COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Aged Care

WEDNESDAY, 23 FEBRUARY 2005

PERTH

BY AUTHORITY OF THE SENATE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Wednesday, 23 February 2005

Members: Senator Marshall *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Humphries, Hutchins, Lees and Moore

Substitute members: Senator Allison to replace Senator Lees for the committee's inquiry into aged care

Participating members: Senators Abetz, Allison, Barnett, Bishop, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Denman, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Greig, Harradine, Lees, Lightfoot, Ludwig, Mackay, Mason, McGauran, McLucas, Murray, Nettle, O'Brien, Payne, Tierney, Watson and Webber

Senators in attendance: Senators Humphries, Knowles, Lees, Marshall, McLucas and Moore

Terms of reference for the inquiry:

To inquire into and report on:

the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training;

the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

(i) assessing and monitoring care, health and safety,

(ii) identifying best practice and providing information, education and training to aged care facilities, and

(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff;

the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements;

the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly; and

the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

WITNESSES

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Committee met at 9.02 a.m.

HORNER, Ms Barbara, Director, Centre for Research into Aged Care Services, Curtin University of Technology

CHAIR—The Senate Community Affairs References Committee is continuing its inquiry into aged care. I welcome the representative from the Centre for Research into Aged Care Services. The committee prefers all evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission. I now invite you to make an opening statement which will be followed by questions from the committee.

Ms Horner—Thank you. I would like to highlight a few points from the submission and add a few other thoughts. In recent weeks I submitted my doctoral thesis, which is a study of organisational change within residential aged care. Perhaps next time the Ms will be Dr—I am awaiting the examiners' reports. There are a couple of things in particular from the research that I think are useful and add additional comments to the submission I made. I am going to refer to each of the points I responded to and highlight a couple of points in relation to those.

The first point asked for comments in relation to overcoming work force shortages and training. The point we would like to make particularly strongly here is that there is a need for a coordinated approach to the human resource issues that revolve around the care of older persons. We take that well and truly beyond the residential high- and low-care market in that we believe there are as many issues that relate to good quality care of older people in other sectors as there are within the residential sector. That relates to and includes the issues of remuneration for staff, which continues to be a major problem, but it is also a more comprehensive approach to recruitment, retention and training.

The area I found particularly relevant in my own studies was the importance of leadership, which tends not to be looked at as a component within human resource management, particularly for aged care. There are some unique issues facing providers of residential aged care that relate to their capacity as leaders. In particular one of the major concerns for them is the need to balance the concept of business accountability with social conscience, and a great deal of that came out within my own studies. There is increasing need to be an efficient provider. There are pressing demands in terms of resource allocation and accountability. And there is a legacy that comes with the concept of social accountability which I think makes it quite a difficult balance to maintain. That social conscience concept is equally presented by the community as it is by the residents who perhaps live in the facilities. I think there is a need to explore the impact that is having on both sectors. I think that the sector would agree with me in believing that the artificial barrier of for profit and not for profit is not useful to the industry. While the church and charitable providers do have a different set of business rules and accountabilities, clearly they are also not to make a loss. I think that some of the issues within the sector are confused and muddied by a continuing separation and perhaps there is a need to look at how that can be balanced better across the sector.

The second point relates to performance effectiveness in relation to the Aged Care Standards and Accreditation Agency. The point that we would like to make strongly is that there is a need to move beyond the concept of minimal standards that are related to accreditation. The purpose of the accreditation process is still clearly important although we would believe that there are some facilities hanging on to that as an artificial way of managing their business and that is perhaps inhibiting or suffocating their ability to be innovative in relation to the accreditation standards that they have to meet. As a centre we believe that there is a need to move beyond the concept of minimal standards and to actively encourage innovation and new approaches. The concept of policing through minimal standards is still very strong within the industry and the accreditation process takes an enormous amount of resources and time out of the provision of all the other things that occur within the industry. I would like to see an expansion of that process beyond the minimal standards. In our experience the standards across the industry in Western Australia are quite fantastic.

The third point that I make reference to in my submission is around the area of special needs of dementia. We make the point very strongly that dementia has moved beyond the concept of special needs. It is now a component of integrated care across the entire residential aged care industry. There is increasing incidence of dementia and we are all aware of the demographic details and the growing numbers. In fact there was an article in the *West Australian* this morning identifying the growing number of people with dementia. That is occurring for a number of reasons. Very few aged care facilities will tell you that they do not have residents with a degree of dementia, and many levels of dementia. We are seeing older people in residential care for shorter periods of time and at the very acute end of their illness. Dementia is not a special need; dementia is a reality. I think that the care of people with dementia across other health sectors is also now a component of good aged care. The hospitals and community groups that we work with through the sector clearly identify that meeting the needs of people with dementia is now an integral part of their role. It is not a special needs group anymore. And with that increasing demand, and an understanding of dementia and the care of people with dementia, are the allied issues of depression associated with that disease, and carer burden. Carer burden becomes increasingly significant. There is a lack of understanding leading to a lack of the use of respite, which is seen as an indication of failure rather than of support.

The fourth point relates to the adequacy of home and community care programs in meeting the current and projected needs of the elderly. One concept that has become very common throughout the industry is that of ageing in place, and I think that needs further examination. It has become a catchcry that many people do not truly understand the meaning of. I would make particular reference to a sector of my thesis in which I discuss the concept of ageing in place, which proved to be a burden in the facility that I was studying. I quote:

> While recognising the relevance of this concept, this study highlights two interesting complications to a preference to age-in-place. First, the spouse, family member or friend who may be providing assistance to enable the individual to live at home, can become increasingly affected by the role and this can progress to a stage where their health is compromised. Second, the person receiving assistance to stay at home feels obligated to ‘soldier on’ because so many people are helping them, when they may be feeling exhausted. In both situations, there is a risk of creating feelings of guilt when the situation becomes untenable; ‘I failed her because I couldn’t cope any longer’, or ‘I am a failure because I can’t cope any longer, even with all this help’.

My point there is that, while we all agree that ageing in place is probably something that most people would aspire to achieve, the complexities of ageing in place need to be examined in terms of the impact it is having on the industry as well as on family members.

I also would make the point that it seems, within the community sector in particular, the philosophy of supporting independence is overruled by the concept of treating dependence. We believe that there is a strong need to re-examine the culture that is behind that. The culture and the attitude towards providing services for people living in the community within a concept of ageing in place tends to still focus on what they cannot do rather than on what they can still do. We would like to see a lot more emphasis put on changing culture and attitudes of care providers towards understanding that their purpose is to promote what a person can still do rather than come in and assume the caretaker role of ‘I will now look after you because you are dependent’—not a small task. There are also issues within home and community care to do with the increasing number of informal carers and the whole concept of how they are not just a small but an integral part of the industry. That needs further acknowledgment or ways of looking at how it can be supported because, without the family informal carer, the whole sector would fall apart.

Also, part of looking at the adequacy of the Home and Community Care program is to further acknowledge that what I found in my study is much broader than just at the facility I looked at. This particular facility has three categories of care: independent living units, low care and high care. In the past, the relationship of the 1 to 8 resident status classifications tended to clearly mean that people in independent living units usually did not need any care, and so it progressed through low and high care. There is quite a lot of evidence, and a number of providers would support me when I say, that in independent living units—and, by that, I mean the retirement industry in many cases as well as independent living units within aged care facilities or aged care communities, such as retirement villages—there are now many who would be classified at 6, 7 and 8. Low care now is usually 3, 4 and 5, and high care is almost nothing other than 1s and 2s. The artificial boundaries between those three categories of care have become very grey and it is a system that continuously moves laterally. Home and Community Care struggles at times to provide the level of care to meet the acuity of the person whom they may think is an independent or a 7 or 8 but, in fact, is much more dependent than that. I would encourage the examination of different support models and different ways of providing community care. The one that I examined very closely within my own studies was the concept of a day therapy centre that goes well beyond day care and, in fact, provides total care for the day hours within a community setting. We found that in many cases families are quite capable of looking after the person overnight, but it is that day period of time when they need intensive support.

