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

THURSDAY, 3 JULY 2003

SYDNEY

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON AGEING

Thursday, 3 July 2003

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

Members in attendance: Ms Hall, Mr Hartsuyker, Mrs May, Mr Mossfield 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 9.08 a.m.

NAIR, Professor Balakrishnan (Kichu), Professor of Geriatric Medicine, University of Newcastle; Director of Geriatric Medicine, Hunter Area Health Service

CHAIR—I declare open the House of Representatives Standing Committee on Ageing. Today we will hear from a range of superannuation representatives, clinicians, academics and the New South Wales government. The committee has previously heard of the importance of planning for adequate retirement incomes, including savings and superannuation schemes. Planning and appropriate research is also essential for appropriate care facilities and service provision. Today's witnesses will inform the committee of current thinking and future trends in each of these important areas.

I welcome Professor Kichu Nair to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of the parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Professor Nair has made a submission, submission No. 154, to the inquiry and copies are available from the committee secretariat.

Resolved (on motion by **Mrs May**, seconded by **Mr Mossfield**):

The committee authorises the publication of additional submission No. 159 received at the public hearing this day.

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

Prof. Nair—Thank you for inviting me to talk to you again. My written submission follows on from my previous submission and presentation at the private hearing in Canberra a few weeks ago. You have my submission there. If you would like me to highlight some of the issues or take questions, I am happy to do either.

CHAIR—We have your original submission here. One thing I noted is that on the second page you talk about the exposure of medical students to ageing in their training, and you say that some of the initiatives in the USA are interesting and worth pursuing. Would you care to expand on that?

Prof. Nair—Basically I believe, with my experience with undergraduate and postgraduate medical education in this country, that our doctors—both undergraduate and postgraduate—do not get enough exposure to geriatric medicine. This will be the major workload for doctors who qualify in the next decade, the next year and the next month. Chronic disease and geriatric disease training are not reasonably represented in undergraduate or postgraduate medical curricula. Most of our specialists—whether orthopaedic specialists or cardiovascular surgeons—do not get enough exposure to diseases of old age during their postgraduate training. In both our undergraduate and postgraduate training people do not get enough exposure to geriatric medicine.

CHAIR—How would you rectify that? In all of those training programs they certainly have exposure to patients from that age cohort all the time. So it would be something additional to the

current training. Perhaps I should also ask you: is it the case that, in physician training, people have a rotation through geriatric medicine?

Prof. Nair—Yes, they certainly do. If you are training to become an FRACP—the Fellowship of the Royal Australasian College of Physicians—they have a rotation system. If you are an orthopaedic specialist most of your patients are going to be older yet they have no exposure to geriatric medicine. Our specialists do not get any exposure to geriatric medicine. The bulk of an ophthalmologist's work is old age medicine, but they do not get any exposure either.

There would need to be a major mindset change within the specialist colleges to do that. It is the same with the undergraduate curriculum. Our own published data suggests that, even in the innovative medical schools in Australia, we do not have enough length or depth of exposure to geriatric medicine. So unless we have a national strategy to change the undergraduate curriculum to reflect what is seen in society it is going to be very difficult. I think we should have a national summit or similar to look at all these educational issues. We have not done that.

CHAIR—How is the issue of exposure to geriatric medicine being dealt with in the Royal Australasian College of Physicians?

Prof. Nair—There are some initiatives to train more general internal medicine specialists and geriatricians. Again, we have a long way to go. According to the AMWAC report we need at least 70 advanced trainees in geriatric medicine at any one time. That is our target—I actually think that target is underreported. We may need more than that in my personal view. We only have 48 or 49 trainees now. By the time those trainees finish their training another two or three years will have passed. It is the same thing with general medicine. General medicine has something like 40 advanced trainees now. When you look at the Australian inpatient population, approximately 35 per cent of our admissions are people over the age of 65. They occupy around 50 per cent of bed days in hospital. We need people with broader skills—like geriatricians or general internal medicine specialists—to look after our older hospitalised patients. We do not have enough of them to do that job. One of the reasons why our health care budget is exploding is that we have too many subspecialties. We do not have enough general physicians and geriatricians to look after people in a holistic manner.

CHAIR—I accept your points. One of the problems that we seem to have is that our younger doctors see the subspecialties as being much more attractive and, dare I say it, lucrative as well.

Prof. Nair—That is correct. To do that, we need more academic leadership and good role models in this country, and I think that there are people coming up. People like myself are happy to stand up and argue the case for geriatric medicine in this country. It is gradually happening but the trouble is that, by the time that trickles down to the advanced training level and we have enough trainees, it will be another 10 or 15 years. We have a big gap now. We have a dangerous disconnection between what is needed and what is available.

CHAIR—How extensive do you think the problem of polypharmacy amongst the elderly is within Australia?

Prof. Nair—It is very common. We have written about this, too, and I can forward my previous articles to the committee if you wish. I think about 12 or 13 per cent of our population

above the age of 65, consume 40 per cent of prescribed medications. If you look at the data, about 64 per cent of general practice visits end up with a prescription. They may need the medication. In 1996, 168 million prescriptions were written in our country. Something like 16 per cent of Australian hospital admissions do have a drug related problem. Some of the data collected and published in Australia suggested that up to 24 or 25 per cent of all the people admitted to hospitals do have drug related side effects. That is a primary diagnosis. It is very common. There are many ways of fixing this. Again, we have articulated this in the past.

The other issue is that, when people get older, there are more diseases: they need more medications. At the same time, when they take too many medications, their body handles these differently. The drugs interact with each other and they end up having side effects. We could do a lot of things. One report, again from Australia, suggested that we should do the right thing by communicating with GPs, pharmacists, specialists—all specialists looking after the patient. Often there are multiple specialists looking after a patient and often they do not communicate with each other. If we do the right thing, we might even save $118 per patient per year by issuing correct prescriptions. Over-prescribing is common, and some people or do not get the exact medication they need. For example, we know that older people with an irregular heartbeat do not get the right treatment. They have a heart attack; maybe they do not get the right treatment. They do not get the right treatment for osteoporosis. Over-prescribing and medication related side effects are common. At the same time, some older people do not get the medication they require. There are two sides to the coin.

CHAIR—In your submission, you also talked about the need for case managing older people, given that I think you said about 40 per cent at least of the hospital inpatient population are going to be older people. I think you were suggesting there is a difference from presenting in emergency, being seen in the ward or being seen in outpatients and so on.

Prof. Nair—That is right.

CHAIR—How would you change it within our tertiary hospital setting?

Prof. Nair—I think case management would be the way to go. Often an older patient comes to the emergency room and then waits in the emergency room for a bed in an inpatient ward. Then maybe they are shifted from ward to ward. In our own hospital, we see even the social worker changes. Social workers are assigned to a ward. A patient moves from one ward to another. The social worker, who is the case manager, changes. So there is no one spokesperson for the patient—not one single coordinator. If somebody could take on this issue and say, 'I'm going to look after this patient,' that might resolve it. There are some initiatives, but we have a long way to go.

Ms HALL—Professor Nair, I know that one of the issues that you have raised on many occasions has been the issue of accident and emergency and better training and identification of people when they present at accident and emergency. In addition to that, I am wondering about the interrelationship and the interface between acute hospitals and facilities, such as nursing homes and hostels, and the community care teams that operate in the community. Do you think that this needs to be coordinated better? Do you think there could be a way that could facilitate a quicker placement of older people in the appropriate facilities?

Prof. Nair—Definitely, because, as we were saying earlier, I think that case management is a major issue. Often case management is fragmented. Patients can move from system to system with different teams and different people looking after them. Patients can get confused with that. Case management would be the way to go.

Ms HALL—How do you think the delays between the two systems, when people are moving from one system to another system, should be addressed?

Prof. Nair—At any one stage, in our own system at our own tertiary hospital in Newcastle there are 20 to 25 people waiting to go to nursing homes or hostels. Because of that, people are waiting to get into the hospital. Then, because in our rehabilitation facilities there are also people waiting to go to nursing homes, acute care patients who need rehabilitation are waiting while the patients in the rehabilitation facility are waiting to go to nursing homes. It is a domino effect and, unless there is a major shift, I think this is going to get worse as the population is ageing.

Ms HALL—The other question I would like to quickly ask is about research. I noticed that you have mentioned research and the need for research. Would you like to expand on that a little bit for us?

Prof. Nair—Sure. We in the consortium of aged care researchers made a submission to the NHMRC last year. I think it is on the press or is just being published. It is called the Scoping Study into Ageing Research in Australia. We worked on it for a long time, and it has gone to the NHMRC now. What we found is that, in Australia in the year 2000, the six grants in aged care and gerontology were for something like $411,000. The total funding for NHMRC was $69 million that year, so we only get a very small proportion earmarked for geriatric and gerontological research. If you look at a similar situation, in the United States there is a National Institute on Ageing. In that same year they provided $US688 million for research. That is earmarked for ageing and gerontological research alone.

We argued in that submission that there should be an ageing stream in NHMRC to look after gerontological and geriatric medical research. There is also evidence in a very prestigious journal of science saying that, if we put money into ageing research, we are going to reap the benefits and save more money because we are going to look after older people in a more effective way. Maybe the public health system will improve through that research data and, in the long term, save us lots of money and improve the quality of care of older people.

Mr MOSSFIELD—Professor, in your submission you quote the number of hospital beds and the number of residential care beds but you say that, while the care for hospital based patients is of high quality, nursing home care is not coordinated and is often reactive rather than proactive. Would you like to expand on that?

Prof. Nair—I think there are approximately 55,000 hospital beds in Australia and something like 141,000 residential care patients—both in hostels and in nursing homes. As was mentioned in my submission, we give excellent care for our older people in acute care hospitals, but nursing home care is often left with general practitioners and they are struggling. We do not have enough general practitioners to look after these people. Often they can only go when they have a spare minute, if they have it—and often they do not have it. They go and do rounds whenever they can, so there is no coordinated approach.

A study done in Australia suggested that most of the care of older people in nursing homes is provided by male general practitioners who are in their 40s or 50s. It is older male GPs who are providing the care for most of the nursing home residents, because most of the female graduates who are qualifying now in medicine tend to take part-time jobs and often they do not have the time to do that. It is the major issue and we see it all the time.

The other related issue is that, even though we have more residents in nursing homes and hostels, most of the teaching is done in acute hospitals. Undergraduates never get exposure to chronic diseases and disabilities and older patients in nursing homes. There are some initiatives, but again we have to go a long way before we reach anywhere close to satisfactory at this stage.

Mr MOSSFIELD—Thank you. In your submission you raise the issue of ageist attitudes by doctors and suggest that, if doctors were exposed to older people earlier in their careers, they might have a more sympathetic attitude. Is this a problem, and how can it be overcome?

Prof. Nair—It is true—ageism is prevalent in the community and that is also reflected in the medical fraternity. It is a reflection on what is in society. There is some evidence that if we expose students at the most junior levels to healthy older people and then gradually expose them to sick older people their attitude will change. But often that does not happen. I think students will only see older patients in the fourth or fifth year of their course. Also, a lot of young Australians grow up not getting in contact with older people because of family structure, unlike in poor countries where they grow up in a combined family where the grandmother and grandfather are part of the team. They do not see that. There are some initiatives to do that—to break that barrier—but again it is only very minimal. As I explained earlier, unless we radically change our undergraduate and postgraduate curriculum, we are not going to cope with our ageing society. People always talk about 2020. The year 2020 is only 17 years from now and, unless we try to fill in the gap now, we will be in dire straits.

Mr MOSSFIELD—You referred to the value of vitamin D. You also referred to the fact that vitamin D is not easily available under the PBS. What is the reason for that?

Prof. Nair—That is correct. People get vitamin D either from dietary supplements or from sunlight. In Australia, even though we have a lot of sunlight, people do not go out in the sun. Older skin does not produce vitamin D. Older people and younger people put on sunblock so they do not get it. Something like 80 per cent of nursing home residents in Sydney have been shown to have vitamin D deficiency. That will give them frail bones and make the muscles weak, and they will fall down. The only food item fortified with vitamin D in Australia is margarine and you need to eat a lot of margarine to get enough vitamin D—or you get enough sunlight. The only way to give them enough vitamin D is to give them vitamin D tablets and they are not on the PBS. Often we ask older people to buy it on a private prescription which will cost $7 or so per month. It is very cheap drug and very effective but $7 is a lot of money for a lot of older people. If you ask them to take it on a continuous basis, some of my colleagues say their patients back and say, ‘I don’t buy it because I can’t pay for it.’ Simple things like vitamin D, which are cost-effective, which will cure a lot of falls and bone fractures, are not available on the PBS.

Mr MOSSFIELD—Do you think it should be available?

Prof. Nair—I think it should, and my colleagues think so too.

CHAIR—In your supplementary submission you talked about the need for more ageing research in Australia. Are there any particular areas in ageing research which you think would be cost beneficial and good avenues for research?

Prof. Nair—With my biased view I think all areas should be researched properly.

CHAIR—Is there no specific area within ageing research that you can identify?

Prof. Nair—I would only say that all avenues should be explored.

Mr MOSSFIELD—You refer to the various vaccinations for influenza and other things and to the fact that these are not being carried out effectively for older people, though they are for other age groups. Is that right? Are older people missing out?

Prof. Nair—The US Alliance for Aging Research said that older people do not get enough preventative care. It is very well documented. For example, the NHMRC evidence based guidelines on older people say that all older people above the age of 65 should be getting influenza vaccinations every year, pneumonia vaccinations every five years and tetanus vaccinations every five to 10 years. That is stated in the evidence based guidelines. But in our own research we have shown that older people do not get this 100 per cent at times. If this happened with any other subgroup of the population, they would be asking for this and there would be a lot of politicking to do it. I think it has been shown that the flu vaccination is cost effective and reduces mortality and hospitalisation, but it does not happen. It is gradually changing from our own research and pushing people to give older people evidence based care. It is changing, but we can go a long way in doing the right thing by these people.

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

Prof. Nair—Thank you very much for listening to me.

Ms HALL—I also thank you for coming and talking to the committee twice and for the quality of your presentation on both occasions. It was outstanding and really gave us a lot to look at and think about.

Prof. Nair—It was my pleasure to do it. I think this is a very worthwhile thing you are doing, and I congratulate you for doing it.

[9.43 a.m.]

FORAN, Ms Christine, Acting Policy Manager, Government Relations Branch, New South Wales Department of Health

GALLAGHER, Ms Elizabeth, Senior Policy Officer, New South Wales Department of Health

KATZ, Ms Catherine, Director, Government Relations Branch, New South Wales Department of Health

PICONE, Associate Professor Debora, Deputy Director-General, New South Wales Department of Health

HERBERT, Reverend Harry James, Executive Director, UnitingCare NSW.ACT

CHAIR—I welcome the witnesses to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of the parliament. I, therefore, remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Would you like to make an opening statement before I invite members to proceed with questions?

Prof. Picone—Yes. Thank you very much for agreeing to see us. I formally apologise to the committee for the lateness of our submission. I will go through and give you a broad outline of it rather than you trying to read as we go, then we could come back to some of the specifics. The way that the government has put together its submission is to provide an executive summary at the front, to detail some of the key issues and to make some recommendations that we think may be helpful to the committee on this important issue.

I have to say to you that, unfortunately, we come before you not to tell a good story but to discuss what we consider to be a very serious issue for the health of the people in this country. It is an issue that has been ongoing for New South Wales Health now for a long time, but we have noticed increased difficulties particularly over the last five years. We thought, with the committee's permission, that we would concentrate on the interface between the acute health care system and the aged care system because from our point of view that is where a number of the key issues are. It has also been the subject of discussion between us and the Commonwealth.

I think a fair comment at the beginning would be that in our view we are probably a few minutes to midnight in terms of what we need to do as a Commonwealth in relation to aged care, particularly for that group of older Australians over 80. We come to tell you a story of a lot of frustrations in terms of our negotiations with the Commonwealth. We are very glad that your committee is hearing these matters because it seems to be going nowhere endlessly and it is now starting to get quite serious every day in our health care system for the people of New South Wales.

I might quickly go through some of the issues. I know that you know them, but I will just retouch on them. One of the major factors influencing the demand on the New South Wales health care system around aged care is this demarcation between Commonwealth and state responsibilities. I will come back and touch on that a little later. It is the principal source of our frustration and the principal source of difficulties and pressures that have been placed upon our acute care system here in New South Wales. There is a lack of integration of services across health and aged care. A lot of that lack of integration is purely jurisdictional. It is purely an issue of what the Commonwealth runs and what the state government runs, and the inability of the jurisdictions to get together and provide a decent health care and aged care system for people in this country.

There is, in our view, a complete lack of flexibility and willingness by the Commonwealth to adapt any new service models. I have personally been leading the New South Wales Health negotiations for the last four years. I have been in health now for 28 years, which starts to show my age. I have to say to you that I have never in my career been as frustrated as I have been in trying to get some resolution for the care of older people in this state. It should be a matter of great concern at both levels of government.

Some of the facts that we know are that 13 per cent of the New South Wales population are 65-plus and use 39 per cent of New South Wales health funding. A lot of these facts will be evident to you but I might just quickly touch on them again. We have a group which the medicos have described as old old, and that is people who are 80-plus. It is a great pleasure for me to know that a 60-year-old is now like a 50-year-old, and that age thing is coming down. It is quite good. It means that you can have much more fun for much longer.

The 80-plus group clearly have complex and multiple acute and chronic disorders. I think we know about those. They are the rising population in emergency department attendances. The 80-plus attendances at the emergency departments have grown by an average of eight per cent per annum over the last five years. The New South Wales government has made specific programs for the care of people attending their emergency departments. I will touch on that later because it is such a significant issue for us in the health care system. In 2001 and 2002, metro public emergency departments treated more than 170 people over 80 on a daily basis. That is a lot of people in metropolitan Sydney, and I have not touched on the rural areas.

Currently, 1.5 per cent of the population are aged 85-plus. But, as you know, that figure is expected to rise to over four per cent by 2042. We spend a lot of time projecting into the future and talking about what is going to happen in 2020 and 2042 with regard to ageing, but the future is today. I do not know whether your committee is going to do any inspections of public hospitals, but every day out there this is a major issue for the New South Wales health care system. In my view, it is a major issue because the Commonwealth simply cannot get its act together with the states and territories around a new model of care for these people. It does not need to be a major issue.

We estimate that there are 49,000 residential aged care beds operating in aged care homes in New South Wales—which is less than the 51,000 beds that were there last year—and 7,200, or 12 per cent, residential aged care places that were allocated but are not operating. This came as a surprise to us. We uncovered this almost by serendipity about four years ago when we were developing an aged care policy which we were going to take to the Commonwealth. I think we,

like everyone else, assumed that, when the Commonwealth put out its bed numbers, those beds were operational. Certainly at a state level, if we attempted to put out bed numbers that were not operational, we would last about 30 seconds—let alone what would happen to a minister. The Commonwealth has this habit of publishing bed numbers, but not all the beds are operational. It means that they have issued a licence but they are actually not operating. So there are 7,209 beds in New South Wales that are not operational.

In 1996-97 the yield turnover of hostel beds was an estimated 30 per cent, compared to 18 per cent in 2002. That equals a loss of $147 million per year in Commonwealth aged care subsidies to New South Wales. That is highly significant. That has, by and large, been picked up by the state government. It equals a loss of $147 million per year in Commonwealth aged care subsidies.

At any one time in our hospitals in New South Wales, 800 older people are waiting for residential aged care accommodation. To give you an idea of the size of that problem, that is slightly more than a Royal Prince Alfred or a Royal North Shore hospital. It is absolutely significant to the operation of our hospital system in this state. These people have been assessed and are waiting for residential aged care or other packages. So it is not the people who come to us who are older, needing acute intervention and treatment. All of that has occurred and they are now in our hospital beds waiting for placement.

You can imagine the impact that that has on the New South Wales health care system. If the Commonwealth would work with the state, you can imagine what that could mean in terms of freeing up capacity to provide acute treatment to people who are currently waiting. It has to be bordering on an absolute scandal. We keep repeating these figures over and over again. The Commonwealth knows the pressure that this health care system is under. We are about to go into winter, and we cannot get them to sit around a table and have a meaningful discussion with us about what we need to do.

Mr MOSSFIELD—So there are 800 people who are in public hospitals waiting for a bed?

Ms HALL—Yes.

Prof. Picone—They have come to us and we have provided care for them and the acute interventional treatment is completed. They might have come to us with pneumonia or have a urinary tract problem—whatever people have wrong with them that requires them to be admitted to a public hospital—and now they are waiting for a more appropriate placement for their long-term care. The other thing I have to say to you is that the acute public hospital system is not good at providing long-term care—that is not our job. We are trained to provide acute interventions and acute medical, surgical and mental health interventions. We are not there to provide longer term residential aged care.

If you visited any of these wards today, you would have an individual sitting up in the middle of a very busy ward, waiting for placement, and not receiving the care that they should be receiving in terms of their longer term care needs. At any one time, we have 150 older people waiting for Commonwealth funded community care. What happens to these people who are waiting? Who picks all this up? What does it mean to them? What does it mean to their families?

The average length of stay for those needing residential aged care is 27 days compared to the average length of stay for an acute episode of care—that is, a person coming in and out for an acute intervention—of 3.1 days. Here we find ourselves in a situation—and it is particularly galling at the moment that it is in the middle of negotiating the Australian health care agreement—where the Commonwealth are planning to reduce the allocation to the states and territories by over $900 million, and yet they would allow this waste of public money to go on every day, day in, day out, week in, week out and year in, year out. The estimated cost to our system is $87.3 million. You can only wonder at what you could do with that money, the care that you could give to other people, if it were freed up to come into the sector that it should come into.

The government funded a very large chronic disease program three years ago, providing $45 million extra to provide better care programs for people with chronic disease.

Ms HALL—Is this the state or Commonwealth?

Prof. Picone—This is a state government initiative. The clinicians who have led the development of this program targeted three areas for the care of people with chronic disease—one is heart, another is lung and the other is cancer. Those people make up 17 per cent of those who attend emergency departments.

In terms of ageing—I know that you would have received submissions on this—neurodegenerative disorders are rising exponentially with age. The rate of heart and lung disease mortality for younger people is declining but is of course one of the major issues for the old old people. So, classically, a person with hypertension over a number of years develops right-sided heart failure, and the story goes on—more people who have engaged in bad habits such as smoking develop chronic airways limitations. In terms of the commitment that the state governments put into ageing last year, they committed $5.5 million to create 36 ASET teams. These are aged care services. What did I call them?

Ms Foran—Aged care services emergency teams.

Prof. Picone—A pet project of mine. The issue around older people attending emergency departments was becoming so significant that we felt we had to provide better care for them and the government funded this program. It involves having a team in the emergency department so that when an older person comes in—at the moment I think we have got the age at 65, but we are receiving submissions that it should be over 70—they are assessed within two hours of their arrival and given a care plan within 12 hours. The idea of that is not to have unnecessary admissions to hospital but to provide almost an immediate acute assessment of what is going on and, if possible, to stabilise the situation and get them back into the community—whether that community be home, their residential aged care accommodation or their community care package. The research of the early results shows that the initiative has the potential to reduce admissions for older people by 17 per cent.

It is quite amazing that the state government has had to fund this. I have to say this to you—from years and years of working in hospitals—that it happened simply because of this: there is no incentive for an older person to be treated in their home, whether their home be at home, in a residential aged care facility or in a hostel. For some reason, which is not clear to us, if you are a

general practitioner and you visit an aged care facility, you will get paid the full reimbursement for the first visit and after that some sliding scale comes in where you cannot see other people. If you are a general practitioner and you have got a good relationship with an aged care facility, wouldn't it make sense when you came in the door not just to see the person you came to see but to do your round and see everybody?

The Commonwealth MBS program does not allow for this to happen. What does that mean? Once again aged care people are treated as second-class citizens and they cannot access general practice services in their own homes that other people would—given that the nursing home is their home, or the hostel is their home—because of some perverse arrangement the Commonwealth has got in around the MBS. Because of the staffing structures and staffing ratios in aged care facilities where there is often only one registered nurse on a shift, he or she is going to be a pretty brave character to have an unstable person in their nursing home facility or hostel in the evening or overnight. Typically what happens is they automatically press the button, call an ambulance and have the person shipped up to the hospital for things like blocked catheters.

