EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 1 SEPTEMBER 2009

SESSION SEVEN

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 3.12 pm

HARDING, MR VAUGHAN
Chief Executive Officer, Uniting Church Homes,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and for your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference.

The Education and Health Standing Committee is a committee of the Legislative Assembly, and this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard staff are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Mr Harding: I do.

The CHAIRMAN: Have you completed the "Details of Witness" form?

Mr Harding: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Mr Harding: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Harding: No.

The CHAIRMAN: Would you please state the capacity in which you appear before the committee today?

Mr Harding: I am the chief executive for the Uniting Church Homes.

[3.10 pm]

The CHAIRMAN: You are aware then that this review is really looking at hospital and community healthcare services in terms of departure from or compliance with the Reid report, identifying any needs and gaps in healthcare services, and also considering the ramifications of the Royal Perth Hospital bill. As we do not have a formal submission from you, I will open the floor for you to make a submission and then if you are happy, committee members will just interject if they have questions for you. I appreciate your coming along to help identify the needs and gaps.

Mr Harding: Thank you. I guess I should make it clear that I have been requested to attend this afternoon; I did not make that initiative myself. Just to give you some background my organisation, Uniting Church Homes, has been operative in Western Australia for 60 years—its sixtieth year celebration is this year.

Mr I.C. BLAYNEY: I am supplying you a cake in Geraldton.

Mr Harding: Excellent, thank you very much for that, we like those sorts of contributions.

We operate more than 26 sites in metropolitan Perth and in three regional centres. We provide a very large suite of services ranging from high care residential through to straight housing services and a big range of community services from each centre to home care programs to the Home and Community Care program. In more recent times we have acquired a general practice medical centre and have rapidly grown the size and scope of the practice and are exploring the full role that such a practice can pursue in preventative health.

The CHAIRMAN: Is that next to one of your homes?

Mr Harding: It is within one of our homes; our largest facility at Rowethorpe in Bentley. Medical oversight of people with complex care needs is becoming an increasing difficulty with our community as the population ages. My interest in WA's community care and hospital services arises due to a range of factors. One is my involvement with the Chamber of Commerce and Industry at the health and community services forum. Decisions taken by the health department can often impact on the private sector and an example of that would be where substantial pay increases for nurses, for instance, has a strong flow-on effect to our operations and our viability. The activities of my own organisation, including admission and discharge procedures, has a huge effect on our residential services, and the ability to meet the needs of our residents when they become patients within the public health system is an issue of ongoing concern for us. The interaction of commonwealth and state systems, we often find ourselves caught in the conflict that occurs between systems —

The CHAIRMAN: Vaughan, are you going to come back, because you are kind of flagging areas but not giving us the detail in relation to the problems for those areas? Shall we ask you as you go through or are you going to come back?

Mr Harding: I was just going to provide you with an overview of my interaction with the system because I do not consider myself to be an expert in the health system.

The CHAIRMAN: You do not need to be an expert, but maybe if we could go back to the first point that you identified and give us a little more clarification into why that is a problem.

Mr Harding: Can I just stay with the overview and then we can go back to the detail—is that all right?

The CHAIRMAN: Yes.

Mr Harding: The administration of the Home and Community Care program in Western Australia and other programs, such as the Care Awaiting Placement program, are interactions with the wider health system. I am also very aware that dysfunction within the aged care system, particularly in areas of high care and dementia care, can have a significant adverse impact on the acute hospital system. The services are quite interdependent and you see that happening as parts of the system start to fail.

That is really my opening comment about how I interact with the general health system in Western Australia. Going back to particular matters, where would you like to focus attention? Is it on the admission and discharge policies or —

The CHAIRMAN: I would like to go through each of those points.

Mr P. ABETZ: Everything—because they are all significant.