Finally, in response to paragraph (e) of the terms of reference, the effectiveness of current arrangements for the transition of elderly from acute hospital settings to aged care settings and back to the community, we believe very strongly at the centre that a great deal of work still needs to be done to improve that. Again, this comes with the recognition that there are such large numbers of older people who are in hospital. Whatever the average age of in-patients is these days, the figures indicate that they are 70-plus and probably older. The concept of discharge planning needs to be re-examined in being able to move people across sectors and discharge them effectively. It is much more a case management role.

I think the acuity that is now being seen within some of the high-care facilities is high-level clinical care, the sort of care you would perhaps see an older person receiving within a hospital. So I think there is still quite a lot of work that needs to be done in recognising that, once again, these sectoral boundaries are no longer as rigid as they were and that there is a lot of transition across those boundaries, which has an impact on the way they are able to provide services.

In summary, I make the following points. I appeal for an integrated approach to the solving of problems; a re-examination of the concept of accreditation, and moving beyond minimal standards; the consideration of community, environmental and social factors, which are equally as important as care—and, in that, looking at levels of dependency within retirement villages and independent living units; and a balancing of the capacity and capability of organisations to meet business accountability while having a social conscience. I think there are many opportunities to look at innovations in technology and in models of care that might better be able to meet the needs of older people in the future. Being the director of a research centre, I have to say that we need more evidence based practice, and certainly the evaluation of existing models as well as new innovations is something I would like to see supported strongly.

CHAIR—Did you identify any issues with the complaints process in the facilities you looked at—whether it was adequate and whether there was any difficulty with follow-through? We have had some submissions which talked about the fear of retribution and reprisal through that process. Have you identified any of that?

Ms Horner—My study was a three-year, in-depth study of one facility. However, the work that the centre does is much broader than that. We have worked with a number of providers in the industry in the five years we have been in existence, so I speak beyond the one facility that I spent so much time with. There is still very genuine concern about an underlying policy of blaming that still comes out of the complaints process. We did a very interesting exercise with a large number of providers in Perth last year to look at how to work more effectively with families to better deal with issues that came up, to avoid getting into the complaints process, so that it did not become a formalised process. There still seems to be a feeling that when a complaint process commences it is an indication of a failure within the facility—that they have not done their job or have not been able to solve the problem effectively. I think that is partly unavoidable in that, when you bring in outside help to solve the problem, there is often a tendency to think that you have not done a good job. But I think a lot of providers would tell you they still feel unfairly judged by the complaints process in terms of their ability to solve the issues that come through.

CHAIR—In terms of what you said about moving away from minimum accreditation standards, can you explain how that might operate? It occurs to me that you actually need a baseline to be able to measure with some consistency across the industry, but I do accept what you say about the potentially stifling innovations in other areas. Could you explain that?

Ms Horner—Yes, I agree that benchmarks, standards and a level of accreditation need to exist, but the people we work with continued to tell us how all-encompassing and all-consuming are the processes of accreditation and follow-up visits. It is not that the agency is not coming to the process with the right attitude; it is not a criticism of the agency. It is more a recognition that while there continues to be measurement against ‘Are you good enough?’ it tends to lower the level of performance.

I have worked in acute care for many years as well and have been involved in other levels of quality assurance—the most recent one was ISO 9002. There was always an attitude that, if we just get there, if we just get to that minimum level, we have done enough. In the process of providers demonstrating that they are meeting those standards continuously, as part of the accreditation process, they are so exhausted—having proved that, with the magnitude of documentation and resources involved in doing that—that they have nothing left with which to do more than that. When you talk to them, providers will say, ‘We’ve got such great ideas,’ or ‘We want to try different things,’ but they have no resources or energy left to do that.

My feeling is that the process of the accreditation standards was certainly necessary. They have proved their point. I think the level of care in residential aged care in Australia is significantly high. There are always some providers that maybe need assistance to maintain a minimal standard, but it is like a reward for effort. It is like saying: ‘Okay, we know you guys have got there. Now, how can we help you raise the standard and look at innovation?’ I think there still need to be baseline standards, but I would like to see less emphasis on the detailed demonstration of those standards and more encouragement to take it up another level.

CHAIR—Were you able to look at the levels of paperwork which you have talked about and come to some conclusion about whether, say, this item was necessary, but this was not? That is one of the things that we are trying to grapple with too, because we are getting a fairly common complaint through about the level of paperwork. We are trying, I think, to come to grips with what may or may not be necessary: what is desirable; what is necessary; what is essential—and what certainly can be discarded.

Ms Horner—The experience I had with the facility I worked with—and I cannot remember whether it was last year or the year before—was that they were aiming to achieve a ‘commendable’ level. This particular facility has independent living units, high care and low care, but they see themselves as an integrated community. They do not see themselves as three pockets of care; they see themselves as an integrated aged care community of some 1,100 residents. They would like to present themselves as an integrated community; whereas the process requires that they demonstrate the achievement in high care and then in low care separately.

Again, perhaps there is a way of looking at overall capacity to demonstrate accreditation status without dividing it up into those subsets. Our experience was that we spent hours pulling together documentation that could be tabled to demonstrate a credible and additional achievement. A lot of it was to do with leadership and the work that the senior management team had done. It was hours of work and folders of documentation that appeared to me to be very repetitious. It was like: ‘If we know you’re here then we won’t ask you to produce all of that again; we’ll ask for something else.’ It seemed to be a rehashing of a great deal of information that was already on the table in terms of having met those standards. It was just hugely time consuming.

Senator KNOWLES—Thank you for your presentation; it has been very interesting. I want to carry on from where Senator Marshall left off, because we have heard moans and groans for years about the excessive documentation. If you put that against the backdrop of a level of demand that people pass or exceed a certain standard then even to maintain that standard is a critical issue for those who are going to be accessing the sector. You asked: ‘If they have met that standard in the past, why don’t they go on to other things?’ Maintaining that standard is also a critical thing. We obviously have a very delicate subject at hand, where, if you get one provider that fails in a big public sense, all the providers are seen as crook. How do we balance that against the expectation of the community and of a supercritical media that will do anything to pull the industry down in the public perception, vis-a-vis the documentation that is required?

Ms Horner—One of the ideas we explored last year with one of the providers was the concept of documentation by exception—almost the case management role—and the concept of clinical pathways, which came into the hospital setting many years ago. There was a lot of criticism of whether that was going to be a whitewash and, ‘How could you say whether all people with a fractured neck were going to do this and all other people were going to do that?’ The overall status of a lot of residents who are in residential facilities does not alter very much. If there were a process of having to document by exception, rather than document everything to demonstrate, I think that would be an interesting model to trial, at least, to see how you could take on a clinical pathways concept within residential aged care. That is in-house, in terms of documentation. I think the public’s understanding of residential aged care is still very coloured.

Again, it is part of the idea of acknowledging that a parent, or whoever, going into a residential aged care facility is still often perceived to be a failure—‘I haven’t done my job,’ or ‘I have not kept them at home long enough.’ I am grappling with that situation myself with my own parents at the moment. Yet, we can all cite very clear examples of where the condition of the person improved fantastically once they went into the facility. They received the quality care that they needed—a person doing their job, rather than their daughter doing 18 other things at once and feeling guilty about what she was not doing; medication management, physical activity; but, most importantly, in the three beautiful cases we saw last year, all of a sudden, they had friends, social and community interaction and an environment. Instead of sitting in their own home, being lonely, they suddenly had a home of people.

