house to that standard adds between one and three per cent to the price, but no-one has any data on what it adds to the resale value of that house. In other jurisdictions—in Holland, for example—they have set targets, and it becomes a marketing advantage to say that the house is adaptable.

Ms ELLIS—Why does it cost between one and three per cent more? Do they say why?

Mr Mundy—Yes, but I do not think I could be definitive.

Ms ELLIS—It would be good for us to look into that.

CHAIR—I have heard other people give a much lower figure because what they were looking at were wider doors and places where you could put studs so that a rail can be put on later.

Mr Mundy—Wider doors would add a tiny bit. I think the person who said one to three per cent was being deliberately conservative about the trend. There are things like not putting power points in skirting boards where you have to reach down. If you put them up higher, it makes it much easier for older people with no flexibility in their backs to use them. That would cost money—you have to rewire the house.

CHAIR—To move it. I think it is more a greenfields site, a new house and so on.

Mr Mundy—I could see there might be some additional costs. It is quite plausible that, if you did the cost benefit calculation, you would come out well ahead. It would be an investment. I know the Japanese, who developed a very elaborate plan for their ageing population, set quotas which they did not come anywhere close to meeting. It would be a strategic investment, adaptable housing, not only for older people but for anyone with a disability.

Ms ELLIS—It is simply a case of, if enough people were doing it, wider doors would become standard as well in layman's terms.

Mr Mundy—I made a suggestion to Minister Andrews in one of the discussions about strategy. We did smoke detectors and made them compulsory. Some places are now doing it with grey water diversion. The city of Geelong is talking about doing it.

Ms ELLIS—There is nothing wrong with wider doors.

Mr Mundy—Maybe we should think about making that a standard for our housing stock. The other issue with housing stock is that much of it is too big for older people. We cannot fix that retrospectively. There is a lot of scope. Our members provide well over 40,000 independent living units. As well as the funded residential aged care, they are providers of older persons' housing in a major way. Many of our members would acknowledge that it could be done a lot better and more creatively than the current stock would provide for but it is one of the things that we do. Legally, they are probably like retirement villages. Many of them cater for low income people, so there is an overlap with low income housing. Our organisation has just surveyed our members to get a better handle on what is out there.

The Commonwealth government used to fund the capital for independent living units up until the early seventies. Many of our members have been building them ever since, because you can sell nice houses to older people quite easily. We have got to the point where we do not know systemically what we have or what the characteristics are. We see housing as very strategically linked to that likely mix of future services and because our members are providers of services in a big way, it is something that we have identified as an important area of work for us as an association.

CHAIR—In your submission, you mention clients with special needs such as mental health issues and so on, who sometimes do not have their needs met appropriately. What about having things like case management, service coordination and innovative policy, and services approaches for people who perhaps do not quite fit into either the disability, aged care sector or even the well mental health group?

Mr Mundy—There is a need for more creative work around people whose needs do not fit the neat program guidelines. There have been lots of pilots and demonstrations where they always seem to strike difficulties, then become generalised across the system. The pilots work really well and everyone says, 'That's terrific', but measuring how much you would need across Australia and then putting that in place is usually the bit we do not do. You need to be careful about exactly what people's needs are. One of the problems from a consumer perspective that providers identify with is capture by the first service you go to to find out if your needs are ones they provide. It is a tricky area. It always pays to do further work. There are good examples of things that work and more needs to be done. Mental health issues per se should be dealt with by mental health professionals regardless of the setting. It should be easier for them to provide mental health care in our system. Perhaps it comes back to the first point, which is that we need to make sure we minimise the barriers we set up between service systems. That is not a particularly helpful answer. It is the orientation.

Ms ELLIS—People with a disability generally, not mental illness per se, and their ability to age is something we all applaud, obviously. Can you discuss briefly where you see the aged care sector in terms of dealing with and providing for people with disability as they age?

Mr Mundy—I will answer that in two ways. One is that our community care members are not keen on identifying themselves as aged care services. They would say that they provide community care to a whole range of people that have needs they can meet. They call themselves aged care services because that is where the funding comes from, but it is not how they think of themselves. From the point of view of providing them with good services they would see no particularly good reason for distinguishing between people who have functional disabilities due

to age and those who have functional disabilities due to other etiologies. It is a question of training the staff appropriately to meet their needs.

In terms of residential care, we have been working with the Younger People in Nursing Homes initiative around, specifically, the 6,000-odd younger people who are in nursing homes. Currently it is probably the only service system across Australia that can provide the level of care those people need. That is why they are there and we are certainly not proposing to say that they should not be there.