Mr Harding: I guess my first point is really to do with the involvement with the Chamber of Commerce and Industry. That chamber is particularly concerned about the significant annual rising cost of health care provision and the impact it has on the state budget, and I guess an ongoing concern as to whether health administration in this state is healthy. We have seen so many reports,

such as the Reid report, over the years and we spoke to Mick Reid a number of times when he was producing his report. To what extent was there a real intent and real energy to implement the findings? Therefore, it is good that this ongoing standing committee is providing some oversight of that. Certainly, our experience has been that the health sector is quite unique, with a number of vested interests that often make it very difficult to implement real change. It appears as though the real change that is required is, as Kevin Rudd would describe it, root and branch; it is not a part of the system, the whole system often needs a complete overhaul as we restructure the use and allocation of resources. We keep a watching brief on those sorts of matters, mainly because the private sector has a view that it is often far more effective and efficient in the use of available resources. Often you will find with health systems in not only this state but also other states there is an inherent conflict of interest between the policy setters, the funders, and the service providers. For instance, we have constantly encouraged the health department in looking at wider initiatives, such as workforce initiatives, that their obligations are not just to their own workforce working in the public health system, but for the overall health workforce for the state. Therefore, when we talk to their officials and representatives, often the statistics that they provide to us are those for their own health workforce, not for the statewide workforce, and we ask for the other figures and often it is quite difficult to discover what they are.

The CHAIRMAN: For instance, figures in terms of, say, care assistants? What type of figures are you —

Mr Harding: I guess the discussions heightened during the boom times when the overall system was scrabbling to try to find people who were upright and breathing who were actually available to provide hands-on work within our sectors. The size of the gap between what was required and what was available is something that we are very interested in, and trying to get our hands on that sort of information. Then you start looking at very particular initiatives, for instance, scholarship initiatives to attract certain categories of workers, like registered nurses, or other points of entry into the system where we can give easier access to school-age children, for instance, to get an insight into what working in the health profession might look and feel like. Those sorts of initiatives were also available to the private sector, which was also struggling very much with workforce at the same time. Therefore, it is that kind of conversation, if you know what I mean.

The details are not fresh in my mind at the moment, but that is the type of conversation that we try to have.

[3.20 pm]

The CHAIRMAN: We are trying to get the numbers that you are trying to get—particularly the numbers for child health services—so that we know the level of need in each of the metropolitan and regional areas.

Mr Harding: Yes. We have all been through a horrendous period during which we could not find the workforce that we needed. Hospital wards were constantly staffed by agency staff, which has a huge impact on the quality of care. In our sector, many programs could not be delivered on the ground because we simply did not have the people available to provide them, even though the money and the places had been released.

The CHAIRMAN: I know that many nursing homes have relied almost totally on agency staff.

Mr Harding: Yes; that can often be the case and it is very difficult to manage under those —

The CHAIRMAN: And very difficult for the patients or for your clients in those areas.

Mr Harding: Of course it is. Continuity is even more important in community care settings in which people go into private homes. The client needs to get to know who the carer is, establish a relationship with them and feel comfortable having them in their home. It causes major problems when a new face arrives every second day. The workforce situation has been horrendous. It has given us an insight, we believe, as to what things will be like in Western Australia by about 2025

when the population has dramatically changed and the number of people available to work will have reduced substantially.

The CHAIRMAN: We heard earlier during previous submissions that some of the current nursing home and retirement village service providers believe that the writing is on the wall. They are not looking to expand their services because, I think, of funding and reporting requirements. Would you care to discuss that issue?

Mr Harding: Western Australia is unique at the moment. For three years running, the commonwealth allocation of places has not been fully taken up by service providers. In years gone by it has been a highly competitive process and the value of bed licences has, for instance, been up to about $40 000 a place for those trying to buy them on the open market. Now you cannot give them away.

The CHAIRMAN: Yet at the moment I believe that we have 400 people who require a bed in a nursing home.

Mr Harding: I do not know where that figure has come from. The lead time to get a new facility up and running in Perth is about four years, by the time you have gone through all the various approval processes. All you need is about three years of inactivity or underactivity and you start to fall behind in your lead times because in Western Australia the number of older members of the population will start to be felt by about 2015 and that impact will rapidly climb by 2025 or 2030. We are heading into the peak numbers by a bit past 2030. When you start to look at the level of activity required to meet the growing demand for service, the most rapidly growing group is that old, old group, the 85-years-plus group, which is growing at four times the growth rate of the general population. That is where you find issues of greater dependence and more demand on services. We really should be very busy now starting to grow our services, but that is not happening and it is of great concern.

The CHAIRMAN: I believe that the chamber has in fact prepared a report in the recent past looking at the needs in aged care.

Mr Harding: It has produced a workforce report on the needs of the sector, but not in terms of the general need of the population—that is yet to be reported. However, the chamber is certainly taking a greater interest in social policy matters.

The CHAIRMAN: Are you able to provide the committee with a copy of the report that was prepared?

Mr Harding: Yes; that is a readily available public document.