I think there is a real need to help the community understand that admission to a residential aged care facility is just an acknowledgement of a particular stage of a person’s life. It is not an indication of failure. We need to do some more work on these ‘motherhood’ statements of ageing in place. Ageing in place is not good for everybody. It tends to have become something that we all think we ought to be doing more about, when in fact ageing in place could be ageing in a nursing home place just as effectively. I very much recognise the community pressure and the damage that is done when somebody does not meet standards. I am certainly not saying there should be no more accreditation standards. I am saying that maybe a part of the process is to acknowledge, ‘You guys have done so well in meeting this expectation that we will give you the opportunity to continue to report against those base standards,’ but let us take the community’s mind off minimal standards and on to ‘What else can we do?’ A huge community education program is still needed. Residential aged care is still seen to be ‘the last place I want my mother to go to’. In fact, in many cases, it should be the first.

Senator KNOWLES—There is so much misrepresentation of what happens, and dare I even raise the subject, but I go back a number of years to the alleged kerosene bath incident. A lot of people were of the opinion—thanks to total misrepresentation—that the poor person was dumped into a 44-gallon drum of kerosene when, in fact, it was a drop or two in a huge bath, which is not uncommon.

The way in which that was blown out of all proportion cast a shadow across the whole industry. Then there was the ‘why aren’t there spot checks’ question. We now have the situation where some people are saying that people should not be sprung with spot checks. It is a real balancing act, isn’t it—as to how we ensure that there is public confidence without the public being terrorised by other people who, for various reasons, want to terrorise them. How do we balance that out?

Ms Horner—I think there are complicating factors because of the nature of the work force within residential aged care—and that is another whole area of exploration. Even now, the majority of people who work in residential aged care are trained on the job or receive minimal levels of education. They come to the position with enormous commitment and dedication to do a tough job in a challenging environment. But they can only interpret the environment in which they work through their own eyes, and it is difficult to understand the complexities and the total care management being delivered by registered nurses, if they are there, or by more senior members of staff. There is this constant pressure of being so busy that they do not have time to help people understand what is going on. There is such a lot of busy ‘doing’ within these places that there is not a lot of time to reflect.

I guess that is part of the point I am making about the old training levy. I worked as a staff development nurse when we had a training levy. We were given an amount of money, and we had to demonstrate that we used that in certain ways. I think it was a really good system. I know it was abused by some companies that just whipped off to conferences et cetera and said that that was a training program. But, with the right kinds of measurements and reporting systems within it, there could be a conscious process of providing targeted money for training that included an education program. A lot of the facilities we talk to would love to do more resident-family meetings. They would love to have more interaction with family members and run information sessions et cetera, but they just do not have the time or the resources to do that. Maybe that could be part of getting the community to understand better what actually goes on in these places. The workshop we did last year with a group of providers who wanted to develop better strategies to deal with these tough family members who were getting in their way of providing good care was all about communication. It was all about family members understanding the complexities of the organisation and the complexities of the care.

Senator McLUCAS—You talked about the importance of leadership in residential aged care. The question in my mind is: given the description you have just given of the senior staff running around madly chasing their tails, essentially—that is the image you have given me—how do we lift those people out of that situation and give them the skills, the time and the ability to show leadership?

Ms Horner—I think it is leadership in a couple of different areas. I think there is a need for clinical leadership because, increasingly, the people who are in residential care are acutely ill and a degree of clinical management is required. That, of course, speaks to the issue of registered nurses and whether they should be there. I am strongly of the belief—and I have made it very clear to a lot of people—that I do not think you need stacks of registered nurses in residential aged care. I think you need care leaders, case managers and clinical coordinators who are highly qualified and specialised in the area of care of the older person. I think there are an awful lot of things that you do with residents in a residential aged care facility that are no more complex than things that you do with your parents at home, and other levels of care workers can be involved in that kind of care.

So I see the need for leadership in terms of clinical management. What I became much more involved with in my own state was the need for leadership at the organisational level. Part of the issue is that there are very limited career pathways. There is very limited acknowledgment of leadership roles within residential aged care. If you have graduate qualifications in health service management you are far more likely to go into the acute sector than you are to go into residential aged care. It is still seen as a bit of a backwater in terms of career progress.

Yet I think the complexities of the role call for some very specific leadership skills. For me, it is the complexity of running the facility, which in many cases now involves multiple sectors. There are business accountability issues and there are also leadership issues. We are still finding that in a lot of the residential facilities the educational qualifications and the experience of people who are in those senior positions need topping up—they need development.

Many of the facilities are telling us at the moment that, as always happens with cohorts of people, the senior people within residential aged care are all going to leave at the same time—like they are in some other sectors. There are lots of progression work force issues that need to be dealt with. Many of the directors of nursing or directors of clinical care in residential facilities are about the same age. There is great difficulty in recruiting young people into those positions. Still nurses view themselves as needing to go and do all that other emergency, acute stuff before they move on to those areas.

I think there is an acknowledgment of the complexities. It has been seen as—certainly these are the words used for many years—a cottage industry. It is clearly not a cottage industry. It is a most complex business and I think there is a need to acknowledge that and to see an investment of resources into the development of leadership capacity, perhaps through scholarships, education programs et cetera.

Senator McLUCAS—The nursing sector in particular has put to us that we need to move more to a ratio approach of delivering a number of care providers, be they care workers or whatever, to the number of residents. I think what you are saying is that, if you brought in a ratio approach, we would limit that innovation.

Ms Horner—No, not necessarily. Again, it is that balance between overregulation and restricting the opportunity to do creative things with what you have. I think there are multiple levels of carers that can be involved within residential care. What I am saying is that some of the regulations and restrictions that are placed on them inhibit their ability to look at doing things more creatively. Individual facilities have some great ideas but they really struggle with the time and the resources to be able to put some of those into place.

Senator McLUCAS—I have worked in child care in another life, and it is a completely regulated system. If you have eight babies, you have two workers with a certain level of skills. Is it possible in residential aged care, where you have low-care, high-care and even palliative care in some places, to dream up a ratio?

Ms Horner—Yes, probably. Again, I guess it is at minimum standards level. A lot of the emphasis is placed upon the administration of medications within residential aged care, which immediately leads into legislation and legislative problems. Many of my colleagues know my position on that. I do not think nurses are the owners of medications and medication management. Their critical and invaluable expertise is their ability to assess, to problem solve and to resolve issues. I think there are lots of other people who can do lots of other things. The role of the registered nurse in aged care is in clinical management, clinical case coordination, problem solving and good assessment because of the depth of knowledge and understanding that they have. We are seeing how that is being interpreted in lots of different ways.

I think there is always need for guidelines. Somehow people do not like an empty plate. They like to have some guidelines to start to work around. Maybe those guidelines include options of ratios that could be looked at, without it being a regimented system.

Senator McLUCAS—A lot of consumers would like to have the security of knowing that there will be a certain number of care providers at all times.

Ms Horner—That again is perhaps a lack of understanding. My experience has been that, when you can sit down and explain to a family member why it is happening the way it is happening and why you are delivering the care that you are delivering—if you have had a chance to explain to them what this person’s role is or why it is working this way and not that way—they are usually quite happy. Again, that is about having the time and resources to be able to do that sort of discussion. Most directors of care will tell you that an enormous amount of their time is spent just interacting with families, reassuring them, chasing up on issues and providing them with the information that they need. Many of them will tell you that the hardest and most difficult thing that they do is deal with misinformation within families and across families. Some family members have their own wars going on and do not come to the table with a common approach and are not necessarily interested only in the wellbeing of their family member.

Senator McLUCAS—Difficult circumstances.

Ms Horner—Yes.

CHAIR—Can you describe to the committee where the facility you studied would sit on the socioeconomic scale. One of the issues I am concerned about is equity and achieving a minimum standard we should all be satisfied with. Some facilities will of course have more money than others. I do not think you will get many saying they have surplus money. Can you give us a picture of where that is.

Ms Horner—The facility that was the subject of my study is a community—a single provider. It was classified as not for profit. But they also say ‘not for loss’. It has been in Perth since the early sixties. It evolved as cheap accommodation for elderly people who could not afford their own private rental, so it was subsidised rental. It progressed from that to now being roughly 1,100 residents, as I said. It is a large single site in Perth. Certainly the accommodation, the buildings and the structure of that very large geographical site are old now. They embarked on a process of rebuilding and modernising accommodation and services and reshaping themselves.