What we have had to do from a state government point of view is increasingly provide acute services, through our area health services, into aged care facilities because general practitioners cannot go in there and practise. It is the most perverse arrangement I have ever seen. What we then do is take an old person out of their home, disrupt them, stick them in the back of an ambulance, send them up to emergency departments—which are absolutely flat out at the best of times—and then put them in a queue of other people for services that could be provided in their homes, like a blocked catheter or listening to their chests if they need to start some antibiotics.

Mr MOSSFIELD—I want to clarify something in my mind about that. The reason a GP cannot see other patients is a cost factor, is it?

Prof. Picone—Apparently the Commonwealth—and I will have to put the details in of this—gives you your full MBS reimbursement for the first person you see and then it goes down on a sliding scale after that. Instead of that, you could say to a local general practitioner, 'You can come in here and you can see all of your patients; you can do a round,' which would make sense for them because they are so busy and overworked anyway. Let us face it: nursing homes are no longer what they were a decade ago. A lot of them are acute palliative care institutions where palliation goes on, where the people who live in them have acute and complex medical needs, and yet the Commonwealth has created this perverse arrangement to not allow a general practitioner, who is really our primary health care physician, to engage in their business. You have to be completely dedicated to go and do a round in a nursing home, let me assure you. What has happened is that the state government now steps in and starts to provide the services that really should be provided by general practitioners—who want to provide it, from the people we have talked to. But they have got to earn a living like everybody else.

The asset teams that the state government has funded are making a real difference. The feedback I am getting back from on the ground is that it is making an incredible difference, but once again we have had to dislocate an older person from their home environment, bring them up to a pretty scary place called an emergency department, put them in a queue and get them in a bed for a service that could have been provided at home—and often in the middle of the night. It is just another example. Of course, as soon as they get there, they get acute deliriums and

confusion and it often sets them back. We are told sometimes people never recover from the trip up the road.

Rural settings have been a big issue for us, and this has been one area where there has been good cooperation between the Commonwealth and the state. This has been around what is called the MPS initiative. The state government has put $230 million into rebuilding a lot of our little hospitals. When I was acting CEO at the New England Area Health Service, the biggest issue I faced was allowing people to age in their country towns. We had a situation where we had a whole lot of little hospitals that were clearly providing aged care—if you just did a round in the morning, you could see that—but, because they were state-run hospitals, it was done within an acute care environment. The state government has made a massive commitment to rebuilding all of those facilities to make them more conducive to providing mainly aged care and some acute care facilities. We have worked closely with the Commonwealth to make it happen. That has been one of our small successes and we still have a long way to go, but that has been good.

We are pretty practical people here in New South Wales. We have been working for four years at a bureaucratic level for some practical solutions. Every day out there hundreds of people's lives are affected by this jurisdictional problem of who is responsible for aged care in this country. Over three years ago we put up a policy to the Commonwealth on how to overcome this difficulty. We set up some practical examples of how this could work through various trials. For want of a better name, we called it 'transitional care'. We basically said to the Commonwealth that there is absolutely no way they will get their 7,000 beds built—I think it was 6,000 beds then. The state is short and people are sitting in our public hospitals, which is causing pressure there. More importantly, it is not an appropriate model of care for them. It is not how to treat them decently. We said we would work with the Commonwealth government to set up a transitional care arrangement while the private sector and the non-government sector built the nursing home stocks and as they came on line. We named it 'transitional care'.

We put a proposal to the Commonwealth three years ago to work with them. We said to them that we would work with the non-government sector here. We have some stock in our hospital grounds that we would have refurbished to the appropriate standards, and you could place older people in these transitional care arrangements. That would buy the time necessary to find them placements and also to allow the building program to go ahead. We know there are money issues involved, and we said we would cap it so that this would not be something you were in for the rest of your life. If we did it over a three- or four-year period, all of the facilities would have been built and the places would have been available for older people.

We have been putting that proposal to the Commonwealth for three or four years at a bureaucratic level and at a ministerial level. We put it up again recently again through the Australian health care agreements, and it was just absolutely and completely ignored. The Commonwealth has thrown some crumbs on a plate, such as the innovative pools program, which you might want to talk about, but it will not move on our proposal. It involves the states and the Commonwealth putting in money. The states indicated they are willing to put the money in, but the Commonwealth will not. We can only assume it will not do so because it currently does not pay for the 7,000 beds that it is down, so why would it want to start paying now. That is all I can assume.

The Commonwealth has never given us a reason for rejecting our proposal. It would assist the Commonwealth to achieve benchmarks for its own residential aged care places, and it would allow the flexible use of the non-operational beds. It would also mean that we would not be captured by some of the restrictions of the Aged Care Act. We have put up other solutions to the Commonwealth as well, such as specialist residential facilities for older people with dementia, mental health problems and severe behavioural disturbances which, as you know, is becoming a fairly major issue—an increased capacity to provide consultation and liaison to residential aged care facilities and an increased capacity to manage older people with behavioural disturbances in the community.

So that is the broad outline. It is a story of absolute frustration being played out every day in the lives of hundreds of people and their families in this state. It has resulted in a second-rate system being provided to people at a time when they most need help and assistance from all of us. Our office sits at the table with the Commonwealth through the Australian health care agreement, and we are starting to seriously run out of time. We are creating a second-rate system for people who have given so much to us through their lives. I hope that your committee might be able to assist in some way because we have certainly run out of options.

CHAIR—Thank you very much, Professor Picone.

Ms HALL—Wasn't Reverend Herbert going to add something?

Rev. Herbert—I will just speak briefly. UnitingCare is the largest operator of aged care residential facilities in New South Wales. We have 33 nursing homes and 57 hostels, with a turnover of $220 million a year, so I think we are one of the largest operators in Australia. I put that forward not to claim anything but to say that we have some credentials in the area. One of our facilities is the War Memorial Hospital at Waverley and, as Debora Picone has explained, that has been one of the places in which we have been attempting to establish a transition care unit. I can resonate with her comments that we have met nothing but frustration there. We have the building and we have the beds; it is all there. For quite a few years it sat empty and then we ran it for a number of years as a respite care facility because we got some state government nursing home beds. They were transferred to St Luke's Hospital at Kings Cross and, since then, we have been trying to keep the facility open. So far we have been running it under the winter bed strategy, but that arrangement ends in March next year. We have been lobbying everywhere we can to keep those beds as a transition care unit. It is centred within a rehabilitation geriatric hospital. It is the best place for that to operate.

Also, we have outpatient services. It is a centre for aged people in that area and provides a variety of services. It is a low-cost facility. The daily cost there is well below the daily cost at, say, Prince of Wales just down the road. But, if nothing is done, in March next year it will close and the beds will again go back to where they were six or seven years ago, leaving an empty building. We think that that facility can move people not only on to nursing homes but also, in some cases I believe, back to their own homes. You have the staff and the expertise there to make those assessments. The geriatric rehabilitation services there, which are 35 places, take people who have had a hip replacement, for example, from St Vincent's. Some of those people move into nursing homes or hostels but quite a lot of them go home. We have outpatient services and the aged care assessment team located on the same premises so, in my opinion, that is an excellent model.

I also share the frustration of the New South Wales government in that we cannot get an arrangement to make that work. It is only 20 beds but, surprisingly, if you are moving people through, 20 beds can be a very significant number. We do not want a hospital to have 20 of the same people sitting there for a long time; that is not the purpose of the hospital. The whole purpose is to get the people in, assess them, make arrangements and move them on to appropriate accommodation.

I will just say something else about the non-operational places in the system—and I will be very brief about this—Mr Andrews is on my back continually about our non-operational licences. The fact is that we do not have the money; the financing is not there to build more high-care places. For the first time in history, UnitingCare sold bed licences this year. Hopefully, those other people will get them going, but who knows? There is a serious problem in financing high-care facilities. Frankly, it does not stack up. When the Howard government removed the accommodation bonds—and that was fine; I did not agree with them—it did not replace them with anything to provide capital infrastructure. At the moment we have all this capital money—hundreds of millions of dollars—in the aged care system flowing into the pockets of private operators who can leave the industry tomorrow and take that money with them. I have never seen anything so ridiculous. That money should have been retained by the Commonwealth and directed towards needy areas—low-income areas, remote areas—otherwise you are just spraying the money all over Australia and getting nothing in return for it.

I will just add in regard to the operational issues that it is even worse than Debora Picone indicated, because in fact a lot of our hostels have quite a number of people who are category 8s in them. UnitingCare are not taking any more category 8s. These people do need some form of care, but really CACPs would be better for them. We have a lot of them in our system. At the moment the Commonwealth is not paying any subsidy on them. Therefore, when the minister says we have X number of places, it really should be minus those category 8s. We have come up with a system to try to use the category 8 bed licences for low care, to amalgamate all our category 8s and then build another hostel somewhere else. But we have not been able to convince the Commonwealth department to agree to that arrangement.

I hope with those brief comments I have explained to you why, from an operator's point of view, you will go on having non-operational high-care beds. We can only build hostels today; we cannot build high-care facilities. Unless we scramble money that we have accumulated from the past—which we are doing at Normanhurst and at Nowra—there is no way we could start a new high-care facility, because, simply, the financing does not stack up.

CHAIR—Thank you very much, Professor Picone and Reverend Herbert. I will now start the questions. Professor Picone, we have heard a lot about the Commonwealth government this morning. Has the New South Wales government done something similar to the Intergenerational Report and looked at what you expect to be the cost drivers in state government expenditure over the next 10, 20 or 40 years?

Prof. Picone—We are actually in the middle of preparing a futures plan for the system. We have done a lot of epidemiological analysis of the ageing issues. As you know, in the year 2016 dementia in women will become the top health issue for us, and the fifth for men. It is in our submission, but I would like simply to say to you that this is not something for the future. The future is here now, the clock is ticking to midnight and people are simply not listening. We have

said that dementia was the third highest cause of disease burden amongst old Australian women and the fifth highest in men in 1996. In 2016—which is not that far away—dementia is projected to become the leading cause of disease burden in women of all ages and the fifth highest in men of all ages. The number will be 91,200. It is highly significant.

The way we have the aged care system set up makes this worse. A person who is bordering anyway and having some difficulty with a neurodegenerative disorder is thrown in the acute care system because there is nowhere else to go. Acute delirium in our emergency departments and in our general wards is a highly significant problem from which some people never recover.

CHAIR—Thank you. Are you aware that the Australian Institute of Health and Welfare has shown that the proportion of state government's contributions to public hospital expenditure has been declining while the Commonwealth government's expenditure on public hospitals has been increasing? What percentage of expenditure in New South Wales public hospitals is contributed by the state government and what percentage is contributed by the Commonwealth government?

Prof. Picone—Catherine might want to answer that. That is not the case for New South Wales.

Ms Katz—We worked out recently that the New South Wales government puts in $1.60 for every dollar that the Commonwealth puts into the acute care system. The AIHW statistics are based on some mathematical formulas that they do. We have some information that we can probably give you about how they are constructed and how we would refute that. There are a lot of things that go into the construction of the AIHW statistics, including a reduction for private health insurance and things like that. I do not have that information with me, but I will give it to you.

Prof. Picone—We are happy to submit it, but it is not the case for New South Wales; it is a national figure.

CHAIR—One of the conditions of the latest Australian health care agreements was that the New South Wales state government match the increase in funds from the Commonwealth government. You have actually said that the Commonwealth should be applying a growth rate for non-demographic costs of 2.6 per cent to the entire Australian health care agreement grant. Is the New South Wales government planning to apply the same growth rate?

Ms Katz—We have not agreed at this stage.

Prof. Picone—We have not agreed at this stage, but we do easily match the Commonwealth in growth—there is no question about that. These are the onerous and rather contentious requirements that the Commonwealth has put on around the Australian health care agreement, requiring the states to match at the same growth rate the contributions of the Commonwealth. Having said that, the Commonwealth still has not even decided the scope of the matching arrangement. In a meeting we had with Commonwealth bureaucrats only last Monday week, the Commonwealth still could not inform us what constituted the scope of that matching arrangement, the technicality of how that matching arrangement would work and what constitutes health care at a state level. So the Commonwealth itself is still trying to work that through. In our forward estimates that have been published here in New South Wales, you will

see that there is quite a healthy growth factor in our annual allocations every year for the next three years.

Ms Katz—And you should also go back to the statement I just made. If you are looking at matching, the New South Wales government puts in $1.60 for every dollar that the Commonwealth puts in.

CHAIR—But if that is the case, and you say that the New South Wales state government would match the increase that the Commonwealth government is proposing, why wouldn't you sign the agreement—if it is more money for New South Wales?

Prof. Picone—Because the agreement has short-changed the states and territories by just under $1 billion. So, at this stage, who would agree to sign a so-called health care agreement that is actually less than the previous health care agreement, with a whole range of stringent conditions?

CHAIR—That is not true—it is actually $10 billion more, or a 17 per cent increase on the previous agreement.

Ms Katz—The $10 billion more is due to indexation and population growth. If you rolled over the current agreement and applied the same indexation arrangements, you would actually get more than what they have offered. That $10 billion is actually normal growth throughout the agreement, not additional funding.

CHAIR—I think you are basing that figure of $1 billion on the forward estimates, which was based on public hospital utilisation increasing at the rate at which it had historically increased. Whereas what we have seen is a much greater increase in private hospital utilisation compared with public hospital utilisation. What sort of increase are you seeing per annum in New South Wales with public hospital utilisation?

Prof. Picone—This is one of the difficulties that we have with the Commonwealth. Over the last 10 years, the way health care is provided has changed quite substantially and there are a whole lot of procedures for which people do not require an overnight admission or even a day only admission—procedures that they can have as an outpatient. A couple of examples which we give all the time are things like chemotherapy, interventional cardiology procedures and a whole range of other options. Those have transferred to being provided as an outpatient. The Commonwealth would have us admit these patients overnight or admit them as a day only to keep up our hospital in-patient activity for the purposes of showing that our hospitals are busier than they have ever been. If we added on the increase in outpatient activity, which is given in a very clinically appropriate way, we would actually have a five per cent increase in hospital activity. The Commonwealth, through this perverse health care agreement, is only interested in measuring overnight or day only admissions to hospitals. If those activities go down and other activity in a hospital goes up, the Commonwealth ignores that.

No disrespect to you, Chair, but there is a lot nonsense that is coming forth from the Commonwealth. Private hospitals admit patients on a day only basis that public hospitals treat as outpatients. The reason that they do that is obliviously to get income: public hospitals do not do it. I cannot say strongly enough that the Commonwealth government suggestion that our public

hospitals are not as busy is an absolute myth. They have never been busier. The government has interpreted statistics in a way which has been found by the most esteemed economic research institutes in this country to be absolutely incorrect. It is nothing but a fiction, and an insult to everyone who works in our public hospitals. Catherine, you might want to explain what is going on in the public hospitals.

Ms Katz—I think I have the figures right, but one of the issues is the complexity of the procedures done in private hospitals. While the statistics show that the proportion of surgery done in private hospitals is slightly more than that done in public hospitals, if you take complexity into account, public hospitals do around 57 per cent of surgery.

Prof. Picone—We would like to put in a proper submission on this so that the record is straight. Coming back to the very reason we are here today, the majority of people who have a fractured neck of femur—which is the most common reason for admission to a public hospital—are seen in public hospitals. They are not done as an elective surgical procedure in a private hospital. I think 60 per cent of people with a fractured neck of femur from a fall are done in the public hospital system. It is an absolute fiction perpetrated by the Commonwealth that our public hospitals are not as busy as private hospitals. They have never been busier.

CHAIR—Okay. The figure was from the *Australian* last week in an article saying public hospital utilisation was up by two per cent and private hospital utilisation was up by six per cent. It might have been from the Institute of Health and Welfare.

Prof. Picone—We would like to put in a separate submission if we can to properly inform the committee that this a complete fiction.

CHAIR—Thank you. Did you say that of the 800 patients who are waiting for residential care the average length of stay is 27 days? What is the average length of stay from the time that the discharge decision is made? How long are they actually waiting around with nothing being done?

Prof. Picone—Are you talking about the acute interventions?

CHAIR—Yes, the acute interventions.

Prof. Picone—The figures were from a Commonwealth study too.

Ms Katz—We actually do not have those figures at the moment.

Prof. Picone—Can we take that on notice?

CHAIR—Yes.

Ms HALL—I am not going to concentrate on the public-private issue, I am going to concentrate on aged care and the way the hospital system is taking up some of the slack that this shortfall has caused. I must say that in the electorate I represent it is very predominant. There is one hospital, Belmont hospital, that has quite a large number of older people who are waiting for beds in hospitals. I had the occasion to go up to that hospital last Sunday night with a family

member who needed to be admitted to hospital. They had to find a bed to put that person on because the hospital had so many people in there and the enormous problems the health system is experiencing in that area. Could you tell me what effect having people needing to be placed in age care facilities is having on the hospital system? What impact is the need for beds for these people having on the services that are provided by the hospitals?

Prof. Picone—If we look at it on a system wide basis, it is 800 beds every day. Every day, there are 800 people in our acute public hospitals who have had a certificate issued saying that they are now ready to go for residential aged care. From the person's point of view, that means it does affect the individual themselves, particularly in the cognitive area. We, they and their family know that they are waiting for placement, but everyone is still trooping up the road to the local teaching hospital and the middle of a busy ward. It increases the person's dependency as well. As Harry will confirm, we are not experts in long-term residential aged care. It obviously increases their chance of contracting a hospital acquired infection. The longer you are in, the more that can happen. It also results in a deterioration of their functioning and cognitive ability, because they are not in an environment where a model of care has been set up to care for them in this new modality. That is for the individual and their family. From the system's point of view, that is 800 beds we need. Regarding the growth rate and the increase in demand for health services in this state, what is the growth figure each year?

Ms Katz—Population is 1.9, and we have worked out 2.6 in technology.

Prof. Picone—So we have an increase in demand each year. The health services are expanding each year. If we could have those 800 beds, I do not know what we would do. I know it would make an incredible difference to people attending emergency departments waiting for beds. When we talk to the area health services, the biggest issue they raise with us, particularly during winter, is older people in the acute hospital beds. The queue there means that we cannot get people out of our emergency departments up into our wards. But at the human level I think that is what it is all about. We do not have a proper continuum of care for older people interfacing with our system either backwards or forwards, and that is simply because we cannot get the Commonwealth to sit at the table with us to talk about these transitional care arrangements.

Ms HALL—What is going to be the long-term implication for New South Wales health if that is not dealt with?

Prof. Picone—I think it is unsustainable, quite frankly. We are doing the estimates now but, based on normal growth in a system, based on population growth, technology and demographics—some of the statistics we gave you earlier—after a while it is simply not sustainable. We need the Commonwealth to work with us to try and come up with new arrangements so that we can increase the capacity. But to us it is more about the individuals, the human beings, involved in this. This is when people need us—both the Commonwealth and the state government—the most, and they are being let down.

Ms HALL—Is there a strong argument for aged care being considered a component of the Commonwealth-state health agreement?

Prof. Picone—We have put it in there. It is our No. 2 reform agenda item. At this stage, the Commonwealth have not agreed to the reform agenda that was put forward through the ministers by the clinicians and the various groups. We are continuing to press at a bureaucratic level that they do.

Ms HALL—What do you think of the system that exists in the UK where, if a person is not provided with an appropriate bed or a community care package within the prescribed amount of time, then the organisation or municipality that is responsible for it there has to pay the acute hospital for caring for that person? Do you think that an argument could be made for a situation like that in Australia where, if a bed cannot be found in a facility, then the Commonwealth pay the state for providing that care?

Prof. Picone—We would love that.

Ms HALL—So you think that is a great idea.

Prof. Picone—We are trying to ask for that through our transitional care program, but we would like that even more. We think there might be more in that. We do not want a lot. It is not as though we are being greedy.

CHAIR—In the 2003 budget, there was an announcement about step-down and rehabilitative services—at least that is something to address those transitional issues between the acute hospital sector and residential aged care.

Ms Katz—Was that new money?

Prof. Picone—No, that is not new money. The Commonwealth has taken money that we already had, without discussing it with us, and given it a new badge. Once again there are more restrictions around that—and a lot of it is capital.

Rev. Herbert—We applied under that innovative scheme and were told by the Commonwealth officers that what we were proposing was not innovative, and therefore not eligible under that funding.

Prof. Picone—We are hoping that the Commonwealth may change its mind, but it is just absolutely and totally perverse. It is our money that they are being perverse with—that is the other thing that is getting to us a bit.

Ms HALL—Are there any special problems that exist in rural and remote areas in New South Wales? Are you experiencing greater difficulties there?

Prof. Picone—That is the issue, isn't it; allowing older people in rural areas to age in their country towns and not be moved out—sometimes hours away. In the evidence we gave earlier, we said that we have had some success around the MPS program but we have got a lot more to go. The other big issue, rurally, is the work force issue of general practitioners and primary health care. That is the biggest issue.

If we could work with the Commonwealth in the way that the Commonwealth has worked with us around that MPS program—but right across the board on aged care—we would start to make some improvements. Mind you, it was the state that put up the major funding for that in any event. The Commonwealth is simply paying the resident classification rates—it is the states that are putting up the money for that.

Ms HALL—What about the interface between the state and the community care packages—getting people into community care—and the interface between residential care facilities and state health? Tell me a bit about that. How does the system work? What are things that could be put in place to improve that? Later, if I get a chance, I will ask you some more questions about those phantom beds.

Prof. Picone—That was one of the things we were really excited about when the Commonwealth announced those packages. There is not enough—we think there are 150 people on any given day waiting for those. We think there could be increased flexibility and more of those packages, because the aim is to keep a person at home for as long as possible. That has been a good initiative—and Reverend Herbert might want to comment on this—but it has been inflexible, there has not been enough, and there are very long queues which the state government is currently picking up through its community health program. Basically, once again, that is an area that we are picking up because there is simply not enough.

Ms HALL—What about the provision in the more outlying areas? How effective are they in providing services to people in the outlying parts of metropolitan areas—those people living in rural and remote communities?

Rev. Herbert—Community aged care packages were a very good idea and they work very well, but only for certain clients. We must remember that. I would think that the people who are blocking up the acute hospitals are probably not the candidates for community aged care packages. Some may be, but basically they are not generally that sort of clientele. All the operators who are using the community aged care packages are generally providing more packages than they are being paid for—because operationally, that means it works better. The Commonwealth is getting quite good service from the operators there. I have not sought information—so I do not know—about how they work in outlying areas. Our network is offering them all over the place and everyone speaks very well of them—for the particular clients that they suit. But, as I said, they do not suit all clients.

CHAIR—Reverend Herbert, while I have you here I would like to ask you a question. Last year the Myer Foundation released a report which suggested having, in the funding area for aged care, a separate funding stream for the hotel services and the care services and I think the capital funding stream as well. Firstly, could I have your comments on that part of their recommendation? Secondly, what sort of capital model would you like to see in the funding of aged care?

Rev. Herbert—That has also been raised by Professor Hogan in his pricing review. He has also raised the issue as to whether or not people with long-term dementia, who stay quite a long time in some of our high-care facilities, might perhaps pay some sort of accommodation bond. UnitingCare is very nervous about accommodation bonds. We did not like them the way they

were proposed the last time, so we would have to think pretty carefully about what the end result of the system would be.

Funding facilities in high-income areas in Sydney is not a problem. The problem with the current policy is that it does provide funds to them. I would just make mention of the fact that we have a serious problem in the policy. If, for instance, we built a hostel in Vaucluse or Waverley—where we have one—the percentage of concessionals we have to take there is 10 per cent. We can raise very high accommodation bonds for low care in those sorts of areas. People sell their houses for $800,000 or $900,000 in Sydney, so a bond of $300,000 is no problem to them. But if you are out at Blacktown, where Mr Mossfield comes from, your concessional ratio is, I think, 40 per cent. Again, there is the question of the capacity to raise the bonds in those sorts of areas. You can raise bonds, but they are not nearly of the order. So we have two things clashing against each other there in terms of funding, which of course in the past was met by Commonwealth capital funding. When that disappeared we were left with nothing. We try to shift money around in our system, but we are a large operator. Not everybody is in that position. And even we have difficulties with that.

In terms of the high-care facilities, the current policy has another clash in it. You have community aged care packages, which we completely endorse, trying to keep people for as long as is feasible in the accommodation of their choice, but at the same time you have a non-viable funding policy for high-care facilities. So what are all the operators doing? You see it every day—they are getting rid of high-care beds and replacing them with low-care beds, for which they can claim an accommodation bond. If you look at the figures, you will see that high-care beds are going down all the time and low-care beds are rising. So we have one policy that says, 'Keep them in their home as long as possible'—that means that if they do need residential care, they will need it at the high-care end—and another policy which is reducing the number of high-care beds available. So the two do not fit together, and I think it is time for that to be thought about.