The CHAIRMAN: Thank you.

Mr Harding: The settings that prevent us from growing and expanding really are the settings established by the commonwealth government for the capital and recurrent funding that is required to deliver services. At the sharp end, you can see the problems that we are faced with in the high-care level which is the most dependent level. We have access to about $200 a day to provide a comprehensive range of services, accommodation, nursing, 24-hour care and products.

The CHAIRMAN: That is $200 a day for an acute-care patient —

Mr Harding: For a high-care patient.

The CHAIRMAN: For a high-level patient.

Mr Harding: That is the highest level that we would respond to.

The CHAIRMAN: I think for someone in a prison that amount is $1 200 a day.

Mr Harding: Well, it is very different! My comparison would be the acute hospital bed which I think on last estimate, cost about $1 000 or $1 100 a day. There is a dramatic difference between the

two. There is a point beyond which you cannot go in trying to sustain your services. In my sort of organisation, which is not for profit, as long as we can break even we are happy. But if we cannot break even we believe that we are going backwards—and that is, sort of, where we are at now. It has reduced significantly the amount of activity going on in Western Australia and we have —

The CHAIRMAN: Have you approached the federal government either as a group or as individuals about the high-level, medium-level and lower-level funding needed on a daily basis?

[3.30 pm]

Mr Harding: Our sector would be about the most reviewed sector that you could possibly come across really. If you have a look back on the past five years, you will find so many reports and so much detail about costs and income and what needs to occur that it would occupy a lot of your time for the next few months, but there has been no action.

The CHAIRMAN: You are asking for each of those levels.

Mr Harding: Yes. The funding instrument we are working to at the moment was implemented in March last year. It is still relatively new. Everybody is still coming to grips with it. However, there certainly has been a swing away from low care towards high care in terms of how the instrument works. For a state like Western Australia, where we have a very big state, a concentration of population in one centre and smaller populations elsewhere, a lot of the residential care infrastructure is low-care facilities. With this new instrument they are looking increasingly unviable, because whatever money they did enjoy has been significantly, and is being, reduced. There are grandfather clauses that are applying to current arrangements as it transits into a new instrument.

Mr P. ABETZ: Low care would be hostel-type accommodation or an actual nursing home?

Mr Harding: Low care is really looking after people who require support for the activities of daily living.

Mr P. ABETZ: That is referred to as hostel-type accommodation.

Mr Harding: Yes, hostel care. The high care is the old nursing care, which ultimately focuses on having 24-hour nursing coverage. Most of the infrastructure in rural and remote Western Australia is low care, and that is looking terribly unviable for the future as well. It is not just a problem about the expansion of current stock. There are also issues about the viability of existing stock. The residential sector is in a very unhealthy state.

Mr P. ABETZ: What percentage increase do you need to regain viability and for the industry to move forward, would you estimate?

Mr Harding: It depends. For instance, the design of a facility and the size of it can have quite an impact on viability. There are good numbers and worse numbers in terms of viability. There are good designs and there are worse designs. Then, in looking at regional and rural areas, there are operational costs that you might experience in one area and not in another. So there is no exact figure, but quite a few of the reports that have been produced have put quantum numbers on the sort of additional income that is required.

The CHAIRMAN: On a bed?

Mr Harding: No, across the overall system.

Mr P. ABETZ: As a ballpark figure, you are getting $200 a day for high care at the moment. The licensing is coming up and there is obviously a need for the beds and so on, but nobody is prepared to invest capital to actually build these facilities at the moment. Just for your organisation, if the high care funding, say, was bumped up to $250 a day, would that make your organisation think, “Hey, this is worth looking at expanding our facilities and trying to meet the need”, or would that still be inadequate?

Mr Harding: That kind of number would probably be sufficient to make the sector more viable. Most residential care facilities have got high and low care under the one roof these days—quite a mix—so it is not that easy just to pick a number for a particular category. The area that is really killing us is that with low care, people who often really require social support, often we are getting subsidies to the tune of $8 a day for them. It is simply not viable.

The CHAIRMAN: From the family?

Mr Harding: No, the payment they would make through—

Mr P. ABETZ: Plus their pension, is it?

Mr Harding: This is the payment by the commonwealth government under this instrument. It is $8 a day for many of these people. It is just not viable. You cannot look after somebody for $8 a day.

Mr P. ABETZ: But don't they have to contribute their pension?