My study was an action research study in which I worked with them as I worked through that process, so it was a study of their change, where they came from and where they wanted to go to.

CHAIR—It still remains a facility where someone on an old age pension could end up.

Ms Horner—Yes, it does. They are now going through stages of redevelopment of their accommodation. A lot of their accommodation was bed-sitters and little one-bedroom kinds of facilities. They are in the process of rebuilding those. They have expanded their market into the 50-pluses, to engage them in coming on board earlier in an independent way. They will still maintain at least an 80-20 per cent mix in terms of being able to offer assisted rental accommodation. Within the market, in Perth they are one of the biggest in terms of numbers of beds and residents, because they provide the three levels of care. But they are a single operator on a single site.

Senator LEES—I will go back to, firstly, the pressure on staff to keep up with the paperwork and, secondly, the issue of medication—who medicates and how that can be streamlined, given some of the evidence we have had about the hours and hours every day, in round after round, involved in dispensing medication. Is computerisation one way of trying to reduce all of that, and where are the facilities in Western Australia up to with that?

Ms Horner—Good. I can tell you all of that.

Senator LEES—Unfortunately, we have only got a short time left but, if you have got some material or research you could give us or if you have done any work, that would be fabulous.

Ms Horner—Firstly, in terms of medication management we completed a study funded by a pharmacy in Perth last year where we did a comparison of two types of medication administration system. One was the traditional dosette box and the other was the computerised sachet. I can provide you with that report. That study was with Co-pharmacy group, and we did a comparison of two facilities within one of the large providers: one that was using one system and one that was using the other.

Senator LEES—Does this also look at who is going to do the physical work—a registered nurse or a care attendant?

Ms Horner—No, it was looking at a comparison of time and resources between the two systems but it brought up—and we highlight this in the report—a number of other issues in relation to medication management. As part of my studies I spent some time in Canada and worked with one of the big providers in Alberta. They had some very interesting innovations in terms of medication management. What you ended up with was a very securely dispensed package of drugs by dose and by time, which could then be literally opened out of a sachet and taken by the person. It is the difference between making decisions about medications and actually saying to Mrs Horner, ‘Would you like to take your tablets now?’—that is the big difference between who does what.

There are some very interesting things being done in Perth. Two pharmacies are running this different computerised delivery system with some very good results. What we found in our study very simply was that there were fewer errors, there was more confidence with the people dispensing the medications and they were able to move away from the big trolley and all that stuff that takes up time.

Senator LEES—It seems to take up an enormous amount of registered nurses’ time when they really should be doing so much else and indeed want to do so much else. The pressures on them lead to an extra hour or maybe two hours a day beyond what they are supposed to do.

Ms Horner—A lot of places are leaving medications with residents. If you are capable of taking tablets at home, why can’t you take them in your residence? So there are lots of those areas but, in particular, in terms of computerised documentation, we have been working with a group in WA that has developed—

Senator LEES—That has been a personal interest of mine for some time. When I have visited nursing homes I have found that there is a whole raft of reasons why it seems to be the last bastion in terms of computerisation.

Senator MOORE—One of the last.

Senator LEES—Some of it is reluctance on the part of staff to have confidence that the accreditation agencies and others will accept what they are doing. It seems there is a role for agencies to maybe give some packages, examples, guidelines and recommendations as to what nursing homes can do.

Ms Horner—WA, I think, is doing some very innovative things in terms of electronic documentation and the use of PDAs that staff can take with them so that the recording of information occurs at the bedside. In this particular case, it is then automatically transferred to the computer so that you do not have to go back and forth between person and desk. I will leave a brochure which explains who the company is we have been working with. We have been trying desperately to get funding to evaluate a trial using that within the provider that I have been working with.

Senator LEES—We will need funding for training of staff. This is a whole new era.

Ms Horner—There are two ways. Yes, there are possibilities of looking at electronic documentation. What the provider wants is accurate documentation that gives them better data to support the claims that they make. It is not just more information. There are certainly some advances in that and there are certainly some advances in the actual administration of medication.

Senator LEES—One other area that interests me is the new model that you have talked about. To me, it sounds like child care. A carer would drop off grandma at the facility at eight o’clock in the morning. She would be provided a proper program of a whole lot of activities, including making sure that she had her meals, and then she would be picked up at five o’clock in the evening. This might occur five days a week. Is that what you are talking about?

Also, is it possible for people to admit themselves? If someone were living at home, they would know that, if they went to this facility, there would be cards in the morning and then lawn bowls and they would have a decent meal. Perhaps all they would have to do at night would be to take home a pack of sandwiches. It is a more intense program of socialisation and it ensures that people who struggle, perhaps because of sight or other impairments, would get a basic meal.

Senator KNOWLES—Who runs it, who funds it and where are they?

Ms Horner—There is a difference. Day centres—day care—have been around for years and years. Lots of local governments and community agencies run day centres which basically have a socialisation role. There is socialisation and supervision and, yes, meals are served. People have a big dinner for lunch and they can take something home which is subsidised or they are supported by Meals-on-Wheels and other things.

Senator LEES—This seems to be going to another level.

Ms Horner—This is different. A day therapy centre is based on a model that has been around forever in the United States. It started in San Francisco; it was called PACE. It has now been translated to Canada and is called CHOICE. It is an alternative option of providing as intense care as the person needs for a period of, say, nine to whenever.

Senator MOORE—It is like the respite model, only extended.

Ms Horner—Yes, it is. The person is picked up in a bus and brought to the centre. It is funded in the same way that home and community care is. The same assessment process occurs. The individual is assessed in a way so that a care plan is devised. It is care but it is occurring during daylight hours, and the person needs to have a carer that they go home to. Day therapy is being looked at. The day therapy concept is in Australia, and half-a-dozen places are trialling it. I am yet to find one that is implementing it as comprehensively as Canada is with the CHOICE program that I studied.

Senator LEES—Have you material on the Canadian CHOICE program that we could have?

Ms Horner—Yes.

Senator LEES—I just see it as another level for an ACAP team to assess: ‘This person needs a far higher level of care than is able to be provided in the home but they do not necessarily need to be put into a nursing home or hostel because they have someone at home who is at least there at night-time.’ Could we have that material?

Ms Horner—I can make that available to you.

Senator LEES—Does it have some costings? ‘What does it cost?’ is a question we will always be asked.

Ms Horner—Yes, the facility that I worked with have been exploring it in detail because it is one component of their new model of care that they are intending to implement. I will gather together whatever I can.

Senator HUMPHRIES—You make the comment in your submission that the model for home and community care programs is back to front in that it emphasises dependence rather than independence. You said today that there is a focus on what people cannot do rather than on what they can do. I understand the concept you are putting forward, but I am finding it hard to understand how that actually works in practice. Can you give me an example of an agency or whatever that uses the back-to-front model?

Ms Horner—It is part and parcel of the role of the health professional who sees as instrumental to their role their being able to help someone to do something that that person cannot do. It is as fundamental as nurses doing things for other people. It is: ‘I’m helping you to do what you can’t do.’ An example would be where a community nurse or a domiciliary home nurse—and I say ‘nurse’ generically—would go into a home and instead of saying, ‘Mrs Horner, how are feeling today? Can I get you a cup of tea?’ they might say: ‘Mrs Horner, I am dying of thirst. Could you make me that cup of tea like you did last week?’ It as simple as changing the language and the attitude.

Health professionals are wonderful people—I am one of them—but we get our jollies by doing things for other people. That is part of the role and we feel important when we do that well. That is really important for some people, but for others it is best if we do not do anything for them and let them do whatever they can. Part of the whole concept of caring is about caring for and doing things for patients. A lot of people are saying that we need to turn that around and say: ‘The best care I can give you is to do very little for you and encourage you to do a lot more for as long as you can.’ That is the difference I am pointing to. It is not that they are going in with the intention of taking away independence; it is part of the culture of caring. It is part of what we train people to do. We train them how to do things that the other person cannot do and it is a fundamental shift in philosophy.