Ms HALL—I want to link into that. There has recently been an increase of 2.4 per cent, and the CPI was 3.1 per cent.

Rev. Herbert—Governments everywhere diddle operators over CPI. There is the all states, the Adelaide one—they would give you the Hobart one if they could because it is the cheapest. That goes on all the time. In the end it is the same old story: if you keep chiselling the operators all the time, you will get inferior services at the end of the day. That is the bottom line.

Mr MOSSFIELD—You mentioned your facility in Blacktown—the Mullauna home. I know that they take in some people who have hearing difficulties. How does that impact on your operations?

Rev. Herbert—Again, that is an RCI issue. There is a lot of argument in the industry about RCIs, as you know. I am not the world's expert on it, but you do have people with challenging and difficult issues, such as deaf people, but they do not rate a high RCI. So you have a conflict there. We have extended that hostel, as you know. Just recently we added another 24 beds, and that will help the financial viability of that place. There are funding difficulties, but the funding difficulties are not as great in the low-care system as they are in the high-care system.

We recently agreed to build a whole new nursing home at Nowra. On our committee there were three votes in favour—including me; because I am a clergyman and I always vote emotionally—two votes against and five abstentions, and the chairman declared it passed. It is a knife edge financially, and that is because of the commitment of UnitingCare to do something in Nowra.

Mr MOSSFIELD—I will move into another area so that I understand. With respect to the federal government registering aged care places, what consultation takes place with the states and local government? Then, once a decision is made, what are the funding arrangements? Are they based on the figures that you have previously given us—is that how it works?

Prof. Picone—I might let my experts answer this question about consultation with the states. What we have been saying to the Commonwealth is that their current benchmarks are far too low in any event, given what they say should be the ratios per head of population. We have been urging them for quite some time to review those. You have a situation where not only do you have 7,000 beds that are not operational but the ratios are far too low. So there is no wonder that the states are finding themselves in extreme difficulty. Ms Foran handled the negotiations with the Commonwealth officers.

Ms Foran—With regard to the planning benchmarks, there is no consultation with the states. From this year, New South Wales Health is on the state Aged Care Planning Advisory Council, which looks at the distribution of places across the state. We are part of that group from this year.

Ms Gallagher—One of the things about the figures is that the planning indicators, which the Commonwealth continue to use, are in relation to 70 years and over, even though most people—and Harry would know this better that anyone—are 85 years and over and take up 52 per cent of the residential aged care places. The projected growth is to 80 per cent in 2021. Often there is a mismatch between the supply and demand. The key paying indicator is on 70 and over rather than on 85 and over, which is the main target group for nursing homes.

Mr HARTSUYKER—Reverend Herbert, you mentioned that operators are providing more CACPs than are being funded by the Commonwealth. How is that occurring?

Rev. Herbert—That is because, as an operational thing, in order to fill all the places that you are paid for, you need to have a couple of additional ones because people drop in and out of the system. In order to keep the system turning over at full capacity, you have to operate a bit above full capacity.

Ms HALL—This is a summing up type of question and a comment too. From your presentation today—and I am sure that when I read your submission I will get a picture—you believe aged care is about providing appropriate care for older people and, in doing so, enhancing their quality of life and maximising their lifestyle choices. What you are saying is that, currently, the system that exists provides inappropriate care with inappropriate facilities and, at the same time, it prevents appropriate care being given to more acute patients who require care within New South Wales. Would that be summing it up fairly?

Prof. Picone—Yes; that is correct. The only other point in summing it up is that it is an area where the Commonwealth, the states and territories must get together to break down the

jurisdictional boundaries that every day are affecting hundreds of people's lives and their families across this state. We have put such sensible, practical proposals to the Commonwealth that are not rocket science but which would make such a difference to people's lives every day. It is getting now to a very serious situation. It cannot go on for much longer.

Ms HALL—I find the silo mentality is the most frustrating thing, when we look at issues like these.

Prof. Picone—Yes.

CHAIR—Thank you very much for appearing before the committee. Are you happy to take further questions in writing?

Prof. Picone—Yes, we are.

Proceedings suspended from 10.50 a.m. to 11.01 a.m.

CLARE, Mr Ross William, Principal Researcher, Association of Superannuation Funds of Australia

SMITH, Ms Philippa, Chief Executive Officer, Association of Superannuation Funds of Australia

CHAIR—I welcome the representatives of the Association of Superannuation Funds of Australia to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The Association of Superannuation Funds of Australia has made two submissions, submission Nos 2 and 72, to the inquiry and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Ms Smith—Yes. I will try to be brief. The primary focus of our submission is the adequacy of retirement incomes that is likely to result from the combination of an age pension, compulsory superannuation savings and other voluntary savings. We obviously acknowledge that there are other very important issues that this committee is looking at, such as health care needs and work force participation. Our report touches on a number of those issues that relate to age discrimination, the importance as we see it of reforms to allow flexibility in the workplace—particularly that transition from work to retirement—and some possible rule changes for that 65 to 70 year bracket to allow casual, contract or part-time work to happen. We would like to emphasise that we feel that increasing that work force participation is important, but it is not actually going to solve the issue that we are bringing to this table, which is that, as it stands, there will be a shortfall in the adequacy of retirement incomes for that big bulge of baby boomers and later generations coming to the fore.

The Intergenerational Report did a good job, I think, in auditing some of those government expenditure pressures and revenues, but it did not factor into the equation the increasing gap between the current level of the age pension and the expectations of later generations. We need to plan for that now if we are going to solve even some of the shortfall that is there. If we do not solve that shortfall, I think future governments will have an unsustainable political pressure on their hands and future generations will not be able to meet the demands that are there, because those pressures and demands would be coming at exactly the time when there are fewer people in the work force to sustain it. We need to revise those policies. We need to plan for them. We need also to plan for the changes that are in society.

For example, when compulsory super was first devised, the implicit assumption was that everyone was in the work force for 40 years—there would be 40 years of unbroken work. That is no longer the case, as you would be aware. Work patterns are broken. We have a situation where many people are facing interrupted work patterns: many women have interrupted work patterns because of other family obligations and many people at this point in time are facing age discrimination from about age 45 upwards—plus we are living longer. Those are the issues we need to deal with.

ASFA has looked at the issues of what is an adequate savings target and what is an adequate retirement income from a number of perspectives. We have done quantitative research, we have done qualitative research, we have interviewed current retirees and we have looked at the ABS figures and seen what different levels of expenditure buy according to expenditure patterns of older people. That is documented. The bottom line really is that for a single person—we are looking down the track for baby boomers and beyond—the minimum target for saving for retirement income is about $25,000, and more realistically $30,000. That is the minimum that people are wanting and when you look at the absolute expenditures it is modest in our current way of thinking.

The Senate committee report that looked at adequacy of income also looked at it from various ways and they came to the conclusion—which verified our $30,000 if you are looking at someone on average weekly earnings—that it was about 80 per cent of pre-retirement expenditure. So they expressed it a different way. We pointed out in our submission that, yes, that is about right but if you are a low income person your percentage needs to be higher. But they are rough rules of thumb; they give you policy targets that we need to strive for.

If you look at the compulsory super of nine per cent, it is still a young policy; it has only just built up to nine per cent now. It only started in 1992 and it has been building up ever since. Assume someone on average weekly earnings has had 30 years in the work force and they have been saving nine per cent for 30 years, they will end up with a retirement income—in today's dollars—of a bit over $19,000. That includes the age pension. It falls a long way short of that target that I was talking about.

Add onto that that a lot of people have not had the opportunity of saving for 30 years because of the youth of the policy. This is reflected in the fact that at the moment the average lump sum savings that are coming out of superannuation are about $70,000. By the year 2020, the prediction is that it will be $135,000. To get to that retirement income that I was talking about of $25,000 or $30,000, more realistically the lump sums need to be about $250,000 or $300,000. That is the shortfall that we are looking at as a society. We want individuals to make up the shortfall of where those expectations are going to be, but I do not think anyone expects that the age pension can suddenly go up dramatically because of the cost pressures. What we are expecting is, looking down the track to a fully mature system, that rather than most people being dependent on a full age pension most people would be dependent on a part age pension. The age pension is still going to be an important part of the pillar and underlying structure of that retirement income strategy.

If we got to that target of improving on the adequacy of retirement income, the scenario we would be looking at is somewhat reduced reliance on the age pension, some discretionary income to deal with things like the dentist, private health insurance, alternative health care such as the physiotherapist and those sorts of things, and some assistance at home. But it would not deal with the catastrophic health care, the institutional care and those sorts of demands and needs that are obviously going to be there. It would certainly help with some of the things that go to living standards but not with the other things you have been discussing this morning.

The task of getting up to that adequate retirement income is also pretty big, so there is not the scope, as is sometimes forwarded, that super or this pool of money—which people look at as a growing pool of money in a macro sense—can suddenly be diverted to other projects, whether it

be education for the kids or other things. We are having trouble getting enough money for the primary purpose, or relevant income, let alone to other purposes.

We have outlined an action plan of what we think are some possible strategies. We see it as both individuals and government having to form a strategy of meeting that gap. If it were individuals alone, over a 30-year-period their savings target should not be nine per cent, it should be 16 per cent. Our work and research indicate that most people understand that they need to do more but are only willing if the government helps them and is party to it. The sorts of things we have discussed include reducing some of the contributions tax up front, which we see as detrimental. It is raising the money and spending the money now on what we know should be savings to be put away for what is going to be a huge demand on society down the track. It is also depleting the savings efforts of individuals. Deferring some of those front-end taxes to the back end would certainly go a long way.

A co-contribution strategy where you are matching or part-matching the contributions of low and middle income people would also certainly help. When you look at all the distribution figures, it is actually that $30,000 to $60,000 group who probably have some capacity to save more but are doing it hardest in terms of lack of incentives to save. The other things we have highlighted are, as I said, some flexibility for those people who want to work, have a capacity to work and have the possibility of working—and they are all big ifs at the moment—particularly in the 65- to 70-age category. Changes to some of the very inflexible rules such as you have to be working 30 hours every week, each and every week, would take into account the fact that people in that age category might get casual or contract work. We should build in that flexibility. They are just some of the issues. I have probably taken up too much time.

CHAIR—No. Did you want to say anything else?

Ms Smith—The other big issue is the complexity of the rules. As I said, we are looking at a picture where most of the people are those with average weekly earnings up to $60,000. The situation is that the private savings through superannuation are certainly going to improve their situation but we have got to look at the integration of social security and private savings to ensure that it works and is flexible. Some real anomalies are there, which we have highlighted in our report. The complexity of the rules, I think, in large part comes down to the 'tax, tax, tax'. Assistance is needed there. We have highlighted the importance of when rule changes occur not to grandfather but to take other strategies—either sunset clauses or an age group that allows transition. It is important not to leave the sorts of grandfathered rules in perpetuity. Accountants tell me that with superannuation you had the pre-1989 rule—

Mr Clare—There is pre and post 1980.

Ms Smith—Pre and post, and if you are trying to work out someone's actual position and what their strategies might be you are literally having to sit down with an array of legislation in front of you and work out a very complex path in working out a strategy for that person and what they are entitled to. It is beyond the wit of most accountants, let alone people reaching retirement.

CHAIR—The Intergenerational Report projected that Commonwealth expenditure on age pensions would increase by two per cent, the OECD average would be three per cent and some

similar countries like Canada and New Zealand would be as much as six per cent. Do you have any comments on those projections?

Ms Smith—The projections I think are correct insofar as they showed the partial success of the compulsory super arrangements. What I was wanting to stress was that they showed the growth of age pensions as they are now. They did not factor in the increased expectations that people have looking into their retirement future. We are living longer, we want to do more and we have higher expectations. So an age pension which currently is at $11,000 for a single person does not allow you to do that. As I pointed out, most people, even if they have 30 years, would still only be getting to $19,000. So it does not allow them to have the active sort of retirement that they are expecting. The government may have managed down the escalation of cost but there is a political pressure building up that should be planned for now.

Mr Clare—Most other countries have systems which deliver reasonably adequate retirement incomes, and that is where they are having the pressures on governments being able to fund that. So the level of expenditure they have as a percentage of GDP can be three, four or five times the level that is in Australia. Australia is quite good at poverty alleviation but our government age pension has not been very good at providing an adequate income in retirement. That is where the SG has come in and assisted. It has also relieved some pressure on age pension expenditures. More people in the future will be on part age pensions. There will not be a lot of difference in terms of the number of people who are not reliant at all on the age pension; it will be more a change in mix.

That is how the Australian system has its success, in the paucity of government payments to individuals. Going forward, the ageing effect is not that great. A 50 per cent increase in terms of share of GDP still is not very much because it was from a low base. The government has taken some comfort in that and says that is fairly manageable. We take a rather different view in that it is a symptom of the paucity of the government provision in terms of adequacy, and that is where our submission to your committee and in other forums has been emphasising the need to improve the adequacy because that is what people expect; and, when you objectively analyse it, that is what they need. In most other countries that higher level is being provided and they are trying to think the way through on how to make sure it is sustainable in those countries.

CHAIR—What do you see as specific examples of the different expectations that the next generation who are going to be retiring may have?

Ms Smith—There is a table in the submission where we look at what you can buy at different income levels by the ABS statistics. On page 18 you can see some of those expectations. The differences are that individuals moving forward expect to eat out occasionally, they expect to go to the cinema occasionally, they expect to be involved with hobbies, they expect to go out.

I suppose you can just look at your own family in terms of what your grandparents did, what your parents did and what you are expecting to do. Longevity and the fact that we are going to be healthier when we start our retirement mean that we view the retirement years as being more active, rather than, perhaps, quiet and meditative. So it really is a matter, I think, of commonsense and thinking through things such as how we now expect TVs and videos while our grandparents might not have and those sorts of things.

CHAIR—I think you mentioned other countries as well. My understanding is that other countries have less of a targeted pension system and that they might have greater government contributions to age pensions and so on. Did you want to elaborate on that at all?

Mr Clare—Yes. Certainly in many other developed countries and even some developing countries you have systems of government provision which relate to pre-retirement income. You are getting up into those percentages of 60 per cent of gross income. They have social security taxes in a number of cases which at least partially fund those measures. But they have come at it from a view of trying to ensure adequacy, and moves in some of those other countries are leading to some social unrest.

It is a bit hard to imagine the future retirees of Australia demonstrating in the streets over issues but in France, Germany and Austria these things are happening at the moment where governments are starting to fiddle around the edges, sometimes more substantially, with the structure of their systems. Those populations have those expectations. We may be starting to see the Australian population being more active and concerned.

I think we have a generational shift, where memories of the Depression and pre-World War II or even post-World War II austerity have conditioned the views of some of our current retirees to their living standards. If you go out and survey old age pensioners, you will find that they are relatively content with their lot. But if you ask them what they can do and what they cannot do, it is a less than reassuring tale. We have surveyed the baby boomers and the generation Xers or Ys—whatever term you want to use for the younger generations. They have much higher expectations and they have much more resource intensive interests. Those requirements are not going to suddenly end when they get to retirement age, which these days is certainly not age 65 for most people; it is somewhat earlier.

Ms Smith—Can I point you to page 37. I am going back to the international comparisons. What that does highlight, as Ross was saying, is that the Australian system is actually very focused and targeted. So we have been quite good at the absolute poverty alleviation principle. We are not saying, 'Get rid of that structure.' What we are saying is that we need to build on the structure that we have. A lot of the international countries are finding that their earnings related pension structure is just not sustainable going into the future. Ross is describing some of the implications of that. We are not saying that that is necessarily the path to go down but we are saying that we have to be more realistic about our expectations. Our focus would be on the middle and lower income people, who need most assistance in closing some of that gap between the age pension and $25,000 to $30,000 as a—

Mr Clare—And unlike many other countries, we have a structure in place which allows us to build in a sustainable way of financing. The SG and the private accumulation of retirement savings is a sustainable method for our society. It does not imply an increase in taxation and government expenditures. It is something that can be built on. That is why we have a regular array of visitors coming to Australia trying to learn lessons about our structure. There are a few things we would not want to export, like our tax treatment and the complexity of some of our social security means test rules. Even the contribution rate is a bit light on. In terms of the basic structure rather than some of those parameters, it is a good system, and it is something we need to remember to emphasise. It does give us a way forward, and that is why we have been putting forward some suggestions to build on its strengths rather than saying, 'Toss it out and look

around the world.' I do not think the European or even the US social security model is one that we want to emulate. We have some elements here that they want to follow and that they struggle to implement because of their history, but we have some things hanging over from our history, like a greater emphasis on poverty alleviation rather than adequacy. However, going forward I think we can move the balance around, and that is where our policy proposals are directed.

CHAIR—Thank you, and I agree with many of your comments. In addressing the need to increase the amount of contributions, especially down at the lower incomes, what do you see as being the role of employer contributions versus employee contributions, compulsory contributions versus voluntary contributions, and even private savings?

Ms Smith—What comes through very clearly in the research that we have done is that people see the task of saving as being a joint responsibility between employers, themselves and the government. The people think at the moment, and I agree with them, that the employers have probably done their bit—they have got up to nine per cent. The next step is really individual and government. If your savings target was 16 per cent as opposed to nine per cent over a period of time, I think you could meet that by individuals going up maybe three per cent and by government matching that three per cent, particularly for low- and middle-income people. That is one strategy. Removing that 15 per cent contributions tax would be the equivalent of giving the savings happening now about a two or three per cent spur along. That could also be important.

In terms of whether it comes through superannuation or other private savings, Australians have a love affair with their houses, and that is probably their primary other form of savings. At this point in time, it is not possible for them to use that fixed asset for their retirement income needs. I think St George is about the only financial institution around that will allow draw down, and there are complications as to why they have not been made available, although they may be in the future. Even though we think superannuation levels are still low in terms of sustaining people in retirement over 20 or 30 years, we know that superannuation at this point is now the second most important form of savings after the family home. It is interesting. You would have thought that people would not like the compulsory savings part of it, but people like the fact that there is a discipline there for them and the community to save—and that is a good thing.

Superannuation is just an investment vehicle; it is not a special thing itself. It is an investment vehicle and then, behind that, there is a diversified range of investments that happen. For the most part, for long-term saving, that works best. For the last couple of years we have felt the pains of the fluctuations of economic investment, but one would have to say that, if you are looking at an investment strategy, that diversified investment strategy will work best over the longer term.

Mr Clare—Leaving retirement savings to individuals has tended not to work anywhere around the world. New Zealand have had several goes at it—they had some fairly glossy campaigns—and the net outcome was that they had about the world's worst household savings record and a whole lot of current worries and inquiries which are ongoing. So, even though there might be some economic free market type thinking that says that we should educate the population about the need to save and we should set up reasonable structures for them and they will go away and do it on an individual basis, it just does not work.

Collective arrangements in one form or another—and employment related superannuation is one of those—tend to work better, even if you move on from compulsory employer contributions to a situation where you have more or less voluntary individual contributions. We do have some examples in place. Most public servants, both state and Commonwealth, now have options relating to the level of personal contributions. If you have a reasonable structure in place and some reasonable outcomes related to those personal contributions, even low-income earners seem more or less content with that structure.

We think some of those things can be built on in terms of moving to having a compulsory system of employer contributions and some incentives for that individual involvement in the co-contribution—particularly enhancement of what has already been proposed by the government. We apparently had negotiations in the Senate about extending the reach of that co-contribution. We see those as valuable ways of proceeding and also, as we mentioned, doing something about the contributions tax, where that is perceived as and is a disincentive for contributions by individuals through salary sacrifice or whatever.

Ms HALL—Your submission is excellent and covered a wide range of areas. I can see that you have really thought about the whole issue of superannuation and income support for Australians in a society where we are living a lot longer. Andrew picked up a lot of the issues, but I would like to look at recommendation R9 in your submission, where you recommend:

... that the structure of the means test for social security be reviewed by a joint government and superannuation sector working group, rather than just focussing on marginal changes or the treatment of specific financial assets or income streams.

Would you like to expand on that recommendation a little bit? Where do you see that review going?

Mr Clare—It is not an easy area.

Ms HALL—No, it is not.

Mr Clare—You could unkindly describe the social security means test as a bit of a dog's breakfast.

Ms HALL—The means test and the assets test—

Mr Clare—The income test and the assets test are components of the overall means test and they do not mesh together very well. There are some internal inconsistencies in those various elements. Different financial assets and other assets are treated quite differently in those tests, seemingly on an arbitrary basis. There might have been an original rationale, but it was never written down very well. Sometimes I think the rationale has been lost in the realms of history.

We also have a lack of incentives to take good income streams in retirement. There are quite concessional asset test treatments as an exemption for complying annuities which are used by a few people. They are a product that can really be offered only by a life company. They have limited or no reversion at the time of death. They are backed by fixed interest securities usually and offer quite low rates of return, so financially they are not a terribly attractive product but

they are the only one that slips through the asset test component of the means test for social security. We would say—and the sector has been arguing for this for a long time—that there should be a wider range of products that might fit within that exemption or some greater incentive to take income streams, which is a sensible thing for individuals and for government, rather than having any lump sum dissipated. It does give a greater assurance for the future.

We think a fundamental look at the basic parameters of the means test is somewhat overdue. We have had some piecemeal improvements, particularly directed at those who do not have a lot of income or a lot of assets. The government has worked out I think that people in retirement do not want to be bothered by a whole lot of complex rules or the need to undertake financial planning to deal with quite modest—

Ms HALL—That was another issue—you touched on the complexity of rules.

Mr Clare—Yes. I think at a certain level the current means test works, but it will work less successfully in the future as more people have substantial amounts of assets and income, which is what our aim is. Really, the current system is designed for people on the full age pension or thereabouts with modest additional income or assets, and that is what most of the current retirees fit into. I think the piecemeal changes have more or less fixed that.

Ms HALL—Are you saying that there is a real conflict between good financial planning and the current system?

Ms Smith—If you are outside the complying pension structure and you decide on a pension stream outside of that and your assets are in that $200,000 to $300,000 zone—as I said, if you are wanting to create a retirement income of about $25,000 or $30,000, that is what you would need—and you look at what happens with the interface with social security, it is like a flat line. Between about $200,000 and $300,000, it is a flat line because of that interface question. As the system matures and hopefully more people get up to that level, that is going to be a huge issue and a huge problem.

Mr Clare—It is another aspect of the effective marginal tax rates that apply to many social security recipients.

Ms Smith—As I said, you can escape that if you go to the complying pension but, as Ross described, it is not a particularly satisfactory or wise investment either.

Mr Clare—It does not have much flexibility for people.

Ms HALL—I was at a meeting yesterday and it probably reinforced some of the things that you have been saying. Two people at this meeting came up to me and spoke to me about superannuation. They were probably people who were nearly retiring or had just retired. They were most concerned about the way the system works at the moment where they are paying tax effectively three times and the implication that this has had on their savings and their planning and the fact that their capital is actually reducing as opposed to increasing. Have you got any suggestions for looking at that issue of the capital investments and the way they are currently dealt with? I know it is a factor of the current financial situation.

Ms Smith—There are a couple of things. The focus on those front end taxes and the disincentives they create is even more palpable in a period of lower returns. It is like people feel they are doing their bit but governments are taking it away regardless of the returns. You can understand that anger. In fact, for that person on average weekly earnings that I talked about before, the impact of just the 15 per cent tax is roughly around $50,000 or $70,000 over a lifetime; that is the impact on their final savings. So there is that.

I feel for people just close to the lip of retirement who are suddenly hit with a negative period. We can say as much as we like that you have to expect a negative return once in every seven years and that super has had a good run. It has been 15 years of double digits, but people remember. This is their first taste of a negative experience and, if you are close to retirement, it is just human nature that you panic and you tend to forget the good times.

Ms HALL—Or you have just retired and your capital has decreased by $100,000.

Ms Smith—Within most superannuation funds, there are different investment options. So for most people there is the option of moving out of the growth or the balance which has exposure to equities to what we call capital stable, or it might have other names, which over the longer term would have lower returns but would not have quite those same fluctuations. A lot of people close to or in retirement might prefer that. If you were looking at it objectively, you would still have to say to them, 'You still need to plan for 20 or 30 years in retirement.' So maybe going for some of the higher growth options is the better thing to do, but it comes with that volatility and that scare. To be honest, I am not quite sure how to answer those people quite often.