Mr Harding: They do. They contribute 80 per cent of their pension in round terms per fortnight. Again, that is not very much per day.

The CHAIRMAN: So it is —

Mr P. ABETZ: It is 85 per cent of the pension.

Mr Harding: Plus $8.

The CHAIRMAN: And only $8 from the commonwealth on top of that?

Mr Harding: Yes, so it is a real problem.

Mr I.C. BLAYNEY: Has the commonwealth got it or do you think they are just off in the clouds as they sometimes are in Canberra?

Mr Harding: The evidence is substantial that is available, and the most recent evidence is that used by the National Health and Hospitals Reform Commission, which is the most recent document that has been produced, which calls for substantial reform in our sector, and I think probably trying to push the Department of Health and Ageing to get moving. But, sitting behind that, there is a whole range of reports from the Productivity Commission; other inquiries; the private sector, like accounting firm initiatives looking at the costs; and independent specialists, such as Warren Hogan, that were brought in to provide more longitudinal studies on the sector. There is an endless number. So the evidence is there; it is not as though people can say they do not know that there is a problem. But is there an acknowledgement of a problem? The answer is no.

The CHAIRMAN: This is a broad review. You are an expert adviser coming to us here today. With all of these reports that you are aware of, what I am hoping you will do is pick out the key reports that have been tabled to provide to the committee by way of supplementary information, because we have two reviews. Yes, this is a very important area, but our staff and the members do not have the time to go through each of those reports, and so we are hoping that, with your presence here today—particularly, as you have said, you are not just representing Uniting Church Homes, but you have told us that you also wear a Chamber of Commerce and Industry hat—you are able to give us a bit more guidance in terms of the validity of those different reports. I know a few years back there was a report by Judi Moylan that was shot down at the time, but I think that it was something that in hindsight many people said may have been a good model and may have prevented some of the problems that we now have in relation to provision of services for the elderly. Would you like to elaborate?

Mr Harding: That is not difficult for me to do, to target and highlight which parts of the reports are most worthy of reading and extracting the information from that.

Mr I.C. BLAYNEY: If you look at the projections, is it pretty uniform across the states or is it particularly bad here in Western Australia?

Mr Harding: Projections of ageing or the take-up of places?

Mr I.C. BLAYNEY: The take-up of places and the cost structure that is making it unattractive.

Mr Harding: The problems are acknowledged right across the country. The states that have been most challenged by the problems have been Queensland and Western Australia. That has largely been due to our rapidly rising cost structures, which have emerged from the booms, and our rapidly rising wages profiles, which arose through the boom periods. So we have been hit on both fronts.

Mr I.C. BLAYNEY: In some of the other states all of the places were taken up, weren't they?

Mr Harding: It is not as simple as that. That is the spin that was put on it, but when you have a look at the way the bids would fall, they were very oversubscribed in particular locations and undersubscribed in other locations. In aggregate, it looked as though they all were to be taken up. We believe that they are not all going to be taken up. But, again, trying to extract the detail from the department has been rather difficult to find out just where the shortcomings have been. There is general acceptance across the country that the residential aged care system is in deep trouble and needs significant reworking to make it able to meet the needs of an ageing community and, ipso facto, take off the pressure on other systems that people will fall back onto if this system is not working well.

The CHAIRMAN: I think you said that 2015 will be the crisis level, did you?

Mr Harding: No, it is the start of the demand, not the crisis level. It is the start of the real demand that we will feel here. We are not as old as South Australia, which is an older state in terms of general profile, but we have had significant migrant populations from the Second World War. They will really make their presence felt in the next decade in terms of their age profile.

We also have particular issues of our own to address in terms of the demographic layout of our state and issues to do with our population.

[3.40 pm]

Mr I.C. BLAYNEY: Have you found that you are having more migration problems over the past few months? Were you bringing people in from overseas?

Mr Harding: Yes, we have brought some people in under the 457 visa system. In all of our interactions with Chris Evans, the federal Minister for Immigration and Citizenship, we have encouraged him to not ease off and allow us the ability to continue that scheme in the numbers that had already been available to us. Of course, that did not happen and they have backed off. However, the noise is going out again now because of recent sign-ups that we get going on that immigration scheme and perhaps find ways to streamline it and make it even more effective. It is quite clear to me, looking at other systems in Europe where the Polish community has moved across the continent to fill certain categories of work, and the example of Mexican in the United States, that we need the ability to attract people to do work that locals do not wish to do. A good percentage of our population are not interested in a lot of the work we have available, or the pay rates that come with caring and that kind of hands-on work. It is very clear to us that we will need a resource to help tackle the issue of an ageing community, and the range of services that will be required to support that community. Immigration has become really important for us.