The best example of its success is with Silver Chain. I understand Ross Bradshaw is speaking to the committee this afternoon. They have a home independence program that is hugely successful. It focuses very specifically on that shifting of value. The program is successful when the patient is so independent they do not need the carer anymore, not in increasing the amount of care that they need. So I do not go into your home thinking: ‘What can I do for you? How much more do I have to do for you? You are more and more dependent.’ Rather, I go in saying, ‘How can I help you to maintain your independence,’ so that one day you say to me, ‘I do not need you anymore—go help somebody else.’

Senator HUMPHRIES—The committee has heard a wide variety of evidence about the standards in aged care facilities and the attitude and reaction of facilities to the accreditation process and the agency. We had one submission yesterday by an organisation representing homes in South Australia and the Northern Territory, which initially indicated that there was widespread concern about the accreditation agency. Then they did a survey of the members and discovered that it was not actually as bad as they first thought. We do not have an equivalent umbrella organisation from Western Australia making a submission to us. Are you aware of any systematic surveys of agencies and care providers in this state that would educate us about the attitude that providers here have towards the accreditation agency and what they might see as the problems with it?

Ms Horner—The two stakeholder groups here in WA are very strong. One is Aged Care Standards WA and the other used to be ANHECA, which has changed its name to Aged Care

Australia. They both, I am sure, have gathered member’s perceptions of interaction with the accreditation agency.

Senator HUMPHRIES—It is strange they have not told us about them.

Ms Horner—I cannot think immediately of a survey that I can provide you with, but I would be surprised if there was not something documented within their general information. I am certainly happy to see if I can source something along those lines regarding attitudes towards accreditation. The accreditation agency probably has lots of its own reports of information that has come to it about its role and how it is relating to the sector.

Senator HUMPHRIES—So, in summary of your views, you would say that facilities in Western Australia overall provide a high standard of care to residents, and that the level of care they provide does not need the level of intrusive assessment that bodies like the accreditation agency currently undertake.

Ms Horner—No, I do not think I can go that far; I do not work with all of them. I am saying the majority in WA do a very good job and have the best of intentions in the work that they do. But the maturity and ability of the organisation to do the best job depends an awful lot on the people who are leading it and on their ability to develop their own staff’s capacity. I am quite sure that I could go into a facility on a particular day and see something that would horrify me, just as I am quite sure I could go into a facility on any day and see something that absolutely excites me in terms of the care that they are doing.

My concern is that, when you are doing spot checks or looking at minimal standards, you are looking at one vision through one set of eyes on one day—or on three days, if that is how long it has taken—and I do not think that is an accurate picture of what goes on in an organisation. The focus is on taking an exam. We assess people with examinations. We get what you can remember on the day, not what you actually know about your subject area or your ability to discuss or explore the issue. I recognise that it is still very important to have standards and to be able to say to the community and everybody else that the facilities meet those standards. What I am saying is that I think we are focusing so much on the examination, which is a snapshot view, that we are restricting the opportunity for people to really demonstrate what they can do.

Senator McLUCAS—You made the comment that you might go into a residential aged care facility and see something that horrifies you. If you do not do spot checks, how is the community comforted? If we give a facility seven days’ notice, they may just tart everything up and everything will look fantastic just for that period. How do we make the community comfortable?

Ms Horner—Accreditation is an examination at a particular point in time. My experience with all sorts of accreditation is that you have great big manuals which you stick up on shelves to gather dust, and they actually have very little relevance to your day-to-day practice. It is an artificial assessment at a particular point in time. When I said that I could go into a place and be horrified, I might see something and on my interpretation of that snapshot I might think, ‘Oh my God, look what they are doing—why aren’t they doing it another way?’ But I do not understand the whole place and what is going on at the time. I think it is unfair to judge from that kind of snapshot view. I know that the accreditation agency does not go in and make snap decisions as a result of tiny views, but they can only assess within the guidelines that they are given and the minimal standards which they are measuring.

How do we convince the public that our hospitals are squeaky clean and tickety-boo when we know that the level of accidents and other incidents in hospitals is horrific? We all still rock up to hospitals. How many of us ask doctors whether we can see their credibility statement or how many accidents they have had this year? How many of us measure that way? We take a judgment and gather our confidence from various sources. I think that, while we continue to focus on the nitty-gritty, we lose the big picture. I am sure that if people knew about half of what goes on in hospitals they would never walk in the front door. They are awful places lots of times. But we build the big picture, which is that, when they are needed, we have confidence in the people who work there. I think we underestimate the general community's ability to make good decisions sometimes too. If you continue to put out a message that our system is good and our standards have been met, you will always have some people who will say, 'Yes, but I know what's happening down the road.' What I am saying is that maybe it is time to stand up and say, 'We actually think the system is good—let us show you how good it is' rather than 'Is it good?'

Senator McLUCAS—So it is an education approach?

Ms Horner—Yes.

CHAIR—Thank you for your presentation, Ms Horner. That was a very valuable contribution to our inquiry.

[10.06 a.m.]

WATSON, Ms Margaret Jean Osborne, Chief Executive Officer, Nurses Board of Western Australia

CHAIR—Welcome. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission, and I now invite you to make an opening statement to be followed by questions from the committee.

Ms Watson—Thank you for the opportunity. The Nurses Board of Western Australia is established under the Nurses Act 1992, which is state based legislation, to regulate the practice of nursing. The board does that through a variety of means. It approves all educational programs which lead to registration as a nurse, deals with all disciplinary matters in relation to the practice of individual users, conducts research and evaluation into the practice of nursing and registers all those who wish to practise as a nurse.

We have three scopes of nursing practice currently. We have the enrolled nurse, who is a nurse who undertakes an 18-month program here in Western Australia through the TAFE sector; the registered nurse, who undertakes a degree program at university; and, now, the newly created nurse practitioner, who is an advanced practice nurse at a postgraduate level who acquires significant expertise in a particular area.

In the year 2000, the board was receiving increasing concerns about the provision of nursing care in the aged care context. At that time the board appointed an external consultant to look at some of the issues from, primarily, a qualitative perspective. So the board, with its external consultant, met with the varying levels of worker in the aged care context to try to identify what nursing issues were arising that the board may have an opportunity to impact on.

A consequence of that review was a report which was sent to all levels of government identifying a number of system issues and a number of professional practice issues. We have a responsibility to deal with the professional practice issues, and we have, but we have no control over the system issues. Our submission is an effort to bring to your attention some system issues that the board has no control over and is unable to do anything about. I am more than happy to talk about the nursing issues that were identified, what our thoughts are about that and what we can do about that.

Senator HUMPHRIES—I have a couple of comments on the things you said in your submission. You talked about the 2004 budget proposals and you said that wage disparity with other sectors was not addressed. Presumably, that is with respect to nursing.

Ms Watson—Yes.

Senator HUMPHRIES—The Australian Nursing Federation spoke to us a couple of weeks ago in Canberra. They have a somewhat different view. The view they put to the committee was that there is enough money in the package over the next three to four years but that providers are not actually using it to bring nurses up to reasonable parity with their equivalents in other sectors. Do you have a view on that? Is it your assessment that there is some reluctance on the part of the sector to use money in that package to principally address the issue of nurses' wages?

Ms Watson—That is the expert view that we obtained on this. The board's comment would be that we prepare nurses for registration regardless of the context in which they work. Therefore, the board does not understand why a registered nurse working in aged care, who has a requirement to meet the same competencies as a registered nurse working in the acute care sector, should be paid less.

Senator HUMPHRIES—The Nursing Federation is saying that there is the money in the package to be able to do that.

Ms Watson—From the discussions that we had, the understanding within the aged care environment is that there is not.

Senator HUMPHRIES—You say in your submission that you are concerned about the operation of the accreditation agency and you say that the ACSA is not independent of the Commonwealth department of health and is seen to duplicate costs. You then go on to say:

> For example, ACSA recommends sanctions and the Department cannot investigate independently or change or comment on the recommendations.