Ms HALL—Neither am I.

Mr Clare—And if they had crystallised their losses back in, say, February or March and gone to a capital secure option, they would have missed out on the recovery and the equity since.

Ms HALL—I have had people come to see me who have done that. So that has just compounded it.

Mr Clare—Yes. They cannot really claw their way back then.

Ms Smith—Ross did some calculations for me. People often say, 'I would have been better in cash.' If they had been in cash for the last 10 years, they would have been 20 per cent worse off than being in a balanced fund with exposure to equities, even after the recent losses. But logic does not always persuade.

Ms HALL—There is one other question I wanted to ask you about, which is recommendation 25 where you talk about a move to quarterly payments for superannuation. Would you like to expand on that a little, please?

Ms Smith—That has happened, so that is good.

Ms HALL—And what are your reasons behind that?

Ms Smith—Basically so that the contributions from employers go into people's accounts so they get the benefit of the earnings and the interest, they can track where it is and, if an employer goes down the gurgler, their money does not go with it. So there are a lot of reasons.

Ms HALL—What about ensuring that they are made?

Ms Smith—That is the ATO's job. If it is made quarterly, they can in fact monitor that in a more timely way. Part of the problem with the annual payments was that there was a lot of time and a lot of distance before they could start following up on the contributions that had not been made.

Mr Clare—We have certainly had comments in the past about the degree of diligence of the ATO in pursuing some of these matters. But to be fair to them, over the last year or two, they have lifted their game substantially. I do not have too many good words to say about the superannuation surcharge, but one of the few good things that came out of it was much better information for the tax office about employer contributions. They have systems in place now which can actually detect an absence of contributions much earlier. Apart from the quarterly SG system which still relies a bit on self-assessment, they have a lot of information and they can target both employers and industries much more than they used to be able to.

So there will always be gaps there. Creditors do not always get paid by certain businesses and sometimes wages do not get paid, but we do have a structure where I think the tax office has the capacity, and is applying it, to achieve much better enforcement, and the quarterly payment requirement is an aid to that. They can start work much earlier, rather than waiting until after 28 July each year before they can really say to an employer, 'You've defaulted on your obligation.'

Ms HALL—I put it to you that it still is quite an issue that workers' contributions are not being paid and that, even though there is that ability for the ATO to chase it up, in reality it does not happen.

Ms Smith—Casual employment is probably one of the more difficult areas. I think it would be policing that.

Mr MOSSFIELD—I want to comment on the superannuation guarantee. Someone said that the employers have done their bit, but initially that was a wage increase, wasn't it, that working people forgo?

Ms Smith—Yes. If you look back into the history it was factored into the wage negotiations.

Mr MOSSFIELD—Obviously, with employers paying that amount of money—nine per cent—even if it goes up, there is less opportunity for employees to get wage increases, because that is a cost the employer has to meet.

Ms Smith—What has happened over time is that it has become part of the salary package.

Mr MOSSFIELD—So indirectly the employees are paying for it. I was surprised at the figures that you produced here, that the average account balance is only $54,000—a lot lower—but I suppose it is a new system.

Ms Smith—It started only in 1992, at a low level.

Mr MOSSFIELD—That would include a lot of new employees who have not been in the system for very long, so that would bring the average down. But then the current average retirement lump sum is only $62,000. That surprises me; I thought it would be a lot higher, particularly when you look at the figure of $230,000, approximately, that you have produced here to give you an income of $30,000 a year. There is obviously a big gap there between people who are getting a reasonable figure and those who are not. I think that puts the focus onto your other comment about the particular reason for focusing on what we would call lower middle-income people on $30,000 to $60,000.

Ms Smith—We have said up to about $60,000.

Mr MOSSFIELD—What are you recommending can be done for those people?

Ms Smith—A co-contribution, or a matching contribution, would be something tangible that could be done and it is focused, and reducing the contributions on that front-end 15 per cent. When you look at the dynamic flowthrough, that goes through to everyone. The equity flowthrough quite often helps the middle-income group the best, so that is another very tangible way in which it could be improved.

Mr MOSSFIELD—So you would like the committee to pick up recommendation R20, which recommends an increase in contributions plus removal of the tax on contributions?

Ms Smith—Yes.

Mr MOSSFIELD—It would be a package in which there would be a government contribution as well as an employee contribution?

Ms Smith—Yes.

Mr Clare—That is something we have elaborated on in our pre-budget submission to the government for the 2003 budget. We have not walked away from that at all but we have elaborated on it to a degree and there are some elements, we think, that can be built on.

Mr HARTSUYKER—The Intergenerational Report tells us that the labour force is going to be relatively declining with time. Obviously there will be skills issues as well as financial issues there. It always seems ironic to me that there is age discrimination when we are discriminating against the most experienced members of the work force. We should be encouraging them to carry on. We talk about the percentage of saving that we need to have to provide for retirement, but when you look at the retirement sum, the most effective rate of accumulation of retirement income is at the back end, not the front end. Have you done much work on encouraging people to work extra years and on the impact that that is going to have? We are focusing on the percentage you have to put away during your early years, when you have much greater spending requirements. But once you reach 65, generally your house is paid for and so on and so forth. Each extra year you work greatly adds to the proportion of your total and increases your retirement nest egg.

Ms Smith—Yes and no. The sad truth about saving is that, if you put your money away early, the time factor alone does a lot of work for you.

Mr HARTSUYKER—The compound is greater.

Ms Smith—It is the compound interest effect.

Mr HARTSUYKER—But there is a tendency for that not to happen.

Ms Smith—Yes. A lot of people are getting to retirement or getting close to retirement and finding they simply do not have enough money. There are two problems happening. One is that a lot of people are finding that they may have been planning to retire at age 60 or 65 but actually get retrenched at age 50, so they have lost the years of saving. Age discrimination really is operating very severely from about age 45 up. A huge amount of work needs to be done to start to reverse that in a realistic way. The other problem is that the health of a number of people in the 55 to 65 and over bracket gets to a situation where work is not an option either. I agree that, for those that can find work, who have the health to find work and have the right skills that are needed in the workplace, creating some flexibility and some options is part of the policy package that we should be looking at. I would not want to rely on it as the fix for what we have got, because it is not going to solve the issue.

Mr Clare—Some of the speeches that have been made in the public arena of late which have been putting the emphasis back on individuals doing the right thing and working longer come from a rather comfortable perspective of professionals in good health who have stable employment. Even they come from some employment areas where they have some institutional incentives to go at 54 years and 11 months or whatever. Some of the thoughts are conditioned by a rather different environment to that of the harsh reality for many individuals, where there are just fewer options open. It makes sense. They would like to work, they would like that income and they would like a greater period to save, but whether it is open to them is another matter. We have explored some of these issues in a March 2003 submission to the Senate Select Committee on Superannuation. There are not many easy solutions there. Many people are struggling with them.

Mr HARTSUYKER—One would make the presumption, given the Intergenerational Report shows the immense strain the work force is going to be under, that those age discrimination issues are going to be greatly ameliorated just by the demand for labour and there being no-one else available.

Ms Smith—We hope so. But if you think of a lot of blue-collar workers, who rely on their fitness and their capacity to work, it is hard. There might be a demand, but whether they can actually fulfil that demand might be another question.

Mr Clare—Employers may not be discriminating against 60-year-old bricklayers, but there might not be much of a supply of them. In terms of some of the restructuring of our industry, some of the old jobs just do not exist any more. It comes down to a matter of retraining and suitability—the match between jobs and the work force—and just how much the ageing process impacts on the capacity to do work.

There are a lot of challenges in those areas which are difficult to deal with. A bit of thought has to go into the solutions. The government has its age pension bonus for the delayed taking of the age pension, but the take-up rates there have been remarkably low. You would not say that it has changed working behaviours much, if at all. We need to think fairly carefully about things that might actually work in terms of changing behaviours or outcomes, rather than identifying it as an area where, if people did work longer, it would be a good thing. Many people can agree on that; developing the solutions is the hard bit. Fortunately, there are committees like yours and others within the government sphere that are really thinking hard about it, and we appreciate that.

Mr HARTSUYKER—Do you think that lack of awareness is a major factor in the low take-up of the age pension bonus?

Ms Smith—I think at this point in time it would be more about the lack of options available to people. The thing about public policy is that it takes time to implement a lot of these changes that we are talking about. I think we have to go the hammer and tong of increasing both private savings and work, and hope that—

Mr HARTSUYKER—Together?

Ms Smith—You hope that the two might work together.

CHAIR—There being no further questions, I thank you very much for appearing before the committee and for your evidence today.

[11.59 a.m.]

LE COUTEUR, Professor David, Director, Professor of Medicine, Senior Staff Specialist in Geriatric Medicine, Centre for Education and Research on Ageing, University of Sydney

CHAIR—Welcome. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. You have made a submission—submission No. 63—to the inquiry and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Prof. Le Couteur—How long would you like me to talk for—five minutes?

CHAIR—Five minutes would be fine.

Prof. Le Couteur—I guess I should give a little bit of my background. I am a professor of medicine, so I am a clinician. I am heavily involved with research. My research is primarily biomedical. The Centre for Education and Research on Ageing is a centre within the University of Sydney and the Concord Hospital, and we have a broad range of academic capacities, going from biological research, through clinical research, through epidemiological research, through to health service research. I would like to think that we are the biggest and best in Australia, and I think in terms of outcomes—NHMRC grants, PhD students, publications and so on—we certainly are.

There are four issues that I would like to raise in regard to ageing. I am sure that you, being members of the committee, are well aware that ageing is a huge demographic revolution, which has been likened to the Industrial Revolution in its impact on society. The first issue I would like to raise is what I think is a fairly simple issue—that is, that any problem related to ageing, be it retirement, superannuation, health care costs, or residential care, relates almost entirely to the fact that ageing is related to disease and disability. To some people, that seems like an overt medicalisation of ageing; to other people it seems like a simplistic aphorism. But, if you think about yourselves or your own parents or grandparents, the issues that prevent them from working, that prevent them from being active members of society, that lead to health care costs, are all related to their age related diseases and disability. I think that needs to be put forward as a starting point when you are thinking about ageing in terms of its effects on society.

The second point is that in the Western world ageing is now the main risk factor for disease. If you walk into a coronary care unit you will see one 40-year-old male that is a smoker, overweight and hypertensive, and you will see eight or ten 85-year-old women. The relationship between ageing and disease is, I think, quite independent of the relationship between other standard risk factors—genetic factors, environmental factors and so on—and disease. Ageing itself, through mechanisms that are not understood, predisposes us to disease. Yet if we look at our hospitals maybe 50 or 60 per cent of our hospital bed days are used up by older people. They are there because of age related diseases; none of our research is being done on why ageing causes disease.

The third point that I want to make is that, if we had therapeutic interventions that worked for age related diseases, it would not matter. If you got old and you got cancer and we could treat the cancer, it would not matter: you would be better and you would be on your way. But ageing is the main reason why medical interventions do not work. It is not just surgery, it is not pharmacological; it is also rehabilitation interventions that do not work in older people—they cause harm. In fact many of our hospitals are filled with people who have got harm as a result of their medical interventions. Yet all of our research on therapeutics is done on younger people. I can give you some statistics on that that are really quite dramatic. Just a number on the run: about 40 per cent of heart attacks are in people over the age of 75; about two per cent of people in clinical trials on heart attacks are people over the age of 75.

The final point I want to make with regard to ageing is that the problem is for the next 40 or 50 years. We have what I like to call the 'pig in the python': the baby boomer generation that is reaching old age over the next 30 or 40 years. Once that has passed, the population pyramid will become much more triangular again. So we are dealing with a problem that is for the next 30 or 40 years, and I think that is an important point. Strategies that we put in place that are going to impact in 50 years or 100 years are worthy and obviously useful, but in terms of managing the problems that you are all very familiar with—the health care problems, the societal problems, the retirement problems and so on—they are problems for the next 30 or 40 years.

CHAIR—Thank you very much for that. You have mentioned specific problems of elderly people in the acute hospital setting and so on. From your point of view, are any of the recommendations contained in the report of the committee looking at quality and safety in health care, formerly chaired by Bruce Barraclough, filtering down to clinicians?

Prof. Le Couteur—Not really. One of the issues in the hospital setting is that older people—and by 'older people' I am not talking of those 65 and above; they were perhaps older 40 years ago, but they are not now—in their 70s, 80s and 90s have health care requirements that are quite different to those of younger people.

CHAIR—You have also mentioned that therapeutic intervention and rehabilitation may be appropriate in a younger patient but may not always work in an older patient. How different is the way they need to be cared for? Is it appropriate for them to have less intervention, less aggressive intervention or different types of rehabilitation? I am trying to think through what it actually means.

Prof. Le Couteur—There are a couple of issues. The trite answer is no-one knows because no-one is doing work in that area. Our drug companies will tell us that it is important, for example, to prevent hip fractures in people in their 80s and 90s by giving them expensive drugs such as the bisphosphonates. What little data we have suggests that that is not the case; they are effective in younger age groups. One of the problems is the extrapolation of data from younger age groups to older age groups. There is a little information around on the negative effects of therapeutic interventions. Rehabilitation is something that you would all think is something useful and a tenet of modern management of older people. A recent study performed in Australia has shown that in the setting of hip fractures standard rehabilitation causes injury; it causes sprains and strains to the leg and thigh muscles and so on. Whereas rehabilitation that is based around activities of daily living—things like walking and going to the bathroom—are not associated with that sort of negative effect.

I should point out that, as well as being a geriatrician, I am a pharmacologist and for my sins I am on ADEC. So I have a fairly major interest in drugs in older people. In terms of adverse drug reactions, about one in five older people in hospital are there as a result of some sort of bad outcome from drug intervention. There is a huge number. We have no data on polypharmacy—the use of multiple medications in older people—but we know that it is harmful. We know that your chances of having a significantly bad effect with multiple medications are increased but we do not know what the benefits are, and no-one will do the studies. I think the most recent figures on a DVA population in Australia were that of those people who were over the age of 65, 90 per cent were on a single medication and 40 per cent were on five or more. We have no data to say whether that is good for people; yet we know that it is potentially harmful. So these are the sorts of issues. You go to a cardiologist who will treat you absolutely perfectly for your heart failure and a neurologist who will treat you absolutely perfectly for your Parkinson's disease but put that together in an older person and you are almost certainly causing them harm.

CHAIR—Is that a result of the drug interaction between the two?

Prof. Le Couteur—It is a result of drug interactions and of the fact that the health care profession are not aware and the pharmaceutical industry are perhaps not willing to promote the fact that there is some data around that suggests that the interventions are harmful and not useful. Another example would be drugs used in heart failure called the ACE inhibitors. These would now be absolutely standard therapy for anyone with heart failure. In fact, it would almost be considered negligent not to use these drugs in anyone with heart failure.

The trials were done primarily in 60-year-old men. The majority of people with heart failure are women over the age of 80. There are lots of reasons why those drugs might not work in older people. In clinical trials the level 1 evidence—the highest level of evidence in medicine—shows that over the age of 75 these drugs do not work. Yet, as a geriatrician I see people on these drugs coming into hospital with low blood pressure and falling over with kidney failure as a result of their drugs.

CHAIR—Why are the ACE inhibitors not working? Is it a result of changed pharmacokinetics, a different mode of action in someone over 80, or is there a need for more research?

Prof. Le Couteur—There are some plausible answers, but basically there is a need for research. One plausible answer is that most ACE inhibitors are prodrugs—they need to be converted to their active drugs by the liver—and there are changes in the liver with ageing. Another answer is that at the age of 80 your life expectancy is about three to five years, so you may not have long enough for those drugs to have their mortality reducing effect. That is obviously an issue. And another answer is that the adverse effects of those drugs may be outweighing the benefits of the drugs, so the fact that they cause kidney failure, falls and hip fractures may be outweighing the benefits that they are having on the heart. It is a complicated area.

I think it is entirely inappropriate to take therapeutic data from younger people and extrapolate it willy-nilly to older people. There are great commercial reasons to do that because that is where the market is; that is where all of the disease is. I think it is also inappropriate to take data on disease causation from younger people. We have heard all about genetics and smoking, obesity,

high cholesterol and hypertension. They are all very important. Those things are being addressed now, so the big problem with disease in the community—and it will be over the next 40 or 50 years—is why people in their 80s and 90s are getting sick, and no-one is doing any work on that.

CHAIR—That is a very powerful point. In your submission you talked a little about the National Institute on Aging in the United States and how you have met with representatives of that organisation. Would you care to expand on why you see that as the most successful international research model.

Prof. Le Couteur—Research funding in the United States is obviously dramatically greater than it is here. There was an editorial in the renowned medical and scientific journal *Science* about two years ago complaining that only $US1 billion a year was being spent on ageing research. They felt that that was much less than you would project on the basis of how much is being spent on health in older people.

The National Institutes of Health has about 10 or so subcategories, including for neurodegenerative disease and stroke, cardiovascular disease and so on. They also have a large institute on ageing. That organisation has two sections. One would be called program funded or block funded. It provides infrastructure—things like laboratories, epidemiological databases, ageing animal facilities and those sorts of things, as well as funding some of the more senior researchers in the area. There are about a dozen laboratories or groups within that. They also fund what we would call project grants: similar to the NHMRC, best applicants are provided with funding to do research in their area. So it is a combination of block funding and project funding. The level of funding is obviously much greater than it is in Australia.

Ms HALL—Earlier today we heard from Professor Nair, who you have probably come across. He works at the University of Newcastle, and is based at John Hunter Hospital. He also talked about research grants and he made the point that in Australia in 2000 in the area of geriatrics and gerontology there were only six grants through the NHMRC and they totalled $411,426. He also made the point that he believes that there needs to be a separate strand in the NHMRC grants that just looks at ageing and gerontology. He said that doing that would lead to an increase in funding. He also made the point that 0.6 per cent of the total funding for grants goes to geriatrics and gerontology. Do you support that argument? Is that the way it should go?

Prof. Le Couteur—In my original submission I attached an NHMRC funded scoping report on ageing research, which you may or may not have had a look at. I think it is considered to be a working document. It has not been fully accepted by the NHMRC. It is sort of on the quiet, I think partly because the committee had difficulty in deciding what outcome they wanted from the scoping report. I think there were some divisions about health policy, population health versus biomedical research, what was the most important. In fact, the scoping report, which I led, showed that all the ageing researchers in Australia actually wanted to work together.

Ms HALL—He refers to that scoping report too.

Prof. Le Couteur—We actually got all the key players together, the health policy doctors, the epidemiologists, the biologists and the clinicians, and we all were totally harmonious. So we do not have any divisions out there.

I think that is right for a number of reasons, and that was one of the recommendations of the scoping report. There are certainly good people doing research in areas of ageing that do not call themselves gerontological and geriatric research. For example, people doing research in dementia, which is a typical ageing area, would not call themselves ageing or gerontological researchers; they would call themselves neuroscience. That is not a major problem except that it leads to rebadging. As I said before, ageing is now the risk factor for disease, so we need the people in dementia, people like Colin Masters and Tony Broe, to say what it is about ageing that makes you get dementia and what it is about ageing that is going to alter your responses to therapy, instead of people saying, 'We are looking at dementia, we are interested in the gene that causes dementia when you are 50 or 60.' So I think ageing is important.

Within the NHMRC there are some 200 experts on the discipline panels and there are two representing geriatrics: myself and Leon Flicker. So we are looking at one per cent of people on those panels looking specifically at ageing and geriatric grants.

Ms HALL—It is not good enough, is it?

Prof. Le Couteur—This compares with about 20 per cent on molecular genetics, about 20 per cent on neurosciences and so on. You might argue that the role of the NHMRC and the role of research in Australia, which is a small country, is to fund areas of strength, and that becomes a self-fulfilling issue because the people that get the money remain strong and contribute. However, I would make two points. One is that the government, both the ARC and the NHMRC, have made attempts to fund areas that they believe are strategic. The ARC spend about a third of their research funding on areas that they see as strategic rather than competitive. The NHMRC have done that to a certain degree. They have identified areas that have less strength, like public health, diabetes and HIV, and given specific money to those because they see that they are important.

With respect to ageing, ageing is certainly a cinderella area. We do not have the work force at any level really to have critical mass, so it needs to be seeded. The other thing is that what we do have in Australia is a lot of good researchers who, if we could draw them into ageing, would really boost our research. If we can get Phillip Sambrook, who does wonderful research on osteoporosis, to start thinking about ageing osteoporosis rather than osteoporosis in ageing, if we could draw those people into the fold as well, that would be fantastic. A simple solution to the NHMRC, for example, would be to take one of the discipline panels and say, 'This discipline panel is on ageing.' What would happen is that a lot of other people who could be doing research on ageing would see that as being an opportunity, plus it would kick-start the people involved with ageing at the moment.

Ms HALL—I return to your submission. You make the point that there is a close linkage of health service delivery, research and teaching and you talk about how effective it has been in the areas of HIV and AIDS. Could you expand, for the committee's benefit, on how you would like to see that work in the area of dealing with older people, disability and disease?

Prof. Le Couteur—There are four issues with ageing research I would like to put forward, with a preface, which is that internationally ageing has been recognised as the priority area for research. In the late 1990s every medical journal and scientific journal in the world got together, had a plebiscite and identified ageing as the priority area. So internationally it is recognised.

Firstly, there is need for a primary focus on ageing. If someone is doing some research on cardiovascular disease, unless they are saying, 'What is it about ageing that causes heart disease?' and 'What is it about old people that alters their therapeutic responses?', they are not really helping older people directly. I think that needs to be the primary focus.

Ms HALL—That is your very strong message for us, isn't it?

Prof. Le Couteur—Well, it is one message. The second message is that ageing is complex. One analogy is a car with a broken axle or a rusted, burnt-out shell at the bottom of a cliff with a broken axle. In one setting you can bring in the broken axle doctor and drive the car away and in the other setting you cannot. Ageing is a bit similar. There are so many factors relating to disability, disease and social issues and so on that for any intervention to be useful it is going to have to take all of that into account. So the research really has to be multidisciplinary. There needs to be either people involved with the research who understand the broader issues or people within each of the domains all working together. It is not enough to fix up a single physiological parameter to get older people well. So my second point would be the need for a multidisciplinary approach.

I think a linkage between health care and the coalface is really important for two reasons. One is that obviously the linkage works. The translation of new discoveries into health care is important, as is ensuring that what the researchers are doing is relevant. So that linkage is obvious. It also works in other areas; we have great research being done in immunology and cancer because we have clinicians and other people in the health care services working with the scientists. We do not have that so much in geriatrics, gerontology and ageing.

With respect to my analogy regarding HIV and ageing, I think HIV is a great example of how to respond to any huge social issue. When you think about when HIV was first discovered, nothing was known about it. There were no therapies, there was a lot of societal prejudice against drug addicts and gay people and there were also work force issues. No-one wanted to work with them because of the fears of contamination. And really, in a decade, that had been turned around. There have been huge public health and societal campaigns to change people's views of the demographics. The area of HIV became an incredibly popular place to work to the point where, in the ACT, where I came from, we had more people working on HIV than we had people with HIV. We got therapeutic advances quite quickly. I cannot see why all those things are not analogous to ageing now. We have a group of people where there are societal prejudices and where we do not understand the basic biology. We do not have good therapies and we have a work force which is very slim on the ground. I think that same sort of global approach will work with ageing just as it has with HIV.

Mr MOSSFIELD—I think we can appreciate the need for specific research into ageing and all the related issues, particularly the need for a multidisciplinary approach. You raise the issue of funding and how in America there is a lot more funding for research, which I think we would accept as being due to their larger economy. But what is the break-up of that funding? Where does that funding come from in America and how does that compare with Australia, especially in relation to government grants and the private industry?

Prof. Le Couteur—The majority of the funding comes from their equivalent of NHMRC, which is the National Institutes of Health. They also have two other large sources of funding.

One is the American Federation for Aging Research, which is a combination of government funding and charitable donations. The final source is through their Department of Veterans Affairs program. Veterans Affairs has set up a scheme, which I think is a very good one, called GRECCs. These are geriatric research, education and clinical centres. There are about 20 of them. They recognise the points that I have raised: the need for a coalface approach when working with researchers; the need to be able to translate care; and the need for the approach to be multidisciplinary. They felt the best way of organising this was to create centres where you could have a focus on particular issues of older people. So there might be a GRECC looking at Alzheimer's disease, for example. They will be looking after people with Alzheimer's disease, doing research on it and educating others on it. There are health policy doctors and genetic doctors all working together as a group. They have funded about 20 of those across the United States.