Mr P. ABETZ: What sort of income is generated by a person working a 40-hour week as a carer in one of your aged care homes?

Mr Harding: Very few work a 40-hour week. Most of the industry works part-time. The hourly rate, which is the easiest way to describe it for you, is between $15 and $20 an hour.

The CHAIRMAN: The basic award rate.

Mr P. ABETZ: It is a fairly basic wage, in other words.

Mr Harding: It is, and that would be for a normal working hour, but most of them work shift work.

Mr P. ABETZ: So penalties apply?

Mr Harding: Correct.

The CHAIRMAN: That would be for a level 3 care assistant, I assume?

Mr Harding: Yes, it would be people with certificate 3 or certificate 4 qualifications. They would be multiskilled carers, assistants in nursing—that kind of category of work. They are the backbone of the sector; they provide most of the caring.

Mr P. ABETZ: Are you seeing backup into the hospital system of people who are in hospital but really ought to be going into nursing home care? Are you not able to provide space, or is there ample space at this time in our nursing homes in Western Australia? I am hearing that there is significant backup into the hospital system as families try to find a place for mum or dad to go into.

Mr Harding: Yes, it is not that easy to actually get a really strong handle on the overall numbers. A lot of the evidence is anecdotal, based on experience. My general experience of high care is that the good high-care facilities cannot meet the demand for services and have not been able to do so for the past few years. There is an endless supply of people looking for a place. There have been surplus beds available in low care facilities; it is a bit difficult to understand why. I think there are quite a few variables. Accommodation bonds are charged in low care facilities, so people often have to sell the family home, and family members are often very resistant to doing that; they often hold mum and dad back from making that decision. It is not all that clear what has caused that. Certainly, as home prices have reduced over the past 12 months during the so-called recession, the uptake of low care residential accommodation has slowed down. My feeling is that it is a glitch in the system, and there is probably unmet demand for service out there. The Department of Health trots out figures on the backup into the hospital system, based on some definition, and it often uses expressions such as "bed-blockers"—that is, older people occupying beds who should be placed elsewhere.

Ms L.L. BAKER: We have heard that term.

Mr Harding: There is no doubt that it is a significant problem. We have been running a care waiting program for the past two years, and it has been full ever since the first few weeks of implementation. That program will be closed at the end of this calendar year and the four hospitals that it serves do not know what they will do when the program closes. It is unclear to me how that will save money, but that is certainly how things are set up at the moment.

Mr P. ABETZ: Is that a government-funded care waiting program?

Mr Harding: Yes, funded by the state government, as a matter of fact.

Mr P. ABETZ: The government has cut the funding to it?

Mr Harding: Yes, as part of the cost savings. If we look at the comparative pricing of that kind of program versus an acute hospital bed, we can see it will not take long before the real impact backs up very rapidly, and residential care facilities are not well placed to take palliative care patients. If they are going to be with us for an extra three or four weeks, it is not attractive to go through all the administration to bring people in and settle them down, sign all the contracts and complete all the documentation required, if before we can blink, it is all over. We have a significant number of people in care and awaiting placement who are not attractive to the residential sector, and we cannot easily find a place for them anyway. In that program, they can be held for 12 weeks, so it was often the best thing for them because they were out of the hospital ward scene and into a more intimate environment.

Ms L.L. BAKER: Following up on CAP program, we have been told that there is an agreement in place between the state government and federal government that the CAP program would be wiped and that federal funding is coming in to replace the CAP beds. Is that true? Can you put the committee in the picture about that? I would hate to have the wrong impression.

Mr P. ABETZ: What is a CAP bed?

Ms L.L. BAKER: Care Awaiting Placement.

Mr Harding: The CAP program is fully funded by the state out of its health allocation. The transitional care places are funded by the commonwealth government, and I believe the state government tops up some of that through recurrent funding. The focus of the programs are slightly different; the transitional care program is very focused on therapy and rehabilitation, to get people back into their own homes or to a residential care facility. It is often a post-operative transition. In the last budget it was indicated that there would be a transition between the Care Awaiting Placement program and the transitional care program. However, my organisation has not been offered that at all, so when this program closes in December, that valuable resource with 90 staff and great capacity will just stop. It is not at all clear to me what is happening there, and trying to understand what has gone on is certainly is not a transparent process.