I am not clear from that whether you believe that the agency should be a freestanding body, separate from the Commonwealth department. Are you saying that?

Ms Watson—Yes.

Senator HUMPHRIES—So it would have the independent capacity to investigate and initiate proceedings based on breaches of the standards.

Ms Watson—Yes.

Senator HUMPHRIES—Is the Nurses Board opposed to the idea of there being spot checks on aged facilities?

Ms Watson—We do have a disciplinary role. Listening to Barbara, who spoke previously, we perhaps would have a different view on that. Arriving as anyone would arrive to an institution, you do get a feel of what normally happens. With the provision of notice, there is opportunity for preparation that may not normally be done. I guess the ACHS would be an example where they were very process orientated to begin with and they have now moved more to an outcome focus and self-assessment. The board sees this more as a progression over time. When both parties are more comfortable with how they are going, perhaps that view can change. Certainly the expert team that we spoke to in the aged care setting were very resistant to spot checks.

Senator HUMPHRIES—Given the background some years ago of issues like the kerosene bath and things like that, do you think that the community of Western Australia would react well to a recommended regime change to move away from spot checks and to there being less paperwork associated with self-assessment and satisfying the accreditation agency? In light of what has happened in the past, would they see that as backward step?

Ms Watson—In my experience, the community have confidence and trust that health professionals will do the right thing by them. I guess from their perspective, as long as they are satisfied that there is a process in place and that process works, how that process is interpreted is really left up to us.

Senator McLUCAS—Your comments about paperwork have pretty well been replicated by everybody. The previous witness talked about reporting by exception rather than this onerous and repetitive filling in of the same information day in, day out. Does the Nurses Board of Western Australia have a view, or do you have a personal view, about whether that is a useful way of getting over those reams of paper?

Ms Watson—Absolutely. Most documentation across all areas of health is by exception. Clearly, if you have the care planning processes in place and the understanding of what is normal then exception reporting is by far the better approach.

Senator McLUCAS—But the barrier to doing that is accreditation, correct?

Ms Watson—Yes. The requirements for the level—

Senator McLUCAS—The requirements of the accreditation process, rather than accreditation itself.

Ms Watson—Yes, rather than accreditation.

Senator McLUCAS—The other area I would not mind pursuing with you is staff ratios. You may have heard my discussion with Ms Horner. Does the Nurses Board of Western Australia have a view about the practicality of implementing staff ratios?

Ms Watson—The board gets many requests by employers to come down and make a statement about minimum numbers. However, the board is very much of the view that it is the appropriate skill mix in the context of where the care is being delivered that determines what you require at any given time. That is not helpful to employers and it is not helpful to the staff on the floor. But the context in which aged care is delivered is varied and it depends on a whole range of variables. For the board to say you need one registered nurse, one enrolled nurse and three personal care assistants for a population of maybe 20 or 30 is entirely inappropriate because the board was not there at the time when the changes to the population occurred. We leave it very much with the nurses at the bedside to determine the needs.

Senator McLUCAS—Is it impracticable to even think that you could have a formulaic approach to care delivery in the context of providing comfort to the families of those people who are residents?

Ms Watson—They have certainly managed to do it in the acute care sector here, although that has had its difficulties and was not 100 per cent supported. Anything is possible. But we are talking about ageing in place and the needs of the elderly will change over time. To lock service providers into a particular minimum number is not perhaps the best way to go. I am not quite sure of the answer but anything is possible. It certainly could be done but whether it would meet the needs would be my question.

Senator McLUCAS—The other question in my mind is whether it limits innovation.

Ms Watson—Of course it does. It is a very limiting model. But it does provide a safety net, and that is what the industry is looking for.

Senator McLUCAS—If we have time I will come back with another question later.

Senator LEES—Staying on that and moving to the potential for computerisation of records, which will hopefully relieve some of the time pressure on staff, I understand that there is something being done in Western Australia. How do the nurses feel about the move to computerised records?

Ms Watson—A personal opinion? Nurses are very resistant to spending much time on documentation, whether it is computerised or whether it is in hard copy form. There will be a lot of education required. If it is facilitated for nurses—if the equipment is by the bedside, in the hand or in the pocket—to be able to do it then it will be good. But if there are not enough computers for all the staff to do the work at an appropriate time then the barriers will go up.

Senator LEES—But it is not just that. You were just explaining that it is about looking at what you are documenting and whether or not we need to document this amount of material, as Senator McLucas was saying.

Ms Watson—But it is more than just the record of care and documentation. It is medication records and assessment forms.

Senator LEES—We heard from doctors yesterday who were saying that they would like to be able to log in and keep track of how some of their patients are going from their surgery. But that would need this whole computer process to be better.

Ms Watson—It needs to be user friendly.

Senator LEES—I had one other question. You mentioned enrolled nurses had 18 months training, registered nurses had their degrees and now there are nurse practitioners. Do we need to go back a step and look at some sort of national accreditation process for—and there are different terms in different states—care givers, aged care workers, aged care certificate staff or whatever you would like to call them? We have evidence in other states as well as here that these often very young people are really struggling to deal with the complexities of aged care and yet they are right at the bedside.

Ms Watson—In our submission we talked about the carers having a minimum standard of certificate III.

Senator LEES—But there is nothing national. Is that a national system?

Ms Watson—There is work going on at a national level at the moment.

Senator LEES—How long will that be? What is the length of training? I guess it is through TAFE as well as hands on.

Ms Watson—That is right, yes.

Senator LEES—What is it—12 months?

Ms Watson—I have no idea of the discussions, but I do know that it is being looked at at a national level. But my understanding is that it is being looked at on the basis of the requirement for everyone to have a certificate III, so it would be whatever timeframe that is.

Senator LEES—But it seems that in some states certificate III does not involve any hands-on experience.

Ms Watson—That is right. The issue from the employer’s perspective is that a certificate III from TAFE will meet the needs but perhaps a certificate III from another registered training authority will not.

Senator LEES—So it is standardisation of certificate III nationally.

Ms Watson—Yes, its content, which includes both theory and clinical.

Senator LEES—I think in New South Wales you can actually start it in years 11 and 12, which seems to be a great way of keeping some of the girls—I do not mean to say that boys should not be doing aged care—who are tending to drop out. They can see a future. It just varies so much from state to state, and the requirements seem to vary enormously from state to state.

Ms Watson—That is right. There is not even a minimum standard. I think that is a major step forward.

ACTING CHAIR (Senator Knowles)—I want to come to the issue of record keeping again. Are you aware of any setting in which electronic record keeping is actually being undertaken?

Ms Watson—No.

ACTING CHAIR—You can go into a restaurant now and order a meal—

Ms Watson—Sorry, I thought you meant within the health system in Western Australia.

ACTING CHAIR—Yes, within the health system. That is what I am talking about. But I am saying that you can go into a restaurant and order your meal. They put it down on a PDA, it flies up through the detector, goes down into the computer and—bang!—there it is. And with any degree of luck you get what you ordered. I cannot understand why, in this technological age, we cannot develop something like that within the health care sector that would alleviate that problem. What do you think the reaction of your colleagues would be to undertaking that type of record keeping?

Ms Watson—Perhaps I could better respond if you gave me an example within the health system. Within the hospital setting, a patient comes in and the nurse keys into the computer what meal they should get—whether it is a low-fat special diet or whether they are fasting—and that clicks through to the catering people. That already happens in that context. The drugs will be keyed in and flicked through to pharmacy.

ACTING CHAIR—What about the bedside?

Ms Watson—Certainly, for documentation, you could certainly have your palm pilot and be writing your documentation by the bedside if the changes are made. That already happens in the US. It is an expensive system.

ACTING CHAIR—It is a very expensive system but, if there is so much angst about record keeping, surely, when these facilities are being built, upgraded or whatever, to suggest that something of that nature be incorporated would not be rocket science today, would it?