We would agree with the disability sector, if you like, that those services often struggle to provide age appropriate environments for those younger people. I know that the aspiration of the disability sector would be to set up specific facilities for those people. They know, and I know, that could well be an expensive option. My prediction—and this is not our policy—would be that the model of some residential care services developing a speciality and building special parts of their facility could well be somewhere between those two extremes.

Ms ELLIS—What about housing generally and community support for people who are not nursing home people at all, say, the intellectual disability category—the Down syndrome folk and people with spinal injury? There is a whole raft of people who live with disability through their lives, who used to die 20 years earlier than they are dying now. We need to cater for them.

Mr Mundy—Yes, we do. There are two points I would like to make about that. Firstly, we should not assume that they should simply go into the aged care system when they get older but we should say that they have the right to do that the same as everyone else. It is one of the dimensions of the Commonwealth-state divide that I talked about before. Some state disability programs say that when people with disabilities turn 65, they become the responsibility of the aged care system. We do not actually say that about anyone else. The sort of policy position, if we had one, would be to say, yes, they have a right to use the aged care system but it should not be assumed that is the best solution.

Ms ELLIS—This is really a very big question. I guess we are really saying that there are non-disability people who go into aged facilities of low level and ageing in place occurs for them where it is possible. Then you have the people I am referring to who live with disability and, if they are able by some luck—and it is not always easy—to find accommodation some time in their life that is helping them live with their disability, they should be able to age in place.

Mr Mundy—That is what I am trying to say. That is a better way of putting it. I think so, yes. Why not?

Ms ELLIS—And if they need to go into an age facility, because there is a medical or obvious living need that puts them there rather than the assumption that they are now over 65, then in they go, they actually age in the place where they are.

Mr Mundy—Yes. It is an argument we would suspect is more driven by considerations about who is paying for the most appropriate service.

Ms ELLIS—It is a philosophical thing that we have to go through; it is a debate we have to have.

Mr Mundy—It is. The normalisation philosophy that the disability sector used in the 1980s, I think, is still entirely valid. We should assume that people with disabilities are exactly the same as everyone else except where their disability gives them a handicap, an inability to do something. That is the right mind-set to bring to bear.

Ms ELLIS—On a slightly different issue—regarding the pricing review. There is a bit of good thought around, that I endorse, that with aged care services we really should talk about and create a benchmark of care. To what degree would that have an impact on any pricing arrangements? They seem to be interlinked to me. If we have a benchmark of care, if we adopt a theory that we believe in a benchmark of care for aged facility service delivery, it equally—or more importantly—should stretch across into the community delivery of care as well.

Mr Mundy—Any pricing system needs to have a clear idea about what the product is that the funding system is supporting. We do not have that currently; there is no clear picture of what is the product—

Ms ELLIS—It is driven by money available to give a service, rather than a service that we see is preferred and then the cost to provide it being met. Which is the horse and which is the cart?

Mr Mundy—Yes. We would support a clearer picture about what it is that the service should comprise, and then—

Ms ELLIS—And then funded.

Mr Mundy—That, or we would certainly not be opposed to some degree of consumers contributing to the cost.

Ms ELLIS—Whichever way.

Mr Mundy—Who pays is a separate question—

Ms ELLIS—Yes.

Mr Mundy—but it is important that there should be greater clarity about what the service is and what the expectation is. That is why we have identified what we think is an area of deficiency in what our members can do in residential care, and that is that the high-touch rather than high-tech type of care has been lost in the name of efficiency in the past few years. A benchmark of care would need to be carefully done because the danger is that you would have an overly standardised product that everyone would have to do, but we would certainly support a clearer picture of what needs to be provided. From our point of view we would be wary of making it too rigid; we would be wary of defining it in terms of inputs. There are some people who, when you say 'benchmark of care', would immediately take the next step to ratios of this type of staff to that type of—

Ms ELLIS—I am not talking about staff numbers.

Mr Mundy—That does not work for us. Some people would use a benchmark of care to immediately invoke those images. We would say that all that is going to do is spend money; it is not actually going to improve the service. But if that is not invoked by 'benchmark of care' then, yes, I think we could use it.

Ms ELLIS—But you would agree that we need to define the product better than we have?

Mr Mundy—Yes. We still do use the benchmark of care term, but we have come across the problem that other people picture something quite different to what we had in mind. But we do need greater clarity about what the product is. The expectation is not that sharply defined and, while that is the case, that is a problem for consumers, for government and for us.

Ms ELLIS—According to your submission you have a concern that the pricing review does not include a pricing review of community care services.

Mr Mundy—It does not; it is explicitly a pricing review of residential aged care. I would concede that you cannot do everything, but if price is an issue for residential aged care why wouldn't it be for community care? From our perspective, one of the dangers in community care is that the consequences of not providing enough—not enough in quality, not enough in quantity—are hidden. It is much more obvious if you need a nursing home and you cannot get one, which is the case in some places. In community care, what usually happens if you cannot get enough is that the family fills the gap. It is a less obvious problem, but it does not make it a less real one or a less pressing need. So there is as much need to look at the price in community care as there is in residential care. The current review is not doing that. I suppose you cannot do everything at once, but it does need to be looked at.