The CHAIRMAN: That would mean that there will be no places for patients who currently move from tertiary and secondary level hospitals.

Mr Harding: The program will wind down between 1 October and 30 December, and hopefully by the last day there will be no more patients; but as we have said to the Department of Health, if they are there, we will send them back again.

Ms L.L. BAKER: Can I pursue this? Have any transitional arrangements been discussed with you?

Mr Harding: Not with us, no. With other service providers, yes.

Ms L.L. BAKER: You have 70 beds?

Mr Harding: Yes, it is the single biggest part of the Care Awaiting Placement program.

Ms L.L. BAKER: I do not know whether I am allowed to ask this question: why do you think this has not been discussed with you?

Mr Harding: I do not know. I have been trying to get an answer from the minister.

[3.50 pm]

Mr P. ABETZ: Does the Department of Health administer it?

Mr Harding: Yes.

The CHAIRMAN: We are all a bit surprised at that, and I think some questions will be asked to follow up on that matter for you. In relation to the high-dependency versus low-dependency beds, a problem that is created in nursing homes is that a resident who is considered a low-level resident before being admitted to hospital may become a high-level resident after falling and having a hip replacement or because, for one reason or another, he or she is no longer capable of independent living—that is, needing assistance to dress and feed. Many nursing homes and retirement centres, not only yours, do not have enough staff. Only so many level 3 and high-level and low-level places are staffed. That is why hospitals complain about the number of beds being limited. It is really about being able to take that resident back; it is not just a case of needing one additional staff member. High-dependency residents require quite a different staff to resident ratio.

Mr Harding: Yes. I do not know how far the committee will delve into the intricacies of the aged care sector, but it is set up in quite a complex way.

Mr I.C. BLAYNEY: That would be the understatement of all time!

Mr Harding: We make generalisations, but it depends on the circumstances. I will give members some background about why the answer to that kind of scenario is not always clear. The buildings themselves have certain classifications regarding their capability. A low-care building is classified in one way and a high-care building is classified in another way. That has quite a bearing on what happens inside the building. The commonwealth is very keen on ageing-in-place. If a person comes

in as a low-care resident, the service provider has the ability for that person to stay in that room until that person's last day, regardless of the resident's changing care needs. If the building was built as a high-care facility, even though it was providing low care, the internal staffing arrangements can be restructured to meet the ageing-in-place. Quite a lot of flexibility can be created in that type of building. If that cannot physically be done, it is quite limited and the provider must continue to provide low care. If a resident leaves the facility to go to hospital and comes back as a high-care resident, it might be that the person's needs cannot be met in that type of building.

The CHAIRMAN: And you cannot take them back?

Mr Harding: The service provider would have an obligation to find an alternative place for the resident, but the resident could not be taken back into that facility or into the same room. Within my own mix of 20 residential care facilities, I have some old-style buildings, such as I have described, that were built as low-care facilities, and there is a limit to what I can do with them. I have newer stock that is a combination of high and low-care facilities under the one roof. I built the whole thing at the high-care standard so that I could have as much flexibility as possible. The work that we are doing in Geraldton will create that capability, so that the building will have a lot longer life in order to meet the needs of the community. There are big dollars in trying to reconfigure an aged-care facility building.

When a person suffers a stroke or something happens to that person and his needs change, how do we meet those needs after the person's acute intervention? We try as hard as we can. With a larger group like ours, often the resident might have to go to another centre. A stand-alone facility that runs one service might not be able to meet that person's needs and the provider must shop around to find alternative accommodation for the resident, which could be very difficult because the high-care places are the most difficult to find.

The CHAIRMAN: It could take several weeks.

Mr Harding: Notwithstanding the allocation of funding by the commonwealth for low and high care, overall about 70 per cent of people who are in residential care are classified as high care. The residents arrive as low-care residents but over time they become high-care residents. That is what actually happens. That is another criticism we have about the planning arrangements. If that is the reality, that is what we should be planning for. We should be using an 80-plus category for our planning ratios and we should be looking at a care profile that meets high-care needs rather than low-care needs. We should be doing a lot of things to change our emphasis to meet the rapidly ageing community that we are confronted with. We try very hard to make sure that people's needs are met. One of the issues we certainly have with the acute sector is that we do not believe the facilities are very well set up to meet the needs of older people at all. If we know that people are unable to feed themselves or cannot do it in a timely fashion, our care staff follow them into the hospital at meal times to make sure that they are actually being fed, because our staff are not confident that the residents will get any food otherwise. The trays can be left for the resident and if it is left untouched, it is taken away again. There are significant issues for the health sector as our community ages because the demand on that sector will increase substantially. A lot more patients will be older people who have particular profiles and needs. That is a big-ticket item that also needs to be addressed.