Ms Watson—No.

Senator McLUCAS—I was interested in your comments about what barriers there are—if in fact there are any—to more nurse practitioners becoming employed in aged care.

Ms Watson—I think the nurse practitioners are going to be a tremendous boost for aged care in so may ways. Saving money would be an obvious outcome. In Western Australia, as is consistent across the country, the expanded practice for the nurse practitioner is that they can order limited drugs, they can refer and they can also read radiological and other tests. The issue, of course, is provider numbers. I am sure there will be others far more eloquent in talking to you about that than I but, until that issue is addressed, there is a clear benefit for aged care to have nurse practitioners across a number of facilities. It is an expert nurse who will be at a consultant level, looking at many issues like pressure areas, the management of wounds, medication, polypharmacy, infection control—the list goes on. All of those are really expensive issues if they go wrong in a facility.

Senator McLUCAS—I am thinking of the funding structures as they currently are. Without going down the route of the provider number, is there anything in the current funding arrangements that is a barrier to the employment of a nurse practitioner by a reasonably sized residential aged care facility, or is it just the money?

Ms Watson—I think it is just the money but, also, there are limited positions. In Western Australia, there are 40 nurse practitioner positions that have been designated. They are designated by the Department of Health. Everyone has an opportunity to apply to the Department of Health to have a position designated but that does require a business case, which I understand is fairly lengthy, and the support of the multidisciplinary team. I do not believe Western Australia is unique, but there is still a lot of resistance by the medical staff to nurse practitioners. If you are in an environment where there is not the support, that role will not work and there will not be the effort to apply for it.

Senator McLUCAS—Are those designated positions funded by the Department of Health here in WA?

Ms Watson—No. They have to be funded by the individual. That is part of the business case that goes out, but there was an agreement to have 40 within Western Australia to begin with.

ACTING CHAIR—Thank you very much, Ms Watson. Your contribution has been very helpful to the committee.

Proceedings suspended from 10.28 a.m. to 10.46 a.m.

BRADSHAW, Mr Ross Edmund, Chief Executive, Silver Chain

EVANS, Mrs Lynette Jocelyn, Chief Executive Officer, St Bartholomews House Inc.

RIDGE, Mr Kenneth Hugh, Chief Executive Officer, Baptistcare

CHAIR—I welcome representatives from Baptistcare, Silver Chain and St Bartholomews House. The committee prefers all evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submissions. I now invite each of you to make an opening statement which will be followed by questions from the committee.

Mr Bradshaw—Thank you. I have kept it short because I am not sure of the process.

CHAIR—Short is good.

Mr Bradshaw—Okay. I would like to make a couple of points. It is possible to achieve significantly improved outcomes in community care. There are great opportunities in community care, and its potential to provide comprehensive services has not been fully tested. The paradigm of care must change from supporting dependence to optimising independence; from funding inputs to funding outcomes; from sickness to wellbeing; from responding after the event to early intervention; from funding hospitals to provide home care to funding community care to replace hospital care. Funding a hospital to provide home care is like hiring a Mac truck to tow the family caravan. You might get to the same point but it costs more, is less comfortable and the outcome may not be as good as it could have been. The last point I would like to make is that many young people with disabilities can be cared for in the community. They should not be in aged care facilities.

Mr Ridge—My comments address residential aged care. In particular, last year’s budget announcement from the government was very helpful in identifying a number of issues. With work force issues, however, we believe that both the Commonwealth and the state governments together with other stakeholders, such as the nurses board, may need to come together with providers to show initiative in looking at new forms and models of care, given the worldwide shortage of qualified and suitably trained carers and nurses. In terms of the agency, ideally there should be choice. Again, in terms of meeting the special needs of people in residential aged care and in the community we see an opportunity for both the Commonwealth and state governments to look at enhancing the Aged Care Act to enable ageing people with disabilities to be cared for under different models than what are currently available to them. ‘The Way Forward’, which the government released, is an ideal start. I think Ross will cover that adequately in his responses to questions. As an aged care provider, I think there needs to be opportunities for the piloted schemes to be made permanently funded in terms of transition care.

Mrs Evans—My passion is homelessness, especially the homeless aged. I think homelessness is a growing issue in the community and the sector needs to respond appropriately to making places available for this clientele. There are only a small number of service providers that are willing to provide care for this group of clients, and this appears to be dwindling. There needs to be a plan for the access of homeless people who have high and complex needs to residential and community aged care services when they require them. The homeless are a specific subset of the aged population and should be considered separately from those aged who have family support, who are financially stable and who do not have complex needs.

Consideration should be given to the needs of the homeless in the future. That should include the special needs of those who currently have placement. There would need to be some changes to the Aged Care Act which would make the homeless a special needs group and not just concessional, and therefore make them attractive to those facilities chasing places. There would need to be a strict criteria for entry, as these places are at risk of being gentrified. Recognition should be given to those facilities that are currently providing quality aged care to the homeless, with strategies in place to assist them to be classified as an extra service facility or similar which recognises the intensive support and care provided.

Senator KNOWLES—Please forgive my familiarity with Ken, who, three decades ago, was one of my very, very best bosses. We go back a fair way. That was in the private sector, I might add. Ken, can you elaborate on this question about the funding needed for competitive wages? As you can well imagine, we have heard much evidence about the need for increased wages in the sector. You might have heard Senator Humphries, before the break, saying that we have also had evidence from the nurses in Canberra that the money was actually in the sector, they were just not seeing it. You are saying that increased funding is still required to provide competitive wages. What is your view of what is needed and what is in the pot already?

Mr Ridge—The 1.75 per cent is something that we are very conscious about because it could be seen as the answer to our financial requirements. Some years back our organisation, and we represent a number of other providers, wanted to demonstrate to our registered nurses that they were valued greatly and we took the initiative in introducing EBAs. We are now about to do our third EBA with our nurses and we have nothing to trade. It is all one way. We do not mind that so much except that we would like it to be acknowledged that when we created EBAs, firstly with the nurses and then with our support and caring staff, there were large amounts of money involved in funding those. Because of that, together with our support workers in our community care programs, we believe the 1.75 per cent is helping us catch up from the funding deficits that we have been endeavouring to deal with for a number of years. Each time, for example, that the nurses in the public sector get a wage increase the gap widens again in terms of the disparity between us and the public sector. We want to emphasise that we value the government's approach to breaking the nexus. We were saying that there was not enough money and the government said, 'We will introduce 1.75 per cent.'

Just as I was leaving the office I got the form that I have to fill out to show we have been using that 1.75 per cent as we are supposed to. I want to create an awareness that we do appreciate the government's response to the industry's financial needs; however, the 1.75 per cent is not even catching us up. I have figures I could make available to demonstrate the cost to us of our EBAs and workplace agreements and what subsidies we have received in the first six months of the additional 1.75 per cent. Does that answer your question?

Senator KNOWLES—Yes, it does. The question that follows on from that is: how do we get nurses into the sector to start with? The attraction, we are led to believe, is more towards acute care as opposed to aged care. How do we attract more young people into that sector?

Mr Ridge—That is a huge question. I again put on record that I believe the industry appreciates the initiatives taken by the government in terms of the number of opportunities that they are providing for people to train or retrain to get into this sector. I am not sure what the answer is to the nurses situation except to say we would hope that the universities would take on a role of creating an awareness of the value and the opportunity that aged care presents that might be seen by younger people. I have known two younger people mid-way through their nursing studies. Aged care, to use an expression, is seen as ‘the pits’. Unfortunately, you only hear in the media about the bad things to do with aged care—you do not hear about the great things that happen—so the younger people hear that. We create some of that by talking about an overly regulated, legislated, compliance and documentation hungry sector, so I guess we sometimes defeat our own purpose.