CHAIR—You mentioned rural and remote areas in the submission and a figure of $450 million. Is there any alternative way of delivering these services in rural and remote areas? I appreciate your submission does highlight that the cost structure of delivering the services is different.

Mr Mundy—There is both a need and a willingness to look at more flexible models of service delivery in rural areas. We have had some experiments around multipurpose services and rural health services, which I think was the bureaucratic name for them. Some of those models were actually much less flexible in practice than people thought. There is a number of communities that felt that inappropriate solutions were being imposed on them, but that does not mean to say that the effort and the spirit of it was not well intentioned. But, yes, I think there is scope to be more flexible.

At the end of the day there will be some people whose care needs are best and most efficiently met by something like our existing aged care services. We should not hide behind innovative and flexible models and deny that that is actually the case. At some point, some people are going to need residential care. In the last two years of life well over half of people need residential care. If we do not want them to have to go from, say, Captains Flat to Canberra—it is probably not that far—and get cut off from all their relatives, then they need the residential care there. It can be associated with the health service; it very often is. Hospitals as aged care facilities are dangerous bedfellows because they tend to suck all the resources away, but it is up to people to work out what compromise needs to be made in a particular community to best meet their needs and aspirations.

CHAIR—There is a shortage of nurses right across the health sector and internationally as well. What is your industry doing to address that shortage?

Mr Mundy—We are doing a number of things. We are participating in a number of projects to increase the supply of nurses. We have come up against a short-term obstacle which is probably very relevant to the work of the committee. We have some really good little pilot projects running through the ECEF process that are getting younger people interested in nursing careers. What we are currently finding, though, is that there is a shortage of university places to train them. When the first round university offers were made just after Christmas, in many jurisdictions they were turning away two out of three applicants for nursing schools. I thought, 'Well, why are we encouraging people to select this as a career—and doing quite well—in circumstances where the universities aren't able to train them?' That is one step forward and two steps backwards, from our point of view. So we could get more nurses than we are getting if we are prepared to fund the university places. Even the initiative of the government to provide rural nursing scholarships has come up against that obstacle. They have awarded all the scholarships, but not all the awardees have got places, so they have to look at second round offers. That is a short-term problem and we will certainly be saying something about that because it is perverse.

There are things that we can do on the supply side. We have from time to time looked at schemes that people have put to us and our members about bringing nurses from overseas. I do not think that is a long-term solution, though people could try it. Thailand, I am told, has an excess of nurses. It is something to do with the fact that a member of the Thai royal family was herself a nurse and it has inspired people. It is not a large part of our thinking and not a long-term solution. The other thing we need to do is be very clear about the tasks that you need nurses for and the ones that you can do safely in other ways. We do not think the shortage of nurses is going to go away, for the reasons that you have articulated—it is worldwide; it is not just Australia.

We need to be very careful that we are not wasting the resource that we have now. We suspect there are two ways in which we are wasting our resources. One, which certainly the current minister has acknowledged, is that we tie up too much of their time in doing paperwork rather than nursing. There is no shortage of evidence that that is the case, and it is hopefully being addressed. The other one is that we need to have a much more flexible division of labour between registered nurses and other trained carers. Currently our registered nurses do tasks that others could do quite safely. Pushing around a trolley full of drugs for two hours a day is not a really good use of a scarce resource, in our view, when you can safely administer medications through blister packs with appropriately trained staff. That is not a popular notion with the professional nursing groups or the industrial nursing groups. It is our view, though, that there is a reality out there that we need to deal with and we need to work out how you can use staff that are more readily available to deliver care in a safe fashion.

The availability of certificate trained staff in aged care is a success story. There are tens of thousands of people who have done the certificate III in aged care in the last three years. We have trained lots of people to be able to take up that sort of caring role. We need to develop workplace arrangements that allow those people to take up the slack that we cannot meet with nurses.

Ms ELLIS—Why aren't they going in?

Mr Mundy—They are, but there are all sorts of restrictions around what they are allowed to do and what they are not allowed to do. We will deal with those in another arena and no doubt sparks will fly. But we think it has to be done.

CHAIR—Thank you very much. I should ask if you have any objections to the committee writing to you with any further questions which may arise.

Mr Mundy—Absolutely not. I welcome them.

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

Mr Mundy—It was a pleasure. Thank you.

CHAIR—On behalf of the committee I would like to thank all the witnesses who have given evidence at the public hearing today.

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

That this committee authorises publication of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 4.25 p.m