Mr I.C. BLAYNEY: What is the bond to get into those facilities?

Mr Harding: There is no upper limit. A minimum is set under the Aged Care Act that requires a person to be left with assets worth two and a half times the pension. It is something like $32 000. A provider can charge anything above that so long as that person is left with that amount of assets. That is roughly how the system works. The bond amounts range from $50 000 to $450 000. For extra service places, which is another little cute arrangement in the system whereby you can charge bonds in high care called "extra service", it could range up to $600 000 or $700 000. It is a bond. There are retention amounts contained in the act. It is a temporary loan. By far the majority of the

funds go back to either the family or the estate after a time. There are all sorts of rules about that. In Perth it costs about $220 000 to build a bed. Recurrent funding from the commonwealth gives you about $145 000 to play with. You can see the tension in the capital funding system to try to get places built.

Mr P. ABETZ: Is that a capital grant that the commonwealth government gives you, or is that the fee the commonwealth government pays that allows you to service that capital debt?

Mr Harding: It depends on what part of the system we are talking about, but for high care, the federal government pays us about $25 a day for an accommodation charge. We estimate that it costs about $45 a day to meet the amortised capital cost over a 30-year life of a facility. There is a substantial gap between the two. If there is a mix of high and low care, the provider can charge a bond and the ratios might be quite different, but it often depends on the location of the facility, the socioeconomic profile of the area and what would be an acceptable bond for that community. Often the bond is set according to the profile and the average housing values of the local community.

The CHAIRMAN: In view of the time, if committee members are in agreement, I would like to thank you very much for skimming the surface with us, and it has been very much just a skimming of the surface. We appreciate having on record your initial introduction, but we have not discussed many of the issues that you flagged as part of your general introduction. I have a nursing background, Liz has a social work background, Ian does not have a health background but Peter has had some experience with palliative care. You are the expert giving us advice about aged care. We would very much appreciate it if, when you have the time, by way of supplementary information, you could highlight not only the needs in an area, but also how those needs could be addressed. You mentioned the capped beds. The committee is becoming aware of the difficulties throughout the entire healthcare system. It is just amazing. Perhaps if you would like to, by way of supplementary information, also forward the committee a copy of the letter that you sent to the minister. Through these hearings, we are aware of all the things that are going on. Therefore, it might be possible for us to follow up on those matters for you. Sometimes letters get put into in-trays. I would often hand something to a minister as well as send it to a minister. Because of the problems in relation to the time for those beds, we might be able to flag that matter for you with the minister and see if he can give you a response sooner rather than later.

[4.00 pm]

Mr I.C. BLAYNEY: Can I just ask one more question?

The CHAIRMAN: Yes.

Mr I.C. BLAYNEY: Who does it best? If you look around the world, who would you say is the model? Who has got it right?

Mr Harding: As a general rule, from what I have seen, the western countries with the smaller populations, such as the Scandinavian countries or Holland, do it better. I think there are a range of reason for that, including how the population inherently lives—they live closer to each other and have more integrated communities. They have often created service and services structures which do not isolate people. For instance, a housing block might have within it a nursing home, a base for community care, families and older people living quite close to each other, and often it will support that person a lot longer, and the need for third-party intervention such as we provide gets significantly reduced. Also I have observed that in some systems, like Sweden's, a doctor will follow a person from hospital into their home, or into a community setting or service setting. They will follow the person through the system to make sure that their needs are met, whereas we departmentalise and sectionalise—we cut things off—and people get lost, basically. That is how I guess I would, in general, describe the differences in the systems that I have seen. The bigger systems, such as in the USA, Britain and France, I did not see a lot that we should get excited about.

The CHAIRMAN: Thank you, Vaughn. In clarifying those needs, we would also appreciate any suggestions that you are able to make to us that we can consider putting forward as recommendations to address what the deficiencies are.

Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Please make these corrections and return the transcript within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence.

Thank you for coming today.

Hearing concluded at 4.04 pm