I think CERA—our centre here—operates a little like that, because we have a lot of commissions, and there is a focus on dementia in particular. We have pathologists working on dementia. We also do biological research. I think CERA is an example of how a GRECC can work. It is an exciting place. One of the things I really enjoy about it is the fact that it attracts young, good people, because I believe that if we can get the good, academic geriatricians, nurses and physiotherapists out there they will see to the rest of the community and improve work force issues. I do not know what the exact funding level is, but it is about half of that for NIH, about a quarter of that for AFAR, and about a quarter through the GRECC funding.

Mr MOSSFIELD—Do we have an equivalent health department attached to Veterans' Affairs relating to ageing?

Prof. Le Couteur—I think Veterans' Affairs is increasingly seeing ageing as being, dare I say it, a lifeline—as an area that they can focus on and get some useful badging. They do fund research. In fact, I have one DVA grant. It goes through the National Health and Medical Research Council system, but the DVA selects some areas that they are happy to fund. They are areas not directly related to ageing. They fund things like prostate cancer, post-traumatic stress syndrome and issues that perhaps are of particular interest to younger vets. Allan McLean, who is now the director of NARI, and I have spoken to the DVA about making ageing another priority area. They are certainly considering that. But their funding is more directed at those sorts of things that you would think would be relevant to veterans—I cannot list them exactly.

CHAIR—There being no further questions, would you like to add anything, Professor?

Prof. Le Couteur—No. You have given me the opportunity to say all that I wanted to say. I do ask you to go back to the original submission and consider the recommendations in the scoping study. They are fairly broad. They are certainly not identified by the NHMRC as their recommendations, but they have accepted them as what the consortium felt was important.

CHAIR—Earlier you mentioned an article in *Science* criticising the $US1 billion being spent on ageing research. Was that the article by Schneider in 1999?

Prof. Le Couteur—Yes.

CHAIR—Professor Nair from the Hunter has spoken to us, and he also mentioned that in his submission.

Prof. Le Couteur—The scoping report is about 150 pages long, so I did not bring all of it, but I thought the recommendations were of interest. Being modest, I also think that there are some chapters in the scoping report that are of broader interest to people interested in ageing. You might find that the sections on the demographics of ageing, the health care issues and so on are useful to you, because they do have a strong Australian slant. That was provided with the original submission, but I would be happy to provide it to you.

CHAIR—Thank you for pointing us in that direction. Thank you very much for your evidence today.

Proceedings suspended from 12.28 p.m. to 1.19 p.m.

WARN, Ms Patricia Pauline (Private Capacity)

CHAIR—I welcome Ms Patti Warn to today's public hearing. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Ms Warn has made a submission, submission No. 26, to the inquiry, and copies are available from the committee secretariat. Ms Warn, would you please state the capacity in which you appear before the committee?

Ms Warn—I am appearing as somebody who acted as a carer and was able to see how a nursing home worked over a period of 18 months in 2000-01.

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

Ms Warn—Yes. It is nearly 12 months since I wrote my submission from the viewpoint of a carer and observer of the daily life in a particular aged care facility in Sydney in 2000-01. While I have had no further contact with that nursing home, I have continued to visit other elderly friends in care. A lot of people actually got in touch with me after my submission was posted on the committee's web site and after Kate Legge's article in the *Australian*.

The issues I raised a year ago continue to be relevant across Australia. They are a key reason why other close women friends of mine are making heroic efforts to keep parents and partners out of nursing homes, at some cost to their own health and security, by choosing to be full- or part-time carers. Yesterday's *Sydney Morning Herald* reports the long-term effects on the immune system of the stress and exhaustion suffered by such carers for up to three years following the death of the person they cared for. But the burden remains great on those with relatives in care because they continue to be carers but also have to negotiate the system every day, often in facilities which are miles away from where they, their parent or partner may have lived.

Just last night I got a call from a registered nurse in Melbourne whose husband has early onset Alzheimer's and has been in care for some time. Her clinical nursing knowledge had earlier led her to suspect overmedication in her husband's case, and she finally discovered that he was on a clinical trial of Olanzapine, which she had not been told about. She objected, and there was then a case in the state guardianship tribunal. Although that issue was apparently resolved, she was informed yesterday that her husband was being moved from a modern dementia specific unit where he had his own room to a shared six-bed ward in an older part of the facility. Once again, she is fighting a system that makes her powerless, even as next of kin. She intends taking her husband home again for as long she can manage.

Imagine how much more difficult it is for people who are not next of kin but who, because of our mobile society and changing lifestyles, may know an aged resident and his or her needs much better than family who may be living interstate. They have no status at all and no right to participate in treatment or care reviews which crucially affect quality of life issues except,

interestingly, in Tasmania, where the recent passage in the lower house of the Relationships Bill 2003 recognises same-sex and medium- to long-term carer relationships in the law.

My submission criticised the lack of palliative care in nursing homes, so I was delighted to learn that Dr Paul Glare of Royal Prince Alfred in Sydney has a federal grant to develop education guidelines for teaching nursing home staff to provide better palliative care for residents. But everyday care needs to be better and is not dependent solely on having more nurses, important as that is. I would be happy to talk about that later too. So much that is wrong in aged care could be improved if regular accreditation insisted on homes following evidence based care guidelines. My comments on overmedication and poor monitoring and reporting of side effects have been mentioned earlier today. Inadequate nutrition, lack of exposure to fresh air and sunshine and the need for respect and appropriate routine and communication are all borne out by research studies, but they are also simple commonsense, for the most part.

I have here two booklets written by Megan Stoyles and Patrick Flanagan in Victoria which provide an excellent teaching tool for all aged care facilities and home carers. I understand they are being widely used in Victoria and by Veterans' Affairs. I have only one copy of each of them. The crucial need for imaginative, evidence based design for dementia units has been recognised by good facilities I know in Tasmania, my home state, and in other places, but there is room for a lot more to be done in that area.

Finally, my plea for a massive public education campaign on ageing and dementia—which was mentioned also by Professor Le Couteur and which I mentioned in my submission in relation, funnily enough, also to HIV-AIDS in which I worked when I was in Parliament House in Canberra—is being addressed already in our popular culture, and I have become very aware of this just in the last few weeks really. I think of television programs like the Channel 10 production *After the Deluge*, which was on just last week—an excellent production about dementia and families coming to terms with an aged parent with dementia—the recent stage production in Sydney of *Proof*, put on by the Sydney Theatre Company and which was also performed in Melbourne by the Melbourne Theatre Company, and of course Kate Jennings, the Australian novelist whose book *Moral Hazard* is a searing commentary on the effects of Alzheimer's. It seems to me that if our creative people are waking up to the problem and are incorporating it into a lot of what they are writing and what is being performed, there are much better opportunities for the general public to have a more immediate awareness of what the problem is than all the statistics in the world—unless you have been through the system yourself, and then you know it all too well.

CHAIR—Thank you very much for your submission and your opening statement. First of all, was there any possibility of this patient remaining in the community with appropriate services? Or was it more appropriate to go to residential aged care in your opinion?

Ms Warn—In my opinion it would have been possible for him to remain in the community, but in his family's opinion it was not. And that is really what it boiled down to. I am not sure that all the available care options were properly canvassed before he left hospital.

CHAIR—Was he still in a position to make his own decision, or was the decision made by the family?

Ms Warn—It was a decision made by the family on the advice of hospital staff and social workers.

CHAIR—Okay. You also note in your submission some deficiencies in the current accreditation system. Do you have any proposals of ways the system could be improved?

Ms Warn—It seems to me that far too much emphasis is placed on ticking off the physical facilities in aged care facilities. That is very important and I recognise that we cannot have people living in places which are unsafe in terms of fire hazards, or designs which make falls more likely than not, or the hygiene of kitchens, or the adequacy of routines and of basic issues like laundry. But these are things that I would call housekeeping; they are things that a hotel would call housekeeping, I expect.

What the accreditation scheme does not sufficiently address is how people are actually looked after, how competent the staff are, how good their ongoing education is and how appropriate their communication is with residents of aged care facilities. They do not have, in my observation anyway, the education or in many cases the competence to understand what they are actually seeing in residents day by day. I made the point that the registered nurses, who are on duty primarily to hand out medication, have very little time to do any hands-on nursing and the assistants in nursing do not have the clinical experience to be able to judge when somebody needs a particular intervention in time. I heard Debbie Picone from the New South Wales Department of Health talk about the problem of nursing homes shunting people off to hospital as soon as anything goes wrong. That is sometimes true, but it is also true that people are often not shunted off to hospital and are not given medical attention by doctors when they need it, so their condition exacerbates very quickly and they become much sicker much more quickly than they should.

I do not know whether this could be addressed by the judicious use of nurse practitioners, if not in each nursing home then possibly in clusters of nursing homes in a particular area, or whether her suggestion of freeing up general practitioners to visit more frequently might work. But my observation of that was that it was disgraceful the way many people were not adequately cared for by general practitioners in this particular nursing home—with the honourable exception of young female GPs, who took a real interest in the identities of the people they were coming to assess and interact with.

So whether accreditation can be beefed up in such a way that you really look at quality-of-care issues I do not know, but I think it is vital that something along those lines happens and that we are looking at nutrition, we are looking at sunshine and we are looking at exercise in a real way. That can also in large part be addressed in the design of homes. This one had no effective garden area where anyone could walk. I made a comment on the meals—the midday meal was fine but the evening meal was appalling—and I think in many nursing homes other people would attest to the fact that, if nutrition is a part of health, that aspect of their health is not being addressed.

I think, too, that in terms of accreditation there is not sufficient effort made to talk to carers, to talk to relatives and to interact in any way with residents—it is just too hard; they do not have time to do that. The other point I made was that I do not see why, if places are funded with Commonwealth money, there should not be random checks between accreditations, to see how things are going. I do not think people should be given any advance warning that that is going to

happen. I think it should happen on weekends and I think it should happen at night-time when the staff numbers are down. Otherwise it is laughable. I have some press clippings here. One of them is from the classified ads of the *Sydney Morning Herald*. Wedged between a 'For sale: hairdressers' and a 'For sale: service station' is: 'For sale: nursing home, accredited until 2006, on the north coast of New South Wales.' I think that is unforgivable.

CHAIR—Are you aware how the home you visited performed in their accreditation reviews? Did they sail through? Did they get three years accreditation or one year's accreditation?

Ms Warn—They certainly got three years accreditation at my intersection with them, which was three years ago. I understand—but I do not know this for a fact—that they may have got a slightly less glowing accreditation than they expected, because they were genuinely surprised that they did not get the highest possible accreditation rating that year. I understand third-hand that accreditation has just been gone through again, it being three years since that time. I do not know how things are going; I would not presume to know. I do not know anything about how it is now.

CHAIR—There is also the capacity for residents, family members, carers and so on to make anonymous complaints. I am certain you would be aware of that.

Ms Warn—Yes.

CHAIR—As a committee, we are trying to think of reasonable ways it can be improved. Do you think the anonymous complaints mechanism is a useful one?

Ms Warn—The problem with anonymous complaints is that they never remain anonymous. If something is done about them, people will know the whistle has been blown and they will have a very good idea of who might have blown the whistle. My own experience was very early on when my friend was in this particular facility. I drew to the attention of the registered nurse on duty the discomfort of a recently arrived resident who clearly needed to go to the toilet and was very distressed about it. It was at mealtime and everybody was sitting around the table waiting to have their meals. I drew it to her attention, but she told me she was too busy to deal with it and he was allowed to soil himself. He sat there in a soiled condition while the evening meal was served and eventually he was cleaned up. For my efforts on that occasion I was the subject of an adverse incident report to the matron and, for some considerable time after that, got the cold shoulder from staff. That was not an anonymous complaint of mine; it was a perfectly out in the open request to a staff member to do something about a resident in distress.

Others have found that, if any criticism has been made or they are known to have given any time to the accreditation team, they will be given a pretty wary eye for a while. You just know that, if you want your person looked after, you keep quiet, because it is very easy to subtly discriminate against somebody.

Ms HALL—I was going to ask you about spot checks but you have answered that very fully. With the services that are provided within the nursing home/hostel facility, have your observations led you to believe that the focus of the provision of those services is around the person—the person being the central piece of everything that happens—or do you think that the person is secondary to fitting in with the system, be it the system at the Commonwealth level,

the state level or the system that operates within the facility? If so, how do you see that this should be changed?

Ms Warn—I agree with you that people become cogs in the system, and some of the reasons for that are staffing levels and staff incompetence. At the moment, staff in nursing homes simply do not have the time to give individual attention to people as they should, and it means that everybody comes down to the lowest common denominator. People get the right idea. They think, 'Oh, music's a good thing; they're all old so the music will be First World War songs.' But some people like opera and some people like jazz, and some people cannot stand music, but everybody gets First World War songs. It is that kind of lowest common denominator.

When people first suggested that I might stay around for the evening meal, because I had not been doing that with my friend, I discovered that everybody around his particular table was eating with a spoon. Some people with dementia get to a stage where they can eat only with a spoon and then only with their fingers. My friend was able to use extremely good table manners until a month before he died, which was 18 months after he went into this place. The easiest thing to do was to give everyone a spoon.

Ms HALL—So that was quite demeaning for him.

Ms Warn—Of course. It is a combination of ignorance and thoughtlessness; as much as anything, it is a matter of a lack of imagination. That goes back to the point that Professor Nair made this morning about people not being familiar with ageing in place. Our family grew up in my grandmother's house, so I always saw her and other elderly people and they were just part of the way the world was. But now, with families moving interstate, families moving away from each other and families breaking up, people are literally divorced from an everyday awareness of the problems and also the benefits and rewards of being associated with older people, and I think that is very sad. It is also the case for a lot of nursing staff as well—with the exception, as I mentioned in my submission, of many staff who come from overseas countries where the extended family pays respect to age. And in many cases these people are desperately missing their own parents or their own grandparents in the Philippines or Fiji or wherever.

I think we have to do something to get younger people more used to age. As the professors who gave evidence today said, we have to do something more about young people and people going into the caring professions to get them used to it. At the end of last year and earlier this year I helped interview prospective medical students for a new intake for the University of New South Wales. The aim was to get people into medicine at New South Wales university who did not have 99.99 in their exams but who might actually be interested in healing and disease and people. It struck me over and over again that young students aged 17 and 18, particularly those coming out of country areas like the Hunter—but beyond the Hunter; areas like South Australia or the outer suburbs—who came from migrant backgrounds were still in touch with those sorts of roots. One of the reasons why they wanted to do medicine was because their grandma had had this wrong with her or old Uncle So-and-so had had that wrong with him, or they would really like to do something on Alzheimer's disease, or they would really like to do something that would make life better for people like their elderly relatives. I think that is a terrific start in that direction.

Ms HALL—Definitely. You believe that more needs to be done to combat stereotyping and to make younger people value older people as individuals and to value the roles that they have played—past and present.

Ms Warn—Yes, very much so. Of the two booklets I gave you that Megan Stoyles and Patrick Flanagan have written, one addresses care needs in residential places and the other care needs at home. In the residential setting one, they focus very much on the need for respect, the need for dignity and the need to give people their names, so that they are called Ms Hall and not Jill, Mr Mossfield and not Frank, and they are accorded the dignity that they are entitled to. These people have done so much for us. They have borne us; they have nurtured us; they have taught us; they have nursed us. It is not right to reduce them to the status of children. I have heard staff in particular nursing homes saying, 'They are just like little children, so we have to treat them like little children.' That is a professional disgrace in my mind.

Ms HALL—It is.

Ms Warn—But it also goes to architectural issues like having their own room, having their own things, feeling like they belong, being part of a community, and carers and relatives being brought into a holistic notion of care for somebody even though their home is now in this setting. I have made the point in my submission that I cannot think of anyone in this place who did not say once or twice a day, 'I want to go home. Take me home. Please, take me home.' The response of the staff is to say, 'But you're at home now, dear. This is your home.' They know it is not. They might know it is where they are sleeping, they might know it is where they are eating, but their sense of home is so rooted in their personality that until they totally lose that personality they know they are not at home.

Ms HALL—I was interested when I read your submission and heard your presentation and the points that you made about medication. The professor who spoke before you also touched on medication. Looking at the way it operated in the facility you were at, do you think there was lack of communication between people that had been involved in the medical management of your friend? Do you think it is lack of recording of appropriate medical information at the facility? Do you think it is lack of investigation, taking proper histories from family and friends? Do you think it is something else, or do you think it is all of those things?

Ms Warn—I think it is all of the above. As Professor Le Couteur was saying, it is very dangerous. The admissions of people to hospital because of adverse drug reactions and adverse drug interactions are putting a big strain on our hospital system, which is something governments worry about. And it is ruining the lives of people, which is something I worry about.

Ms HALL—Do you believe all medications are trialled properly?

Ms Warn—I do not have enough clinical knowledge to know that, but I suspect—

Ms HALL—In your submission, did you mention people trialling drugs without giving proper informed permission to trial them?

Ms Warn—In my comments today I made the point that this woman in Melbourne who is herself a registered and trained nurse was able to see at a particular point a rapid deterioration in her husband's physical condition and also mental condition despite the fact that she knew that he had Alzheimer's. When she tried to find out what the situation was, even when she looked at the medical charts it was impossible to find what it was that was wrong with him. Only after a lot of digging did she find out that there were separate charts being kept for a clinical trial of olanzapine, which she as next of kin knew nothing about and which her husband was clearly unable to give permission for. I think that may have been because it was a state-run facility in Victoria. I am not sure of the fine print of that kind of thing. But my suspicion is that that kind of thing is happening, and anyway we do not necessarily know all the complications that arise with medication for one condition being overlaid with medication for another condition. Certainly in my friend's case he was also put on an anti-Parkinson's drug. Even the staff were able to see that that just turned him into a zombie almost overnight. But I just do not think the staff are bright enough often or educated enough to know to note these things, and they are not confident enough to pass them on. If doctors are not regularly visiting and themselves do not know to report adverse side effects, how on earth does anyone get a handle on it?

Ms HALL—I have a couple more questions but I believe I should let others ask questions and then come back.

Mr MOSSFIELD—I was interested in some of your comments, particularly about the residents' activities. Was there any volunteer group operating in the nursing home?

Ms Warn—Not to my knowledge. I think that was a very unfortunate thing to happen. There were people who regularly visited their relatives or their partners and there was a fair once a year, but that was it. There was really no sense of 'We are all in this together. We can all help each other.' An extra pair of hands is actually a godsend at meal time. Nobody wants to choke anyone, but it is really helpful, because if you have got a lot of people who need help with feeding and a limited number of staff then the people who get help first are fine and the people who get help last have a cold, unappetising meal. Again that affects their nutrition; it affects the way they think about themselves. We just do need to involve the community more somehow in those places.

Mr MOSSFIELD—One particular nursing home I had been to on several occasions did have a volunteer group. As a matter of fact, I was involved in presenting them with volunteer certificates. I think their physical presence meant that the standard was kept fairly high.

Ms Warn—Exactly.

Mr MOSSFIELD—In the same nursing home they also had outings of various descriptions. Local groups would put on a Christmas party or a Mother's Day or Father's Day party.

Ms Warn—In the best facilities those sorts of things happen, and in others, particularly in ones where there is no real attempt to get any volunteer involvement, it is all too hard.

Mr MOSSFIELD—Do you think lack of qualified nursing staff is a problem?

Ms Warn—Yes. In the funding for nursing homes, that is a problem too. As I understand it, there is no requirement for minimum staffing levels. That means that you will typically have a registered nurse who is dispensing medication to a very large number of people over possibly a two-hour period, but all the rest of the work is being done by enrolled nurses or assistants in nursing. It must be possible to harness people with overseas qualifications, which are not recognised and which are really hard to get through the nursing councils, and to retrain them. It might be possible to get into this area people who have been retrenched early and who would be prepared to think about a caring career change, even in their 50s. It must be possible to provide better ongoing education for people already working in facilities.

I have been backwards and forwards with various people—with different neighbours—to St Vincent's public hospital over the last 12 months. I am noticing that there are more men coming into the profession as assistants in nursing or enrolled nurses as opposed to registered nurses—although there are some who are registered nurses, too. They are coming in quite late in their career, having done jobs that they have got sick of and that are not fulfilling.

Mr MOSSFIELD—Or they have been retrenched.

Ms Warn—It is important for men to see a few men around too. There was an article in the paper the other day about the fact that nursing homes are feminised—although feminists might not agree that that is the right word. They are pastel, they are pasty and they are dull places. We know that blokes get depressed if they do not have a shed to go to, just like a lot of older women get depressed if they do not have a kitchen or garden they can spend some time in. But so many of these facilities have nothing like that. In the inner city and suburban areas, particularly in Sydney—I mean, real estate is just crazy—the imperative is going to be for homes to go further out into green belts and further away from relatives, friends and neighbours. One of the things we have to do, in conjunction with the architectural profession, is work on ways of sending nursing homes up into the sky but still incorporating gardens, which is something the New South Wales government architect has advocated for ordinary high-rise buildings in Sydney. You cannot just have concrete shells with no greenery. You need places where people can walk and see sky and plants and things like that.

Ms HALL—I want to push the staffing issue a little bit further. You were talking about the level of competency, the training and the actual minimum levels of staffing as well as the types of training and the competence of the staff. To what degree do you think the level of wages that assistants in nursing are paid and the fact that it is probably one of the lowest-paid positions that exist within the community impact on the type of staff that are attracted to work in those positions?

Ms Warn—I think it has a huge impact, as it does throughout the nursing profession. I can remember many discussions among the nursing staff at this place about the fact that they were, I think, at that stage on $13.90 an hour and how much more they would get doing almost anything else in the community.

Ms HALL—And what about the difference between what they receive in a public health facility and what they receive working in an aged care facility?

Ms Warn—That is also more marked now, because there have been rises in public hospital nurses wages. So that is a problem. But so many of them are using agency nurses and casual nurses. They do not have the same staff on from one day to the next. You could not possibly see how somebody's condition had changed from one day to the next. You could read it in the nursing notes if you had time, but you could not actually see it, because you do not know the people. There is little sense of responsibility for someone if you are moving in and out willy-nilly. It makes it very difficult.

There is also the question of communication. A lot of the assistants in nursing in this particular place were—I have to be careful about what I say, because I am not actually sure of the facts. But it was certainly the case, when I had my encounter with the administration at this place, that they had just been raided by Immigration and half-a-dozen people had been carted off. They were, as I understand it, illegal immigrants and presumably had been given haven in this place, possibly by an administration that thought they were legitimate.

Ms HALL—Workers that were prepared to work for a lower wage?

Ms Warn—They might well have been prepared to work for a lower wage, and I do not know what they were being paid. They were very grateful to have work, and many were very good at what they did. People like this are being sent back home after they get taken to Villawood, because they have often been here for a long time and often have been working sort of underground in nursing homes for a long time. They become part of the furniture—often quite an affectionate part of the furniture—but they are illegals, and when the system catches up with them they will be taken to Villawood or a detention centre and their case will be reviewed. They do not fit the law and they must go back. Then there is another position that is not filled by someone who might have filled it, with some retraining and some support. It is very difficult. I am not advocating illegal immigration.

Ms HALL—You talked about public education. What format do you think that public education should take, how should it be directed and whose responsibility should it be?

Ms Warn—In the first instance, it might as well be the Commonwealth government. When I was working in Canberra, I was actually working for Dr Grimes and Dr Blewett at the time that the HIV-AIDS epidemic was looming into view. As Professor Le Couteur said, there was a criticised but nevertheless full-on education campaign directed at the whole community about HIV-AIDS which led to people seeking treatment more quickly, which led to better research for treatments, which led to less discrimination, which in many instances led to a better social situation for people at risk and people who developed the disease. If you can do it for HIV-AIDS, for breast cancer, for heart disease and for cancers, it is just so easy to start doing it for ageing—particularly for dementia. It is nice for our creative people to be doing television, plays and films and writing novels about it, but we somehow have to get it into our schools.

We need to make sure that people are valued. We need to ensure that if people need care in the community it is good care and that if they get carers at home they are good, safe, reliable, competent carers who are not going to prey on people and take them down, which is a big fear in some instances. We need to ensure that when they go to a residential setting they will be accorded the dignity, gratitude and affection—as well as the health care which goes with it—that they deserve. The Commonwealth and states could have a joint program; individual facilities

could have programs. Mr Mossfield has talked about volunteers. I notice that often in my local community newspaper there will be a small ad for volunteers to visit nursing homes. Lots of people are doing it—but in a piecemeal fashion.

Ms HALL—Could it be required to be written into the care plan as part of the accreditation process?

Ms Warn—It could. I think we just have to open our minds to what the possibilities are and not be so fixated on the money. We have got to be much more fixated, as you were saying, on the person. What is best for the person is going to be best for the other people living next to that person, and will be best for the staff looking after those people, because it will be a more rewarding place to work. It will certainly be an easier place for people to visit, because at the moment it is really tough.

CHAIR—As there are no further questions, I thank you for the evidence in your submission and also for your opening statement.

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

That the committee accept exhibit No. 43, *In their shoes: caring for resident as individuals* by Patrick Flanagan and Megan Stoyles; and exhibit No. 44, *In their homes: caring for people as individuals* by Megan Stoyles and Patrick Flanagan.

[2.05 p.m.]

BLOCH, Ms Jo-Anne, Deputy Chief Executive Officer, Investment and Financial Services Association

GILBERT, Mr Richard, Chief Executive Officer, Investment and Financial Services Association

CHAIR—Welcome. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The Investment and Financial Services Association has made a submission—submission No. 51—to the inquiry and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Gilbert—Thank you very much for inviting us here today. It is indeed a privilege to come before this committee to speak about ageing/retirement income policy. In our six years as an association this is the first opportunity we have had to speak on these broad issues before a House of Representatives committee, and I think it is a very strong and positive move on the committee's part to get this inquiry going.

IFSA is concerned about retirement incomes policy fundamentally. Ageing policy and those associated care issues are less important to us, because that is not our focus. However, retirement incomes policy affects not just those who hit 40 or 50, or who have retired—this is a cradle to grave agenda which must be addressed squarely by both political parties. Where possible we must have bipartisanship, because this is the only way that sustainable outcomes can be achieved which can bridge changes in governments.

I would like to instance the superannuation guarantee initiative, on which we have had bipartisanship. Initially the coalition opposed it, but then the coalition supported it and we now have a very strong three-pillars policy. Another area where we have had very successful and strong bipartisanship is in relation to the regulation of superannuation retirement incomes moneys. We had Labor introducing SIS, the coalition backing it when in opposition, and the coalition supporting it now and building on it. More latterly we had the Managed Investment Act, which the coalition promoted and the Labor Party opposition supported, and we have been through the toughest markets in 30 years and we have not had substantial fund failure—a good example of the need for security of retirement incomes and people's money. However, there are issues on which we do have partisan debate and we have become bogged down. Clearly taxation is one of those—and I do not want to speak it about it here, but later on there might be some questions on that.

For your information, IFSA represents 75 life insurers and fund managers and we offer investment products directly or indirectly to about nine million Australians. Our members hold more than $630 billion in funds under management. Retirement incomes and long-term savings strategy is one of our No. 1 priorities. In difficult investment markets this has meant that we

have had to redouble our efforts to inspire and maintain confidence in the system. I would welcome any questions on that as well, because a good retirement incomes system is only as good as the confidence underlying and underpinning it.

Essentially, our submission addresses adequacy, the savings gap, what we call the perceptions gap, the political consequences if we do not bridge these gaps; and we also traverse some solutions. I would like to reiterate our support for the surcharge reduction and co-contributions package of reforms. I also think we need strategies and solutions to address consumer confidence by way of education. That is important, and I am happy to answer questions on that. I am also happy to answer questions about how we can de-link superannuation from employment. I think that is a problem, because people do not spend all their working lives in a job and yet people want to save for superannuation and for retirement. There needs to be flexibility there. That is why we put to the government—and they are still reviewing it—a thing called the growth pension initiative. That is in our submission, and I hope to get some questions on that. And finally we are happy to answer questions about what is the best way of educating our retirees and prospective retirees. That concludes my opening statement.

CHAIR—Thank you very much. You have addressed in your submission the issue of adequacy, and we have had evidence already today from the Association of Superannuation Funds of Australia who have said that, based on 30 years and nine per cent SG, people would be looking at a retirement income of about $19,000, including part pension. What sort of initiatives do you think are going to be required to meet this expectation of 75 to 80 per cent late working life consumption expenditure or 60 per cent of gross income?

Mr Gilbert—I do not need to remind the committee of the three pillars. We could actually reach that by giving people more age pension. That is one way. We could do that by having more compulsion, but we do not see many groups around the community calling for more compulsion at this point in time. Another means is having the right incentives for people to put more in and that is why we support the co-contributions initiative. That is something that was run in a different form by the opposition parties five or six years ago. The other method would be to reduce taxes on front-end contributions and/or investment taxes and move those taxes towards the end of the cycle in order to see people accumulating funds and to have the snowball getting bigger.

CHAIR—In your submission, you talk about the need for a well-targeted education campaign looking at these issues. We heard from ASFA this morning that an education campaign in New Zealand had not been successful in targeting private savings. I am interested in your comments on that.

Mr Gilbert—I will speak initially and then Ms Bloch might want to add something. Our position would be that education campaigns on their own would not drive the sorts of targets we need, but we can come into that. As for the campaign that we would put in place, Jo-Anne, would you like to speak about that?

Ms Bloch—Richard mentioned cradle to grave, and I really think that is where the pitch at education needs to be. It is not a pre-retirement thing, it is not something that happens when you are 55 and you are thinking about retiring and you think, 'I wonder if I've got enough?' That is really too late. We have done some research on planning for retirement—the subject of another

inquiry and submission—which indicated quite clearly that people do not plan enough for retirement and have, I think Richard has also mentioned, incorrect expectations about how much they need and how much they actually have. Education actually needs to start at an early age. ASIC has recently launched a Flying Start campaign, which has a foundation around the school curriculum, and IFSA is very supportive of that approach. But then there is the 18- to 24-year-old category, there is the working category, there are women who are in and out of the work force, there are disadvantaged groups—there are all sorts of different segments in addition to the retirement category that we need to start educating with issues such as these: do you actually know how much you need to retire on? Are you aware that there are different strategies to actually get there? What are you going to be doing in the various phases of your life to make sure that you actually achieve your goals? I reiterate that education is a cradle to grave issue—it is probably not a cradle thing, but it can certainly start at school. It needs to be categorised, segmented and targeted, and it needs to focus not simply on superannuation per se but also on the need to actually look at retirement in a holistic sense. IFSA is looking at a number of initiatives to build on the school curriculum program, which then deal with the other segments.

Mr Gilbert—As a former secondary educator, I have noticed in the last 10 years a falling off of these sorts of issues in the secondary curriculum where there is great advantage to be gained. When the federal government is looking at its education priorities, this is definitely one of those core elements that must be addressed.

CHAIR—In your submission you said that people who are nearing retirement, who have low superannuation balances, are being hit by the super surcharge and that they have not accumulated much in their superannuation fund. What sort of impact is the superannuation surcharge having on this group? Would they get any relief from a reduction in the superannuation surcharge?

Mr Gilbert—Our belief is that they would. There are many claims and counterclaims made on this front, and one of the claims made is that the surcharge only applies to wealthy people. We contest that. We have been into two of our very large funds that went amongst our members. We got the first fund to do a computer scan of members over 40 paying the surcharge and we found that the average balance of people over 40 in that surcharge was $87,000. Fifty per cent of the balances in that fund were less than $40,000. In another large fund the median balance was $50,000 and the average age was 47. The average surcharge paid in 2000-01 was $4,500. These people are not wealthy. If you have $87,000 when you retire at age 65, that would scarcely buy you an income stream of $7,000 a year. That is not wealthy.

What you have to look at is that if people are allowed not to pay the surcharge—in other words, we just leave the contributions tax there—are there sufficient mechanisms to make sure that the wealthy do not receive too many tax advantages? That is the question. My answer to that question is that there are age base limits on contributions; each year you cannot put more than a certain amount in. That is the first limit. The second limit is the RBL. You cannot accumulate a tax preferred benefit beyond a certain amount. We think the surcharge was equity overkill. We see any measure by any party to reduce it as a gigantic step ahead, in principle. If the tax regime is too easy, let us address the RBL. Let us address the annual contribution limits. You can clearly see from the experience of those two funds—and they are very large funds run by two very large brand name managers—that this tax is hitting people that should not be paying it and who will never receive a retirement income which will generate a sustainable retirement.

I have one more point to make. There are people out there who might be earning $50,000. They are paid a $60,000 retrenchment benefit. That puts them into surcharge territory. They spend the $60,000 and then receive a bill from their fund saying that they owe money for the surcharge—and they are in between jobs. I think we can do better than that.

CHAIR—You have mentioned the three pillars, and it seems to me that has been quite successful. Our projections are that the Commonwealth expenditure on the age pension over the next 40 years will increase by two per cent of GDP, which is very modest compared to other OECD countries and much less than comparable countries, such as New Zealand and Canada, where it will increase by six per cent of GDP. How do you see the three-pillar model? Do you think there is an overseas or alternative model which would be better, or do you think the three-pillar model is quite a good way to go?

Mr Gilbert—Our belief is that, fundamentally, we have a very good model. But we have a population which have aspirations which exceed the amount of money which is going to be produced for them to retire on. We have to change the settings on those three pillars in a way which allows for more sustainable retirement outcomes. One thing we should not do is massively increase the pension benefits. Five years ago, the self-sufficiency ratio in this country was about 15 per cent—15 per cent of Australians could put their hand on their heart and say, 'I don't receive any government benefits.' That ratio has gone down and it should not be going down. We should be pushing self-sufficiency up.

CHAIR—Is that for retirees or for all Australians?

Mr Gilbert—For retirees. Clearly, we have to look at our retirement income streams policies. We have to finetune them to ensure that there are greater incentives for people to take a retirement income stream rather than double-dipping on a lump sum.

Ms HALL—An area that I am particularly interested in is something that you have talked about—that is, flexibility and simplicity, and the impact that the current system has on people who have fragmented working patterns, in particular women. How do you see that this would be best addressed?

Mr Gilbert—One way is to attack the age base limits and make them more generous in the middle years. In the beginning years, when a woman is having children and is out of the work force—and my wife personifies this—perhaps you do not need to change the age base limits. But in those middle years, when they do have a chance to get back into the work force and earn an income—and often these people have been to university part time and got a degree and suddenly their earning power is increased quite substantially—they are not able to put as much money as they would like to put into superannuation. They are limited.

Ms HALL—What about low-income earners?

Mr Gilbert—For low-income earners I think the co-contribution concept is the way to go. That is definitely a good incentive, and we applaud the government's decision, in the release the other day by Senator Coonan, to increase the range of co-contributions from $30,000 up to $40,000—a very strong development. Once that concept is enshrined in our policy, then other governments and other parties can look at boosting those benefits. Our research—which I think

we provided to the committee but which I will send—shows that in the income range between $20,000 and $50,000, there is very strong demand for a co-contributions model.

Ms HALL—Another problem that I, as a member of parliament, come across quite frequently—and this was put to us this morning—and this should be a lot better now that superannuation payments are paid quarterly, is that the superannuation guarantee payment is not always made by employers and consequently workers spend a lot of time running around trying to get it. Even though there is an ATO office there to recover that money, I do not think I have yet come across a case of someone having their money recovered.

Mr Gilbert—That is a difficult question. I am sure you are aware that we have literally millions of lost accounts.

Ms HALL—Yes, I am.

Mr Gilbert—I think we can do better on tax file numbers and matching. Once balances get to a sizeable level—for example, $10,000—it is our experience that people start taking a greater interest and are more likely to put their money together. I think this committee has to look very closely at choice and portability in that regard. Having a piggyback pension which you take from job to job would definitely stop someone setting up a new account with each new employer. That is clearly something we have to do, but with the proper consumer constraints to make sure that these people are not disadvantaged by virtue of higher fees and commissions.

Ms HALL—That is always an issue, isn't it?

Mr Gilbert—Yes, it is an issue. Hopefully the FSRA reforms will give us the transparent disclosure which we need.

Mr MOSSFIELD—What is your view on the superannuation guarantee? Would you support an increase in that, bearing in mind your own comments about reducing take-home pay?

Mr Gilbert—We have thought long and hard about this issue and basically we have come down on the side of what we consider to be community opinion. In a way, it would be very self-interested of us to say that the government should pass a law to increase the amount of money coming out of an employer's profits to pay for the individual, and it would be equally very self-interested of us to say that it should come from the individual's pay packet. We agree that the goal should be to have a greater total amount of contributions; but as to where that should be apportioned, I think that is for the body politic. So I could not, and will not, say at this hearing that employers should be asked to put another three per cent in, as was mooted once.

CHAIR—What about employees?

Mr Gilbert—That was mooted once too. It was originally going to be nine plus three, but industrial relations conditions changed and it did not get there. If employees were asked to put in, we would have to look at the other two segments, governments and employers, so that it was a community-wide response.

Mr MOSSFIELD—One way to boost the value of superannuation schemes would be to remove the contributions tax. Do you support that?

Mr Gilbert—Yes, absolutely. Lowering the front-end taxes and pushing them to the back would be a gigantic step forward. The surcharge reduction and the co-contributions tax are about removing front-end taxes for about one million Australian workers. When you add the numbers you see that it is 500,000 plus 500,000. They are steps in the right direction. We also support reducing the contributions tax, which I think your leader mentioned in his budget speech. But we have to be realistic here. This government has something on the table. It is the government and it has control of the policy levers. We have been waiting for a long time for some superannuation tax relief. So our contributors and account holders are always saying, 'These taxes are too high.' In many respects we represent their views in saying that we want some movement now, not in three or four years. We have had nothing but tax increases in this industry since 1988—there have been successive tax increases at the front end.

Mr HARTSUYKER—You raised that issue of tax at the front end. Another issue which a lot of constituents raise with me is the issue of fees and charges. Whilst no-one minds paying fees and charges, particularly when a fund is performing in the upper quartile, there is a lot of resentment expressed to me about when funds are underperforming, when there is dubious representation or disclosure with rose-coloured glasses, if you like, of the charges that actually apply to a particular investment. I think it does not do the funds management industry as an industry any good. I certainly believe it is prejudicing the net retirement income of people when they cannot necessarily make an informed decision. What is IFSA's view of a fee regime that rewards performance rather than rewarding a fund whether it performs or not and the impact of that on retirement income?

Mr Gilbert—That is an excellent question, Mr Hartsuyker, and I came partially prepared for it. Funds management has been running for about 30 years in a grand sort of way. During that 30 years we have delivered average returns of about eight per cent. You take three per cent inflation off and you get about five per cent real. You compare that to three per cent productivity, which the economy has driven. We have delivered pretty good results to investors over that period of time. When three years ago we were delivering double digit returns, no-one was saying to us, 'Put your fees up.' They were still saying, 'Put your fees down.' We had two negative years—for some investors three, but let me tell you that not all investors had negative years—and people are asking us to put them down. I think there are two sides to this coin.

We do have performance based fees in the wholesale part of the industry. That has not come yet to the retail industry, and that is why you are getting those comments. But the industry funds, for example, pay performance fees to my members in the wholesale space—not all of them, but there are performance arrangements there. But a person who is not performing can be sacked, and my wholesale managers can have their mandate withdrawn overnight. So there are very punitive outcomes for fund managers. They do not get a reduction in fees; they actually get no fees.

Ms HALL—Can I add to what Luke was saying. I as a member find it very difficult to justify the fact that people's capital is being eroded by fees. It is very hard to say, 'Okay, this is your saving. You have invested it in superannuation and yet it is $20,000'—or so many thousand—

'down from the previous years.' It is all very well to say somebody will get sacked if they do not perform properly, but they see it as their life savings, their retirement plan, being eroded.

Mr Gilbert—I get the message. My members are in a very competitive environment and, where people can move their money to a lower cost fund, they do.

Ms HALL—But they often lose money by moving it. That is all part of the problem.

Mr Gilbert—On that front, if you leave an industry fund and go to another industry fund, it is $20 or $30 at the most. If you are in a fund which a financial planner put you into and that financial planner, rather than charging you a two per cent up-front fee for the advice, has put it to the back, that is a difficulty. I think consumers should be educated about the fact that they are the consequences of paying an entry fee, and perhaps that consumer, if they felt that way, should have agreed to pay the planner a flat fee.

Ms HALL—But they do not always understand.

Mr Gilbert—It comes back to education. It comes back to—

Ms HALL—Disclosure?

Mr Gilbert—Absolutely. We have no disagreement with what this government is doing with the Financial Services Reform Act and what ASIC is doing to make fees be more transparently disclosed. I cannot go to any one of my members and say, 'You've got to stop fees or to cap them.' But what I can do is advise my board of this. We are actually coming out very strongly in support of even more transparent disclosure. We have worked closely with ASIC; we were with ASIC six months ago to put together a fee calculator so that people could actually go to a zero fee web site to work out what their fees would be, given the prospectus they had in front of them. We cannot do too much on this front—I agree with you—but we will try.

Mr HARTSUYKER—I think this is the disquiet that has been expressed to me: while nobody complains specifically that, if a fund is managing in a particular market and globally those markets are down, I think that investors can accept that they are taking benefits and potential losses by participating in those higher growth funds; but where your fund is actually performing in the lowest quartile it is a different scenario.

Mr Gilbert—Clearly, if it is superannuation money, the individual should be in a position to move those moneys, and when we have a choice regime and a portability regime, that will be open. If we look closely at the current practice in terms of exit fees, they are largely not there now. There is historical baggage there from when life insurance was predominant in this industry. That is not the case now. If you look at the prospectuses that are on the market right now, exit fees are uncommon, basically—they are not triggered—but perhaps Ms Bloch might want to add to that.

Ms Bloch—We have done some research on fees, and of course the superannuation industry itself has a number of segments—I must be obsessed with segments today; I have talked about segments in education and segments in fees. I think you do need to understand that there are different services for different fees. You can get a whole range of different fee structures

depending on which superannuation fund you are in, so I think there are a number of issues to understand there—that there are different services. For example, some of the products offer a wide range of investment choice. They offer online access and a whole range of other things other than investment performance. You buy into diversified structures in which some asset classes are not performing and others are, but these are long-term investments.

If you look at underperformance during the last couple of years, you actually need to look at the last five or 10 years or the next five or 10 years—you need to look at those sorts of strategies. We do talk a lot, through education and so forth, around the fact that this is long term, that you need to have money in different sorts of asset classes to balance the sorts of investment strategies you have, that the fee per se is a fee for a service and that, if you do not like the service or if you do not think you are getting that service, you should be able to choose between funds.

Mr Gilbert—One of the things that we acknowledge—and I think the last three years have taught us this—is that there needs to be more education on risk. We are seeing the markets going up 12 per cent or 15 per cent and individuals are still putting money in them, in the offshore—and the dollar has gone up again so the value of assets will go down. So people who are exposed offshore are still going to have pain, and that pain will not go until simultaneously our dollar is falling and the US market is rising. Perhaps some of those people needed to be more aware of some of those risks when they went into those products. Perhaps those people were ill advised to go into it and so the financial planner might need to answer some questions. If that were the case, there are mechanisms for those consumers to appeal to the tribunal which looks at those advice issues. The industry has a body called FICS which hears those sorts of disputes.

Ms HALL—It is very difficult, though, for an ordinary person, particularly somebody who is a little older, to go through that process and the bureaucracy that is attached to it. The actual moving of a claim through it is exceptionally difficult even when it is a good and valid claim. I think part of the problem is making sure that people do understand upfront. It needs to be explained in a way that is relevant to that person. I really think that what is lacking is education—talking about what should happen and everything. That needs to happen, and it needs to happen not by handing people sheets of paper and saying, 'This is what it's about,' or being very obscure in the information that is given to them. It needs to be explained in terms that they understand, and I do not think that happens.

Mr Gilbert—Are you suggesting that financial planners have to do a better job?

Ms HALL—Yes, I am.

Mr Gilbert—We do not represent the financial planners.

Ms HALL—I know you do not.

Mr Gilbert—But some of our members own those groups.

Ms HALL—Yes, I know that too.

Mr Gilbert—I appreciate that.

Mr HARTSUYKER—Do you see—and we have talked about disclosure of fees—a potential conflict of interest in which potential investors are guided in areas which may have a greater benefit to a particular financial planner, bearing in mind that a lot of these customers are not particularly financially astute and will take the advice of the people they retain?

Mr Gilbert—Under the act, if a planner is doing that, that planner should not have a proper authority to deal. ASIC has to come down very hard on those individuals. In conflicts of interest, the client comes first, not the planner's pocket. It is a simple answer.

CHAIR—Do you have any ideas about how to manage the expectation gap? Would you say that we should meet expectations and increase contributions and so on?

Mr Gilbert—I do not think we have done a lot on managing the expectation gap. We have let it build a head of steam which is going to be very difficult for both parties to assuage. Managing it is via education. It is via good financial advice, and it is education which begins to have effect as soon as a person is employed. There is about a 10 per cent gap there. I think the figure is that people are going to get about $20,000 and they want $30,000. They are the sorts of rough figures in today's dollars. It is possible to bridge that through fairly copious savings. Our savings at present are historically low. We can do more with the right education and the right gap.

Ms Bloch—I think one of the things that we have missed but one of the things that IFSA is certainly looking at is how you get people to understand how much they need in retirement. To ask a 20-year-old how much income they think they are going to need in retirement is a difficult ask. We need to start helping people. We talk about budgets in terms of 'here is your income; here are your expenses', and I think we need to develop some sort of way to understand how you can work out what your needs might be. We talk very easily about needing to reduce your debt, needing to go into retirement free of debt and all those sorts of issues—and I think that is difficult.

We need to focus on helping people work these things out, work their strategies out, then work backwards from there and work out how they can meet those strategies. Financial advice is always critical to that. I know financial advisors try to do that, but I do not think all the population has access to financial advisors. They need to be able to work that through, and they need to be able to work almost 40 or 50 years ahead and backwards. I think that is going to be the trick to helping people manage that expectation and then feel comfortable that they will meet those expectations.

CHAIR—You mentioned that private savings are low by historical standards. If we look at similar countries, like the United States, the United Kingdom, New Zealand and Canada, all of them seem to have very low household savings. Is this due to either a wealth effect from existing investment, or is it due to credit card loyalty schemes and that sort of thing? What do you attribute this very low level of private household savings to in, it seems, most OECD countries?

Mr Gilbert—I think the wealth effect is clearly operating. It is operating in owner-occupied housing, as people live in bigger and bigger houses with fewer and fewer people. That certainly is having an impact. The housing boom probably has contributed to it. That is the evidence I get from economists within my member companies. I think it is the consumption effect too: the drive to travel, the drive to educate one's children and the drive for leisure is clearly much bigger

and stronger than it was. As a consequence, the savings rate is low. To some extent, the SG—whilst it was a very positive measure—was always meant to be added to, and I think the SG may have given some segments of our community a false sense of security.

In relation to education, in order to retire, people need to know the sorts of things they will buy—the sort of vehicle, for example—in retirement. If you went to the average 50-year-old, for example, and asked them, 'What is an annuity? What is an allocated pension? What does it mean?' I do not think they would know. What I would like to do—and I am not saying you are the average politicians—is give out our little handout of what distinguishes these products and how they are affected by social security, tax and the like. What I have put in that chart is a middle run, which is in grey, which is an alternative, middle-of-the-road vehicle which we have suggested the government take up. We have also suggested this to the shadow spokesperson on superannuation, Senator Nick Sherry. Hopefully, in a bipartisan way, this is going to have take-up.

We believe that the gap between the treatment of allocated pensions and annuities is too great, and we need something in the middle which will encourage people to take a third vehicle and have a more balanced offering of retirement income stream products. I think we have mentioned this in our submission, but I am happy to take questions on it.

CHAIR—So how would this growth pension differ from a fund which a private individual got into now? It seems the main difference would be that you limit the amount that can be removed each year. Is that right? You would be removing the income and a little bit of the capital as well, based on what the life expectancy is.

Mr Gilbert—That is the best definition I have heard, Dr Southcott. That is precisely right. We are happy to give the committee our research on what consumers need. I think we might have given some of it. Our research showed that people want control. They do not want to have all their money in an annuity which dies with them. There could be a balance there; 10 years after dying there could be another 20 years worth of money there. People do want to have the right to bequeath money. It is about control. People also want to have the right to commute sometimes, although the growth pensions allow that.

Essentially what would happen with the growth pension is that every year you would recalculate what the person could draw down, having regard to what was earned over the last year and what their life expectancy is. You would not let them have access to the capital, but you would allow the bequest to take place. When these moneys go into a bequest they are taxed unconcessionally. In other words, they go to the beneficiaries with taxation attached to them. They certainly do not go to the life insurance company, as happens with an annuity. The great benefit is, we believe, that over the long run a growth pension will give a better return than an annuity. Recent history might not prove that, but over the long term it will. We should be optimistic about this economy and the financial system that underpins it.

CHAIR—Could you just point me to the section in the submission on the growth pension?

Mr Gilbert—I think it is towards the end. I think it is one of the attachments.

CHAIR—Here we are: appendix 4, page 38.

Mr Gilbert—It is not the intention that every retiree puts all their money into a growth pension. A good financial planner would balance those moneys across the three sorts of products. You might have read in recent times that annuities are very popular. But people putting all their money into an annuity are, in effect, getting a return of about 2½ per cent. In five years time, when rates are high, we could have some people complaining.

CHAIR—You said there was going to be a new class of complying superannuation pensions and annuities. What is the hold-up on the discussion paper?

Mr Gilbert—The government promised to review these things in the election policy it took to the 2001 election. We have had some discussions with the Treasury. Obviously we would have liked those discussions to proceed at a faster pace. Perhaps some of those discussions have been drawn into the Intergenerational Report that the government is doing. I am not sure about that. But I hope and trust that, if they have been, this becomes a viable option for debate in the IGR.

CHAIR—Do you want to add anything in closing?

Mr Gilbert—I would just like to say that this has been very constructive. I hear your messages about consumer fee and consumer confidence, and they will certainly be communicated to my board. Our public statements on these things will be louder, I think, and more helpful.

CHAIR—Thank you very much. Is it the wish of the committee that we accept the growth pensions proposal from IFSA as exhibit 45 to the inquiry? There being no objection, it is so ordered.

Proceedings suspended from 2.44 p.m. to 3.06 p.m.

GALE, Mr Andrew Crawfurd, Vice President, Institute of Actuaries of Australia

KIRK, Mr Andrew James, Manager, Policy and Research, Institute of Actuaries of Australia

WALSH, Mr John Ernest, Member, Institute of Actuaries of Australia

CHAIR—I welcome representatives of the Institute of Actuaries of Australia. I advise witnesses that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I, therefore, remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. The Institute of Actuaries of Australia has made a submission—submission No. 138—to the inquiry, and copies are available from the committee secretariat. Would you like to make an opening statement before I invite members to proceed with questions?

Mr Gale—I thank the House of Representatives Standing Committee on Ageing for this opportunity to speak to our submission. We had preliminary discussions with Dr Southcott pre-Christmas last year and we made our submission in February. We really welcome the opportunity to speak to and expand upon that submission. By way of introduction, my role is to chair our public affairs committee, and the subject of this committee inquiry is one of the key issues that we are focused on an ongoing basis. I will make some introductory remarks and then Andrew Kirk, in his role in public policy, will speak in particular to some of the retirement funding and retirement incomes related issues. John Walsh will speak to issues particularly focusing on health, long-term care and aged care.

The Institute of Actuaries of Australia has a key keen interest in ageing related issues. The profession overall has the capacity, obligation and indeed an interest in contributing to public policy across a wide range of practice areas. Many actuaries work in superannuation and retirement incomes, health and financial planning and related financial services fields. Therefore, we believe that we are well placed to make a valuable contribution to developing appropriate long-term policies.

Financial analysis of the impact of an ageing population is also a core competency of the actuarial profession. We have been actively involved in that area in a range of capacities. A few years ago, in 1999, we developed a position paper, which is cross-referenced in our submission, called ‘Financing the ageing’. We think that would be worthwhile research as part of the consideration of all of these issues. We also made submissions in response to the Intergenerational Report last year and we have made numerous submissions on retirement funding related issues. We also covered some of these issues in our pre-budget submission.

The committee on ageing has the advantage of a two-year time frame. One of the key points that we would like to expand upon is the advantage of developing at an early stage in that process a set of principles which could guide the inquiries and findings that you make over the course of the next couple of years. We think that time frame also permits the fact that there is some valuable additional research to be done in this field. Given that sort of time frame, we

would be very happy to suggest areas where additional research would be worth while and, indeed, assist in that research if that would assist the committee.

First of all, I will go to some of our key recommendations and expand upon them, especially around the issue of principle and so on. On page 5 of our submission, which is part of the executive summary, our core recommendation is that the committee establish and publish early in its term an interim set of ageing population principles which will underline its recommendations on strategies.

I would like to expand on that first recommendation. A good example of the benefit of that approach is the work we did in the area of retirement incomes. Indeed, in appendix 3, which is on page 31 of our submission, you can see an example of a principles framework that was established in another context and which was focused in particular on Australian retirement incomes. In this case, the Institute of Actuaries was instrumental in coordinating, leading and facilitating a group of 18 different stakeholders a few years ago to talk through principles associated with Australian retirement incomes. We gained what we thought was a very significant achievement in getting those 18 bodies, which included APRA, IFSA and others, to agree to a broad set of principles that could provide a very useful framework for consideration of issues to do with Australian retirement incomes. It is that sort of framework that we think will be very valuable at an early stage in working through all the issues to do with ageing, which is a daunting and very broad agenda. Getting that sort of principles framework in place could provide good guidance as you work through the range of issues you will be looking at. To the extent that you follow that approach the institute would be very pleased to help facilitate such a workshop if that is something that would be useful to you.

In the framing principles we also recommend a set of criteria against which they can be assessed. Without speaking to our submission in detail, section 2, which is on pages 8 to 11, elaborates to a much greater degree some of the high-level principles, such as taking the long-term view, adequacy issues for individuals and families, community balance, and the principle of economic effectiveness and efficiency.

As those principles are being developed, we also suggest on page 10 of our submission a set of criteria that can be used to assess the usefulness of them. We have borrowed from our 1999 paper entitled ‘Financing the ageing’, which discussed some of the criteria against which those principles could be assessed. Principles relevant to personal community consideration are confidence that the policies will provide Australians with a secure knowledge that expected benefits will be available when they need them across a broad range of areas, whether that be retirement funding, health or long-term care and some of the infrastructure type issues that go along with that; that the policies developed will be simple and easy to understand—in other words, a transparency principle; that they contain an overriding principle of fairness so that there is available a minimum level of benefit for all aged people, determined in the context of economic, social and policy conditions; that the policies contain the principle of political neutrality and acceptability; that the policies are independent; that the policies contain the provision of family support and encourage active ageing. These are some of the criteria that we recommend would be useful in assisting the development of that principles framework. As I said, I want to expand on that first recommendation, because it is probably a key one. We believe, especially given the time frame, that if we have that sort of principles framework, have it

assessed against those criteria and have it done at an early stage it could provide a very useful structure for the committee's work.

I will touch on the other recommendations briefly. We recommend that these principles be established on a bipartisan basis; indeed, the makeup of the committee should certainly help that process. Further research is required in a number of key areas and we recommend that the committee commission financial and other modelling work to investigate alternative strategies and issues. We think that will assist in an informed debate. A very specific part of that recommendation is that we suggest a second Intergenerational Report be commissioned for publication no later than the first year of the next parliament and that future reports be produced every three years.

We also submit that a key underpinning to the Intergenerational Report was the retirement incomes model, which was very useful in developing the initial Intergenerational Report. We believe that there is a range of different scenarios which would be worthwhile modelling. If you wanted to understand the outcomes of different policy settings or frameworks, they could be tested through the retirement incomes model. We believe that if the institute had access to the retirement income model we could make a very useful contribution to the workings of the committee. The final recommendation is based on the principles adopted that we identify separately: those long-term directions that are confirmed and the topics which remain subject to further public policy debate. That is a very broad framework.

The other approach which may be useful—and we touch on this briefly on page 4—is the development of strategies. Another area in which we think we have assisted is that of medical indemnity insurance. When we met with a range of stakeholders in October last year, we played a role in facilitating a workshop and establishing a road map for working through the complex medical indemnity issues. Again, we can send that document to you, if you like. The sort of structural framework of the road map that was used for working through the medical indemnity issues could be very useful in working through the ageing issues. That is all I want to say in terms of overview comments. I now hand over to Andrew to work through retirement funding and retirement income related issues.

Mr Kirk—I am going to say a few words about retirement income and superannuation related issues generally. To lead into that, I would like to touch on some key points in section 3 of our report that address some top level key decisions that need to be made in relation to all aspects that are covered in this report that relate to ageing and the funding of ageing programs. I will talk about them as they relate to superannuation and retirement incomes, but they relate across the board.

The first point, 3.1, is a fundamental decision about whether a given program should be funded, prefunded or pay as you go. Different programs are funded in different ways. There is a range of things that are pay as you go, such as the age pension. Others—such as the SGC, for instance—are funded. The extent to which the programs have a balance between those two is a key threshold decision. Another one is whether a given benefit should be targeted as a safety net or at a key part of the population or whether it should be universal. Again, looking across the public policy spectrum, there are aspects of both. That decision needs to be made in principle for the key aspects of the retirement incomes program. Whether it is voluntary or compulsory is another issue. The retirement incomes program has aspects of both. Another issue is whether

they should be publicly or privately funded, including, of course, tax concessions that are an element of public funding.

The Australian system for retirement incomes at present has what we call the three pillars system that has been around for quite some time and has aspects of all of these. It rests on a base of the age pension, which is to ensure that no Australian in their retirement should be without a minimum level of funding for living. On top of that you have the superannuation guarantee, which is a compulsory form of saving for people that are working. On top of that, there is the voluntary system, where tax concessions provide incentives to people to save in order to top up those other elements and provide for an adequate retirement income.

The question of what is an adequate retirement income is a key one because it goes to the heart of the question of how much it is going to cost and how it can be reasonably funded. The work that we and others such as Treasury and ASFA have done seems to indicate that under the current system most Australians will not have a retirement income at a level that is generally regarded as being adequate. It is important in that context to think about what adequate means. A generally accepted definition amongst those that discuss these things is defined in terms of replacement ratios—what proportion of your income prior to ceasing work do you get? Typically, a generally accepted figure is 60 to 70 per cent of your gross pre-retirement income. Because of the progressive nature of the tax system, that comes in at about 70 or 80 per cent after tax.

The projections that have been done indicate that a person on average weekly ordinary time earnings would be expected, after a 35-year career, to achieve a replacement ratio of only about 60 per cent or slightly below, depending on the assumptions that you make. But, critically, more than half of that would be made up out of the age pension, so there is a very heavy reliance upon the age pension in order to achieve that. And the higher income levels go above average weekly earnings, the lower that replacement ratio goes. In terms of generally accepted notions of adequacy, the current system is not expected to deliver what most people would expect. In addition to that, the Intergenerational Report indicated that the costs of providing benefits, including age pension benefits, will increase quite substantially as the population ages.

There are a range of policy alternatives that could be looked at to address both of these issues, in terms of both improving adequacy and containing cost. In section 4, we look at a variety of these things. A range of issues are raised, and one point we want to make is that some of them are quite controversial. We recognise that there are political sensitivities, but all options should be on the table at the start and approached with an open mind in order that they can be evaluated and the best solutions found.

One of the issues we have looked at is the pension age. The age at which people can commence drawing the age pension is 65. It has been that way for about 100 years. Now, with increased longevity and the increased health of older people, one option is to look at whether that might be increased over time. With that is the ability of older people to continue employment, especially in a part-time capacity. Alternatives should be looked at to see whether that can be encouraged so that employers may provide options to older people. The retirement income system can provide much more adequate incomes if people take their benefits from superannuation as income streams rather than lump sums, yet the tax system at present provides very little incentive to do that and in some cases actually works in the opposite direction.

Reviewing the way in which the regulations and the tax system approach the balance between those things could assist.

The age pension currently applies to a very large proportion of the population, and as time goes on the cost of that will increase. Thought might be given to whether a targeted proportion of the population should receive it, but we should ensure that the other measures—the other pillars of the three-pillar system—are structured in such a way as to make sure that people still receive adequate benefits. The means testing of social security benefits, and of the age pension in particular, currently excludes the family home. This is a sensitive and important issue. We recognise that. There are strong arguments to allow any means testing to so exclude it. But it also creates considerable problems, especially in places where real estate can be very valuable and there can be asset rich but income poor people who are still drawing down the age pension. Consideration could be given to encouraging structures that would enable people in such situations to obtain an income based on their asset without having to sell it or give away what they may see as the inheritance of their children. Reverse mortgages are one particular type of structure that may allow that to occur, and encouraging a reverse mortgage industry could be a very positive aspect in that regard.

In terms of government borrowing, pension funds and superannuation funds in Australia currently rely on government bonds as a key part of their investment strategy, yet the supply of these bonds is rapidly diminishing. Consideration needs to be given to whether or not it is important to have a supply of bonds to enable superannuation funds and others to set sensible investment strategies. On the other side of that, in setting government policy in relation to retirement incomes and other things, taking a longer term time frame of the costing of certain initiatives may allow a better long-term outcome to emerge. An example of that would be to move part of the tax on superannuation from contributions to benefits.

This initiative would have a number of advantages—in particular, it allows a much more progressive taxation system at the benefit end than can ever be efficiently applied at the contribution end. Looked at on a one-year basis that sort of initiative would be seen as having an enormous cost to budget, but looked at over a whole-of-life basis it has a zero cost because the tax is eventually collected. The other side of that is that there is borrowing in the meantime; but, in an environment where there is a very low level of borrowing, that may not be a negative. These are all examples of initiatives and issues that we believe ought to be brought out and considered with an open mind to see what may emerge that would be beneficial.

Mr Walsh—My main area of practice is in the area of health care, aged care and long-term care. I have been asked by the Institute of Actuaries of Australia to present the submission to the committee. The following figures are a way of setting the scene. The current Australian economy spends approaching $60 billion on health care. Of that $60 billion, perhaps $50 billion is on people with advanced ageing. The curve of expenditure on health goes up exponentially when people get past the age of 75 to 80. So health care is a major issue for ageing. This year—I am sure you are all aware—the Australian health care agreements are being signed. The nature of health care and health care planning over the next five years is to a large extent going to be determined or at least planned in the next few months. So I think it is relevant that the committee considers the issues around ageing and health care fairly significantly.

As a general overview, the Australian structure of health care financing and delivery is fragmented. It is fragmented across both areas of funding and areas of service delivery between Commonwealth funding and state funding and resource allocation to different areas within each of those branches. Service delivery and providers are segmented as well. General practitioners have very little to do with institutional care delivery, and residential age care providers have limited amounts to do with the community sector. There is segmentation in both funding and service delivery, which needs to be considered carefully.

Overseas models are moving far more towards community ownership of health delivery and health funding. We think there is a good opportunity at the moment for Australian governments—Commonwealth and state—to work together in considering a way in which communities could take a much more active ownership of their own health planning, health funding and health delivery.

Within that overall structure, our institute supports the general thrust of a basic level of care and safety net for all Australians and, beneath that basic level, an increased flexibility in other arrangements to top up, co-pay or finance alternative delivery. We believe that the development of resource allocation methods and assessments of funding based on need and risk are crucially important at the moment in determining the amounts of money to be allocated to communities. We think there are a number of ways in which individuals have the opportunity to save for their own health care requirements in their advanced age.

I have also been asked to talk about long-term care as a particular issue. I guess that long-term care falls between acute health care and residential aged care. While it is crucially important to the aged, it is also important to younger people with disabilities. While that is not directly relevant to your committee, I think the argument at the moment around medical indemnity and no-fault long-term care and so on crosses the boundaries. We believe there is a strong argument to take indemnity for long-term care out of the Commonwealth system and to institute a more comprehensive system of long-term care funding in such a way that services are paid for and delivered as they are consumed, for both the younger disabled and people of advanced age requiring long-term care in the community.

Moving to residential aged care and long-term care in the community, we believe that there is a need to move more fully to means tests and needs tests to determine access to residential aged care and community care and that there is probably a need for a more structured transition between the two. Certainly over the last decade dependence on residential aged care has shifted more to community based care delivery, but the movement between the two and the cooperation between the two still have a long way to go.

Particular issues in health care, long-term care and aged care that might be of relevance include the treatment of rural and remote areas—and I note that there is a cross-section of constituencies on the committee—particularly with respect to after-hours general practice availability and the general practice work force. The differences in socioeconomic advantage between different areas need to be considered in resource allocation. The particular needs of Indigenous Australians and their ageing must be an issue you have contemplated, because ageing for Indigenous Australians starts more at the age of 55 than at the age of 75. I am not sure if that falls within your ambit or not.

The last thing I would like to talk about before handing back to Andrew is the whole notion of the assessment of health outcomes and the need for health. Historically in Australia there has been the notion that you pay for health care on an episodic basis and then it is over. What has not been carefully thought about is the way in which an episode continues. An episode of care is crucially linked to the initial diagnosis, the treatment by the general practitioner and specialist, the admission to hospital, if required, and the discharge planning and clinical pathway that follow that. There is the whole notion of crossing the boundaries of service type, service provider and health outcome for the patient. We think that the resource allocation and community funding that I spoke about earlier needs to be involved in that.

Mr Gale—I have some concluding remarks. There are a number of other areas covered in our submission which we will not expand on right now, but we would be happy to take questions. They cover such issues as the role of immigration; child support and the impact it could have; employment and education policies in terms of labour productivity rates and the extent to which that could contribute to ageing population issues; the encouragement of active ageing and transitioning, rather than having cliff-top changes in one's life; and issues to do with infrastructure needs and the taxation base. We will take those as read at this stage but would be happy to take questions. My concluding remark would be the same as my opening one. We would encourage the committee—and we would be pleased to assist—to develop a principles framework. We would also be very pleased to make further submissions, to undertake specific research in areas which you may identify along the way, into which you would like to delve deeper and in which we have expertise.

CHAIR—Thank you for that and also for setting out the framework. On the question of funding, or pay-as-you-go, are you talking specifically about retirement incomes? I am looking at 3.1.

Mr Kirk—It was intended to apply across the ageing spectrum. I addressed it in terms of retirement income, but it applies equally to health—for instance, to health insurance. Whereas they do have a fund there, it is in a sense pay-as-you-go because the cost of paying benefits will increase as their membership population ages and they do not build up a fund in advance for that.

Mr Gale—It is commonly seen in the context of retirement incomes but it applies equally strongly to health and, to a certain extent, it is being addressed on the retirement income side. One can work through the adequacy issues but there is just as compelling a need on the health side.

CHAIR—My recollection is that in the United States about six or seven years ago they were working on an advance funding scheme for their pension. They had a congressional report which said that their pension scheme would be broke by 2020, or something like that. Do you have any familiarity with that?

Mr Kirk—I am not familiar with the United States. You are referring to their social security pension?

CHAIR—That is right, yes.

Mr Kirk—I am not familiar with that. All the social security systems around the world that I am familiar with are unfunded, which is pay-as-you-go. Therefore, in a sense, they are all broke and they do not have any money. The pay-as-you-go system eventually can only be broke if whoever sponsors it is unable to meet that year's payments. In the case of the United States government, that would be a very serious outcome.

Mr Walsh—My understanding—and it is not my area of expertise—is that the OASDI, as it is called in the United States, was set up in about 1935 on a funded basis. The funding was always in IOUs, so there were never actually hard dollars in the bank. It was thought: 'The government will pay this when it is required.' So it is a funded system in the balance sheet but not in actuality, I believe. More recently, it has been acknowledged that that would put an impost on government which, with the ageing of the population, it would not be able to fulfil.

Mr Kirk—The New Zealand government, you may be aware, has set up a funding scheme to smooth out its aged pension funding over the next 50 years. They are building up a fund now in order to get over what might be called the hump of the largest number of people moving through that retirement phase.

CHAIR—My understanding is that, whereas Australia will see an increase in the percentage of GDP the Commonwealth government spends on the aged pension of two per cent, New Zealand is going to have an increase of six per cent. So they have a problem of another order of magnitude in terms of being able to afford their age pension in the future.

Mr Gale—In terms of some of the high-level impacts, one of the papers which was cross-referenced, which we can send to you, is the *Financing the ageing* paper, which was done in 1999 by the institute. In the introductory section, it sets out some forecasts, which are really in anticipation of no major policy changes. These forecast that, if you look across the areas of the age pension, health care, aged care and then the funding by tax revenue and then you look at net additional costs over a period of time, for example, by 2011 there will be a net additional cost of 1.4 per cent of GDP, moving to 3.6 per cent in 2021 through to 8.5 per cent in 2051. That probably provides some of the imperative for the work that you are looking at over the next couple of years.

CHAIR—I was going to ask you about the idea of a reverse mortgage. I think you are right to say it is a sensitive and important issue. While it provides a solution to a problem, politically it needs to be handled very sensitively. Recently I heard Malcolm Turnbull talking about providing a market for equity in houses. Do you think that would dovetail in with a reverse mortgage sort of thing?

Mr Kirk—The item that Malcolm Turnbull was talking about, if I am thinking about the same thing, was at the other end of the age spectrum. It was for people entering into the home market. The idea was for a mortgage provider or financial institution to provide, say, 30 per cent of the capital and have a 30 per cent share, and take a 60 per cent share of the capital gain. The idea was that this form of co-ownership might enable people to get into the housing market who could not otherwise do it.

There are some similarities with a reverse mortgage. I understand there is one institution at the moment offering a reverse mortgage in Australia. The general idea is that a retired person would

be able to borrow—to gradually draw down on a fortnightly basis—up to a maximum of, say, 30 per cent of the equity in their house. That way it retains a very large margin of security. It is not an equity holding of the house as the Malcolm Turnbull proposal is, but it is certainly a completely new, structured type of product that is very different from the market we have got at the moment and requires a change in mind-set of financial institutions to get there.

Mr Gale—I think there is quite a range of issues associated with that. It is probably a good example of a specific area where we would be pleased to assist with further submission work, if you wanted to make further inquiries and assess some of the options—the pros and cons and the like.

Ms HALL—With reverse mortgages, there was a scheme that was introduced back in the late 80s or early 90s that was a little bit more widespread. At that time interest rates were a lot higher and there were people that found themselves experiencing a lot of difficulty and very quickly losing the equity in their houses. Is that right?

Mr Gale—There has been a range of reverse mortgages marketed going back to the mid-1980s. You are right, it starts to exemplify some of the issues—how that might impact on you if you move into a higher nominal rate environment. You need to work through those sorts of issues—how that co-ownership might change. In the context of what you are examining, you also need to look at the extent to which social security policy settings are sympathetic or empathetic to that sort of development.

Ms HALL—It could be means-tested, couldn't it?

Mr Gale—Yes. So there is quite a raft of issues. To the extent that people have sought to market them thus far, consumer acceptance has been an issue, especially for people in their post-retirement years. There is still this strong focus on owning the family home and so there is a behavioural or mental shift which needs to occur about saying, 'I will actually start using some of the equity in the home to support an income stream.' That is not to say that it is not achievable, but in terms of consumer acceptance that is one of the issues which any providers or marketers of those arrangements will need to work through.

Ms HALL—Going back to your principles where you are talking about confidence, transparency et cetera, what about equity of access? Where would that fit in?

Mr Gale—When we talk about some of the criteria against which the principles get assessed, one of those is fairness related principles.

Ms HALL—You see that as covering it, do you? I am not quite confident it would.

Mr Gale—The point on fairness covers both availability of a minimum level for all people but also intergenerational equity. So there are two dimensions to looking at that.

Ms HALL—That brings me to another issue. It is a German system, I think, where they are paying a percentage of their income to provide aged care in the future. Have you looked at that sort of system within the Australian scenario?

Mr Walsh—We have. Five or so years ago, the institute actually sponsored a seminar on long-term care and we invited the architects of the German system. It was an innovative system at the time and I think it is working moderately well. One of the controversial issues with it is whether benefits are paid in dollars or in services. My understanding is that the preference of consumers is that they take a lower dollar amount rather than a higher service amount, so the system is compromised a little bit by whether or not they actually purchase the services. Having said that, the funding structure is sound. It is an impost on amounts earned during a working lifetime to fund a liability in retirement, which is one that we would support.

Ms HALL—That is very interesting. I have read a little bit about it and it interested me, and your comments make it even more interesting. I suppose the rest of my questions will probably be directed to you since you handle the area of ageing and health care. Earlier today we heard from the state health department. They also talked about the fragmentation, the segmentation and the way services are funded in aged care and health. How do you think that this should be addressed to streamline it and stop a lot of the problems we have now where it is moving from the Commonwealth to the state, each blaming shortfalls on the other and, in the long run, it is the individual who misses out? How do you see that we can get around that and develop a system that does what I think everyone in this room wants it to do, and that is to make sure that when a person is older, if they need special care they actually get it; they are going to have the financial support that they need; and everything just automatically flows?

Mr Walsh—I think it is a fundamental structural problem in the health care financing system which is a political one. As long as primary care is funded by the Commonwealth through the Health Insurance Commission and Medicare, in-patient hospital care is funded by states through a grant of the health care agreements, residential aged care is funded independently by the Commonwealth and community based care is funded by HACC by Commonwealth and state jointly, there will always be borderline issues about who pays. A classic example is primary care treatment in emergency departments. GPs are increasingly bulk-billing less and charging more, so in lower socioeconomic areas people will go to the emergency department, which is paid by the states, rather than to a GP. It is a real cost-shifting exercise between levels of government that needs a high-level agreement before it can proceed, I believe. I would argue that it is in the nature of the health care agreements for the states and Commonwealth to start working it out.

Ms HALL—I think we probably agree. You were talking about the interface between residential aged care and community based care and looking at the means test/needs test. Do you have any sort of framework design or any idea of how this should work?

Mr Walsh—We have not done a great deal of work on it. At the moment it basically works on an accommodation bond system plus government subsidy for anything over and above 87 per cent of the person's age pension or whatever it is. That goes some way towards funding the system. We have not talked about this at the institute level, but my personal view would be that there is a risk in that system that those who need it most are compromised by the fact that care is given on a needs basis rather than a means basis to those who can afford it in any case, so there is, if you like, a reverse subsidy of the limited resources available for residential aged care. So I would probably argue for a greater levy or ability to pay for those who have the means to pay.

Ms HALL—You talked a little about the assessment of the health services. Do you think there should be a more outcome based approach to measuring whether or not there is an ongoing

requirement as regards health care—whether it flips over into aged care and how they interrelate?

Mr Walsh—That is a tough one. To some extent it exists already through the ACAT teams and the RCS assessment for admission to residential aged care, so once you get to a stage where you are assessed as needing residential aged care you move into that safety net. Primary care and institutional care are still provided through the health system, so GPs still deliver care under the Medicare system within nursing homes, and people in nursing homes who need institutional care are transferred into institutional care. There are some pilot projects which I am sure you are aware of. For example, there is one in the Hunter trialling 'nursing home in the hospital' stuff, which makes a lot of sense to me.

Ms HALL—Yes. This will be my last question. From an actuarial perspective, do you think the RCS is a good system?

Mr Walsh—I have not studied it in detail, I have to admit. I would be happy to look at it for you. There was a big review of it over the last 12 months or two years. I think it is probably a better system than the old RCI. It is based clearly on functional ability rather than medical assessment, so it does seek to provide a subsidy to the level of need of the person rather than a medical diagnosis which might or might not be appropriate for the need for care. I think it seeks to be equitable. That is about as much as I can say.

Mr MOSSFIELD—We spoke earlier about the need for, say, 70 per cent of pre-retirement income for people to be able to retire on. At the moment what is being delivered by the system? Is that figure being reached or is it below that figure at this stage?

Mr Kirk—I think it would be, in most cases, substantially below that figure, even for people on AWOTE. There is a transitional reason for that, which is that the second pillar of the system, the compulsory superannuation guarantee, has only been with us for 10 years. I suppose if you count award superannuation before that it was another 10 years, but that was only at the level of 3 or 6 per cent at most. People retiring now, or who have retired recently—unless they happen to be with an employer such as a public sector employer or one of the very large corporates that have always had generous superannuation schemes—would have very little in the way of their own superannuation and they would be relying entirely on the age pension. At $11,000-odd, it is not going to be anywhere near the 70 per cent of a typical income. The situation will get better as time goes on and as more people have the benefit of a full career at the full superannuation guarantee level.

Mr MOSSFIELD—What are the predictions and what needs to be done to ensure the delivery of 70 per cent of pre-retirement income for people?

Mr Kirk—The projections by both Treasury and ASFA—and we have also done our own projections and come up with similar figures—are that, for example, a male on average weekly ordinary time earnings for a career—saving at least from age 30 to 65—would end up on a retirement income of about 60 per cent of their pre-retirement income. That is assuming they would get the full entitlement to the age pension—which they would under current means-testing rules—and a nine per cent superannuation guarantee contribution throughout life.

There is always the possibility of greater tax concessions for superannuation which would increase the benefit but that, of course, comes at a cost to revenue. A somewhat easier approach to the problem is the third pillar of the three pillar system, which is the voluntary system. That involves providing incentives, encouragement, education and a range of other elements to encourage people to save more for their own retirement. At present, people are rather discouraged from putting additional money into superannuation because of a lack of confidence in the system. It is seen as overcomplex. Very few people would claim they understand it, even in a most basic way. What people do not understand they are usually reluctant to put money into, so simplification would be a major step in terms of encouraging people to put more money in and therefore having a more adequate retirement income.

Mr MOSSFIELD—Has your organisation done any work relating to educating people? At what point do people become interested in their superannuation savings? Are they young married couples buying a home and all that and that is their major focus point? They even come to us, as members of parliament, and they want to draw down on their super for various reasons—illness or other matters. When does the interest peak so that we can start getting the message through to people about the need for additional savings and so forth?

Mr Gale—I am not familiar with the institute itself having looked at consumer attitudes towards that and how they might vary over time, but there are a range of surveys about attitudes towards savings available around the financial services industry from some of the sponsoring institutions linking up with some of the research bodies which make those available. There was one that came out just last week, I think, that was sponsored by AMP with NATSEM, which came out with some findings on attitudes towards savings. Some of that picks up on how some of those savings attitudes shift over time, their degree of comprehension towards superannuation versus non-superannuation savings and the like. Some of that information is available.

Mr HARTSUYKER—There has been a bit of discussion in the financial media particularly about American companies and the very substantial unfunded superannuation liabilities that they have and the impact on the ongoing operation of companies as a result of that. I note your comments on the 1999 study that you referred to earlier on unfunded retirement benefit liabilities. What is your organisation's view of unfunded liabilities in Australia and its impact on the economy downstream? Are we heading for a train wreck?

Mr Gale—It is a fairly large question. You have got two impacts: there is the private sector and the public sector. The public sector impacts of ageing and retirement needs and the like are covered in the *Financing the ageing* paper. This indicates some of those percentage increases in GDP, although the most significant one of those was actually the health related costs even more so. The ultimate cost of that is also a function of what emerges, if you like, and whether it is an explicit or implicit population policy: the extent to which you have an ageing population, the extent to which you have different settings for immigration, the extent to which you might encourage family formation—which is one of the other issues we talk on in the paper. If there were increased incentives in the frameworks for family formation, that could also assist in some of those ageing related issues. The ultimate result is actually very sensitive to what are some of the population trends which emerge. One of the interesting papers to cross-reference there was the work done last year by the CSIRO which looked at three broad scenarios: a high road, medium road and low road in terms of a future population policy for Australia, looking at what

the population might be in the year 2050 and a whole range of the consequences of that. I presume that is already part of your research base, but that helps to instruct and respond to that.

What has tended to happen in the private sector, for a range of reasons, is that there has been a fairly material shift from defined benefit superannuation schemes to defined contribution schemes. To a certain extent that reduces some of the potential funding concerns for the employer but it then makes that the responsibility of the individual to have an adequate level of savings. They also absorb some of the differences in returns which emerge over time. But there are a range of factors which have driven the shift from defined benefit to defined contribution. One of them is related to the question you asked.

Mr Kirk—On the question of government unfunded superannuation schemes for government employees, such as the CSS and PSS, that was covered in the Treasurer's Intergenerational Report last year. It was quite interesting to note that it seemed to be fairly manageable, which is not necessarily what you would expect for an unfunded scheme. I suppose these are fairly mature schemes that have achieved the point at which the outflow is becoming more stable, but it was a relatively small item. It starts at 0.6 per cent of GDP now and declines gradually over the next 50 years. That, however, only covers Commonwealth expenditures, and the state government unfunded superannuation schemes have a varying degree of financial—

Mr HARTSUYKER—You have answered my question.

CHAIR—There being no further questions, thank you very much for your very comprehensive submission, statement and evidence today before the committee.

Ms HALL—It is really good to get an actuarial perspective on the issue of ageing and its implications in Australia—thanks.

Committee suspended from 4.00 p.m. to 4.16 p.m.

OLSBERG, Dr Diana, Director, Research Centre on Ageing and Retirement, University of New South Wales

CHAIR—Welcome. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. We have received your submission—No. 84—to the inquiry and copies are available from the committee secretariat. Do you have anything to add to the capacity in which you are appearing?

Dr Olsberg—I am also deputy chair of UniSuper, which is one of the largest superannuation funds, and I am also a part-time member of the Commonwealth government's Superannuation Complaints Tribunal.

CHAIR—Thank you.

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

That this committee authorises publication of additional submission No. 161 received at the public hearing this day.

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

Dr Olsberg—In the submission to the standing committee on ageing I have particularly addressed the present and future experiences of the ageing of Australian females. One area in which I have done extensive research and about which I have particular expertise to speak to the committee concerns the factors which constrain adequacy, access, equity and economic and social justice for women in Australia's current retirement income system.

I believe that the future lifestyles and social, economic and personal wellbeing of large numbers of ageing Australian women are at considerable risk if policies are not introduced which recognise women's current disadvantaged position with regard to superannuation. Through no fault of their own, Australian women have much less accumulated retirement savings than men. On average, they have half the amounts accumulated by men, and in the current period of investment volatility many superannuation funds are producing negative or extremely low returns, so on current savings trends, only a small minority of ageing Australian women will be able to confidently look forward to a comfortable and financially independent retirement lifestyle.

With the ageing of the population, increasing proportions of women will be in older cohorts. Also, women will continue to live longer than men and so there will be increasing numbers of women in their 80s and 90s in Australia. Unlike in earlier periods, when many women were dependent upon men to help them with their resources, increasing numbers of women will be entirely dependent upon their own and government resources, not just for their own financial requirements but for the welfare of families in general. Contrary to the images we see in retirement village and financial investment advertisements, more women will age alone. As well,

the number of older single women shouldering family responsibilities for still dependent children and dependent grandchildren increased greatly over the 1990s.

It appears that our current retirement income system is likely to fail in its task of providing adequate resources for many older women. Today I want to talk about what can be done to improve that situation. I will briefly go through some of those things which I think are possible strategies. I have drawn particularly on a lot of overseas examples because it seems to me that we do not want to start reinventing the wheel; we want to look at what has worked overseas and evaluate that, particularly in terms of how it sits with our own culture, our own institutional structures and our own expectations.

There are four areas I want to look at. I want to argue that the possibility of women having a reasonable lifestyle in retirement is dependent upon there being greater equity for women in the paid work force and greater education and incentives to save. We have to create a more attractive savings culture. We have to assist women to maximise what superannuation savings they do have and we have to provide an increasing role for women in the corporate governance of Australia's superannuation and retirement income system across the public and private sectors.

I do not want to take up too much time, but I would like to emphasise the particular strategies I have highlighted in the paper. We have to ensure that Australian workplaces adopt family-friendly policies such as flexible working hours, part-time work, job sharing, home based work, career breaks and leave for people who need to care for family members. This is really important because so many women are now actually having to care not only for children still at home but also for elderly parents and infirm members of their family. The introduction of family-friendly policies will lead to an increase in female work force participation, which will be good for employers and national productivity as well as for women but, most particularly, will result in women accumulating much more adequate superannuation savings.

At the very least—regardless of what happens in terms of maternity leave arrangements—women should be entitled to continuing superannuation guarantee contributions from their employers while they are on maternity leave. This will give them continuity of savings despite broken periods of employment. We should give people who are out of the work force caring for others some access to the superannuation guarantee because it is totally unacceptable that women particularly, who are out of the work force caring for others—shouldering the burdens of society's responsibilities—should be disadvantaged, not only in terms of their present-day income by being out of the work force but even into retirement, by not having any accumulation of superannuation. We should have immediate SGC contributions paid by government in addition to the carer payment. This could provide a means of rewarding carer services. Perhaps a system of credit bonuses could be developed which would allow people out of the work force caring for others to accrue additions to their age pension on a pro rata basis.

It is important that we have education and incentives to save, but education campaigns and retirement planning seminars should be targeted at people with varying amounts of superannuation benefits and total retirement savings, people with different occupational backgrounds and personal circumstances, and people with different levels of financial expertise. The sort of one-off advertising campaigns we see on television are not going to do anything; we need creative programs that are culturally diverse and appropriate for people with different levels of financial awareness and different levels of language skills. So there is a need to create an

understanding and an appreciation of the relative and intrinsic importance of savings. One thing which I want to bring to the committee's attention is that we have to be looking long term. So we have to be thinking about longer-term school programs which must be developed to teach young women and men basic principles about savings and investment and to create a savings culture.

We have got to think about voluntary contributions. When I was waiting to appear before the hearing, I could not help but hear one of the previous speakers talking about the fact that people with current superannuation would get 60 per cent of their final average salary after a lifetime in the work force. In fact, that will continue to be a reducing number of people who will have spent 40 years in the full-time work force. Women particularly are at risk because of their broken patterns of employment and their long periods in casual and part-time work, but men also are in an increasingly casual role within the work force.

We have to look at how we can create assistance for people to save. One way would be to look at co-contributions from government. I want to draw to the committee's attention that the government in Germany has recently introduced a co-contribution for voluntary pension contributions on a two-level basis. It provides tax benefits for people on a high level of income and direct subsidies for people on low levels of income. We are trying to increase retirement savings right across the work force. There are also schemes in the United States for co-contributions whereby employers share profits in terms of making contributions to people's retirement savings.

We have also got to think about looking at the tax system, and I want to argue about the contributions tax on superannuation. I want to say that the first 15 per cent contributions tax on superannuation contributions should be concessionally taxed or even eliminated altogether for those with below average incomes. But I think there is a particular opportunity in the superannuation surcharge, about which there is constant discussion. I think that women are particularly disadvantaged by that superannuation surcharge, because many women come back into the work force after their children have grown up. They then perhaps are getting a very good income and could make very good contributions, and I would suggest that the additional superannuation surcharge should be assessed on the basis of total savings in superannuation funds rather than on current income. For example, anyone, women and men, who had superannuation savings of, say, less than $300,000—which is very much less than what would be the age pension on an allocated pension—should be exempt from paying the additional 15 per cent superannuation surcharge. I would argue that this would significantly enhance the possibilities of women coming back into the work force to top up their superannuation retirement savings.

We have also got to encourage superannuation fund structures to be amended to provide for irregular and flexible rate contributions so that women coming in and out of employment can maintain consistency. We have got to think about financial planning, investment products and maximising what money women do have in the funds. Major banking and investment houses and fund managers must be encouraged to develop products which are suitable and offer maximum investment opportunities for people with savings that fluctuate across the life course, for whom there are occasional breaks in contributions, and for people who have less amounts of money to invest. My research has demonstrated that women are very dissatisfied with the current financial planning industry, which seems to be completely dismissive of women who have broken patterns of employment or who have small amounts of money. We have got to look at that.

Also, government must provide increased resources to the very successful Centrelink Financial Information Service, the National Information Centre on Retirement Investments and the Department of Family and Community Services. These information services are absolutely vital to assist people to make investment and savings decisions on a cost-effective basis. I would argue that there is a pressing need for government encouragement and promotion of financially registered financial planners who will provide financial planning advice on a fee-for-service basis rather than commission based advisory services.

Finally, I would like to see an increasing role for women in both the public and the private sectors, particularly in the governance of Australia's superannuation and retirement income system. It is important that strategies be developed to provide women with the opportunities to have a greater say in the process of evolutionary change taking place in Australia's superannuation and retirement savings system. Women must increase their representation on the trustee boards and management committees of superannuation funds. They must also take a leading role in policy making processes for the reform of any social security or superannuation national savings income system. I have identified particular overseas strategies which I would like to draw to the committee's attention, and if at any point you want further information on them I would be happy to give it later.

CHAIR—Thank you very much. On the issue of labour force participation, what sorts of things could be done to encourage the employment of mature age women?

Dr Olsberg—The interesting thing is that mature age women have higher levels of employment than mature age men. That is, of course, because they are more willing to accept casual and part-time work. But greater possibilities for some security in that part-time and casual employment is very important. In my research I have spoken with a lot of women who have been in very insecure casual positions, where they have been called in when needed and asked not to come when things are not so busy. If there could be some sort of support for greater security for casual employees in that situation, that would be a very good way to look at it.

CHAIR—With women having a greater life expectancy than men, there is an even greater need for a greater lump sum when they retire.

Dr Olsberg—Absolutely. We have to be moving much more to encouraging people to take it as a pension stream, to get rid of that lump sum mythology which is so dangerous for many people because they come out having had no experience of investment and no experience of handling people who are advising them about investment. In my research, I have come across many people who have had their money carefully stewarded by their superannuation fund but who then walk out, go into small businesses of which they have never had any experience and lose all their money. So we have to encourage people to take a pension stream when they retire.

CHAIR—Yes. I could have phrased the question better. I meant essentially that they will need to have greater savings, if you like, because their income stream will be over a longer period of time, based on actuarial tables.

Dr Olsberg—Absolutely. A female baby born today has an average life expectancy of 93. We are going to be living longer and we want to have a decent lifestyle, and I think the mark of a just society is that old people do have a decent quality of life in retirement. It is a requirement of

society that women, who have contributed so much to society over their lives, be supported in their old age. We are going to be having many more women living well into their 80s and 90s, so many of them are going to be longer in retirement, even if they have been in the work force, as most women will be in the future. They are going to be 30 years, perhaps, without an income other than the age pension, and their retirement savings are going to have to assist them.

Ms HALL—I think that you have identified some very important issues. Most of the discussion we have heard about superannuation and superannuation changes looks at people who have had continuous time in the work force. Women do have some particular issues—they are the lowest paid workers.

Dr Olsberg—Whatever the sector.

Ms HALL—Yes; that is right—the casualisation and all those issues impact to a greater degree on women than on men. I was very pleased that you picked up on the issue of carers.

Dr Olsberg—Absolutely.

Ms HALL—Those people, who are usually women, are being doubly disadvantaged. I turn to the issue of family friendly policies and the need for government to introduce family friendly policies that will enable women to maintain a longer period of time in the work force. What are the most immediate and pressing of those policies? Which ones do you think government should look at introducing immediately?

Dr Olsberg—I think the most immediate should be the carers benefit. They should have a superannuation guarantee charge on top of their carers pension. We are not talking about a huge amount of money. I have the details in the submission of what the latest figures are, but not a lot of people receive that. But somebody who has been evaluated as being worthy of getting a carers pension surely is worthy of having a superannuation guarantee charge on top of that pension to accumulate to assist them in their retirement, because they have made the sacrifice to look after people who, perhaps, society might have to look after otherwise.

Ms HALL—What about the other group of women who get the allowance but do not get the pension because they live with a partner who earns too much income? The only thing they get is the $46-odd a week.

Dr Olsberg—I would like them to get a superannuation guarantee. Women should have their own superannuation fund and not be dependent upon, perhaps sometimes, a male who may be high-income earning but then that marriage does not survive until retirement. We are seeing many more women entering old age alone. I think particularly, too, within the workplace there has to be greater recognition of caring responsibilities and greater possibilities for compassionate periods of leave. We are entering a period in which people's parents will be living into their 80s and 90s. They will require somebody to take them to the doctor, and somebody to take them to the hospital. If we do not have an imposition upon the taxpayer to continue to provide huge amounts of support, we will be reliant upon people within their families. They will need to have time off to shoulder those responsibilities, particularly for urgent attention. Somebody whose father has had a stroke has to be able to go to the hospital and be there for two days in case he does not survive or to take care of what is going on.

Ms HALL—The other issue I would like to pick up on is education. You talk about long-term school programs being developed to teach young men and women basic principles of investment and to create saving principles. How do you see this structured and do you think it will be effective? How can you make it relevant to young people at that age?

Dr Olsberg—I think that is the important thing. I do not see it as a course on retirement savings; I see it as a course on financial management. There is a lot of talk about the inability of young people to handle their mobile phone accounts. I think that is because they just do not have an understanding of financial management. So I would see school programs actually addressing the requirements of handling credit and financial management—what are the advantages of savings? I find it extraordinary that, when I am talking to women, they do not understand how important it is to leave their money in a superannuation fund. With compound interest, it is so much better to leave a small amount in for 30 years. If you are in the work force and you put money in when you are young, it will accumulate over time, much more so than if you are 55 and try to pick it up at the end of the day. So I would see the importance of school programs which actually address financial management and those sorts of issues. I think they are much more important than some of the things which children are learning in school today, because these are life skills which will give them the opportunities to live decently and responsibly as citizens of Australia.

Mr MOSSFIELD—Take the hypothetical situation in a lot of superannuation schemes where the husband dies first and the widow continues on. What is the general practice as far as superannuation entitlements are concerned? Is there a set pattern or does it vary from fund to fund?

Dr Olsberg—It varies from fund to fund. In some funds there are reversionary spouse pensions in which the spouse will get a pension continuing after the husband has died. The fact that there are now opportunities to split superannuation is a very good thing because it will mean that perhaps women will have superannuation savings on their own account. It will be separate account and the women will not be dependent upon a husband's account. But what sorts of facilities are available vary from fund to fund. The important thing is to encourage women to take responsibility for their own retirement provision. The wives of servicemen are in a particularly difficult situation. I have come across many of them who have been married to a serviceman and expected to get a very good pension but later on in their lives that marriage has broken up and they have access to nothing. Many of them, because they have lived everywhere—all over the world—do not even have a home. So there are particular groups in society who have been seriously disadvantaged, and I think the way to address that is to try to support women to have their own superannuation and retirement savings. I think the fact that we are now looking at splitting superannuation under family law, under divorce, and actually providing the opportunities for spouse accounts is a step in the right direction. But we need to encourage that and to educate people about that facility because many people do not even know it exists.

Mr MOSSFIELD—So is that working satisfactorily? I was going to ask you that question specifically in respect of the new changes to the Family Law Act allowing for split superannuation.

Dr Olsberg—It is still early days to really see. There are still great difficulties in defined benefit funds as to how you actually split up the benefit, but it is a step in the right direction. That is why I am so keen that we actually look at strategies by which we can do something. I remember doing research 15 years ago about superannuation and divorce. It took us about 15 years to actually get to the point of doing something about it legislatively. I want us to do something about women's disadvantage to actually give them that possibility, otherwise there are going to be many more older women affected. In many of the research groups that I have been in, women say, 'I know what the situation is but I think I'm going to be a bag lady when I get old.' We do not want to have older Australian women in that situation.

Mr MOSSFIELD—Regarding women's entitlement to the age pension now, the retirement age is levelling up to 65, isn't it? Is that to the disadvantage of women at the moment? Would it not be better to allow them to get the age pension at a retirement age of 60 or 61?

CHAIR—It is gradually increasing.

Dr Olsberg—Yes, it is gradually increasing. These are the swings and roundabouts. We get equality and sometimes we do not gain. Of course women are disadvantaged, because we used to get the full age pension at age 60 and now women are getting it later and later. So it has been a cost to women, but I think these are the swings and roundabouts. We gain some and we lose some.

Mr MOSSFIELD—So where is the advantage?

Dr Olsberg—There is no advantage for women in increasing that pension age. If you look at the examples of other countries, they are already increasing the retirement age to 67. I would not be surprised to see at some time in the future that we look at increasing the retirement age for men and women to 67 or 68. The important thing is to give people the opportunity to be able to augment whatever government provided pension they get by assisting them to make good and possible decisions about their own retirement savings.

CHAIR—Thank you. Is there anything you would like to add?

Dr Olsberg—Only that I would like to see action. I am sick of talking about the problems. I would like to see some action.

CHAIR—Thank you for that, for your additional submission and for your evidence today. I wish to thank all of the witnesses who have appeared before the committee today.

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

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

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

That this committee form a subcommittee of two members for the hearing on 4 July 2003.

Committee adjourned at 4.48 p.m.