I think there are greater opportunities to attract enrolled nurses to our sector. There are some attractive things about working in our sector. The hours often suit older ladies or ladies with families, so there are some things that we do offer them. There is an opportunity, too, to actually see people longer term in some cases and to benefit from direct involvement in their care needs. I think we have seen some initiatives in relation to enrolled nurses. One of the things that I hope may happen is that the state and the Commonwealth might recognise, particularly through the TAFE system, that there are currently some difficulties in this state with certificate IV. What I mean by that is that there are limited locations where you can do it. From what I gather—I do not know this personally but this is what I have been told—there are onerous requirements that you have to fulfil as to the hours that you have to volunteer for. There are a number of issues that I believe our peak body is going to be looking into in endeavouring to make it easier for people to go into enrolled nursing. I would suggest that we need to get a number of stakeholders on board so that we can change the requirements. The nurses board is one stakeholder in particular that we would need to convince that we are not going to fix the shortage unless we work together to look at different ways in which we can have models of care that are acceptable to the various stakeholders.

Senator KNOWLES—We heard evidence yesterday to suggest that there was age discrimination, that a lot of places were not willing to employ older people because they were going to be more prone to injury or illness. It is my experience that older people will be half dead and still go to work while younger people might be a tenth dead and decide to have the day off. From your experience, what is the attitude within the industry to employing older people?

Mr Ridge—We are sad when we say farewell to 65-year-old and older registered nurses; that is the reality.

Senator MOORE—Why are they leaving?

Mr Ridge—I guess it is time to go as either their husbands are retired or they feel that they want to do something different in their lives.

Senator MOORE—So it is their life choice that they leave?

Mr Ridge—Yes, it is. I think that those of us that have multiple sites can look very favourably on very loyal nurses that have given many years of service, but there comes a time when to their mind it is time to leave. There are frightening statistics—and I do not have the figures in front of me; I have them back in our office—that show we have an ageing work force, particularly registered nurses. It is very difficult to attract young people.

We are fortunate, in one sense, that there are a number of Baptist schools in this state—about 14. We have begun some work with them to help students see that this is a career opportunity for them. There was some recent publicity about one of the students at Carey Baptist College and some work that she did with us which was helpful background for her, in that she was not able to complete her TEE but was accepted to university because of some prior undertakings of hers. So there are some good success stories. She has not indicated that she wants to come back into aged care, but that is just one thing that we got really excited about—that we were fortunate enough to be part of that young lady's opportunity to go into nursing.

Senator KNOWLES—In relation to that staffing question, is Silver Chain able to attract and maintain its core group of people?

Mr Bradshaw—We fare reasonably well. However, we can see, on the five-year horizon, it is going to be a major issue. We think part of it is remuneration, part of it is the nature of the work and the other part is what I would call 'real jobs'. Young people need to earn full-time incomes, and the nature of work in our industry is part time. So there is a fundamental disconnect between their needs and our needs. Meeting those needs is one of the challenges. If you are a young person, growing up and paying a mortgage, 30 hours a week is great—but it is just not enough. So it is the nature of the work and the construction of the very, very high level of part-time work. That is driven by both the needs of our clients and the funding realities.

Senator McLUCAS—I understand 'the needs of our clients', but are you saying that 'the funding realities' move you to employing people on a part-time basis?

Mr Bradshaw—Yes. If you imagine the demand exceeds capacity supply, and therefore the role is to maximise the outcome for clients, you have to get the most you can out of the money you have. In community care a lot of people like their care at certain times in the morning and certain times in the evening; very few like it in the middle of the day. So, to be effective, you operate on a part-time structure. Most of the work is in the morning, actually. That is the structure of your needs. If you employ people beyond those hours to offer them more reliable hours, say, then you are less efficient in the use of resources and less people get care. So it is the nature of the needs of the clients and the funding system that come into play in that.

Senator McLUCAS—Following on from Senator Knowles's questions about the work force, the other issue that has been put to us is that there is a lack of career path options for people entering into the residential aged care sector in particular. Does your organisation do anything to try and develop those career path structures as an enticement to stay in the sector?

Mr Ridge—There are limited opportunities, as Ross said. Many of our positions are part time—30 hours a week—and there are limitations in terms of the management structure. The opportunities also depend on the size of the facility. I believe that most providers today want to encourage their staff to take opportunities for further education and further development of their skills. I guess we are like most organisations in encouraging that to happen. We are on the lookout for funding for scholarships for some of our staff and we have paid for people to be re-registered as registered nurses. Similarly, for enrolled nurses we have encouraged and sponsored some studies to enable people to qualify at that level. So in terms of career paths there are limitations. However, our sector is growing, and more and more we need suitably qualified and experienced people to become leaders and managers, both in residential care and in community care. There are career opportunities, but they are limited compared to the multiple choices that may be available in the public sector. I do not know the public sector all that well.

Senator McLUCAS—An earlier witness today talked about the training levy. She thought it was a great opportunity and very useful in developing the education standards of care workers. I suppose the other part of that is that part of the condition of payment of the 1.75 per cent is that you, as a provider, have to provide your staff with information about potential training. But that is all you have to do, isn't it.

Mr Ridge—Yes. As I said, I will find out more. We have been waiting anxiously for this document, because we wanted to make sure that we were not caught short in fulfilling our responsibilities. At the risk of labouring the point, I think the 1.75 per cent and the recognition that there are certain requirements are fine. We do not believe any of those conditions are difficult for us, but we do not see that that is additional funding for us to do anything more than we are currently doing. We just do not see that opportunity with that additional 1.75 per cent.

Senator McLUCAS—But, in terms of staff education, the condition of payment is that you simply provide your staff with information about potential training opportunities. There is no requirement in the condition for you to progress it further than that—just to tell them that they exist. You are saying that 1.75 per cent would not have been enough to do anything more than that anyway.

Mr Ridge—That is correct.

Senator LEES—Mrs Evans, what specific services are available for the homeless, particularly those who are elderly, in Western Australia?

Mrs Evans—St Bartholomews House was set up in 1995 as a 16-bed residential aged care facility specifically for people who were financially and socially disadvantaged. That has been quite successful, and it increased in 1999-2000 to 20 beds. There are some other hostels that do take homeless people, but there are not very many and the numbers appear to be dwindling. It is very hard for us—we are a low-care facility—to try to get anyone into a high-care facility now. Every one is always 'full' when they know the person is coming from St Bartholomews House. They are all concessional residents, they are all challenging, and people really do not want to have them. The staff ratio or the effort you need to put into looking after someone with challenging behaviours is higher than a lot of people are prepared to offer.

Senator LEES—So these people really are people who have a disability as well as people who are ageing.

Mrs Evans—A lot of them have a mental illness and a lot of them have behavioural issues. A lot of them have had substance use and so their brain function is quite deteriorated.

Senator LEES—Are there any specific community based activities or day-care activities where these people can at least spend some time in a supervised and supportive service?

Mrs Evans—We do maintain a lot of them in the community. In a lot of cases it is a better lifestyle for them to remain in the community because they are not challenging other residents in a residential care facility. But they do deteriorate to such a state that they have to go into residential care. I can give you an example of a gentleman who was in community care. He had been in three residential care facilities and been kicked out—his behaviour is appalling, so I am not denigrating these services—and then he went into the community. But he was really unsafe—he smoked, he drank. He went into hospital. We said: ‘We cannot manage him any longer. He is not safe for us to look after. He is not safe to be in his home.’ We got a message from the social worker to say, ‘We’re discharging him and someone has to pick him up.’ From St Barts’s point of view, that is our mission, so we ended up picking him up—which was silly on our part really, but we could not allow him to go back into a house unsupported. That seems to be happening more often: no-one is prepared to take that responsibility.

Senator LEES—Mr Bradshaw, do you have experience with elderly people who are not necessarily homeless but who have challenging behaviours and who you basically have responsibility to provide services for?

Mr Bradshaw—Yes, we do. We have a large number of people with mental health issues and this is primarily where the problem arises. They are very complex to care for and typically the household is very complex. The most significant part of the effort actually is in the coordination of staying and surviving in the house more than the physical provision of the care. It is due to the complex nature and the sorts of problems that we have described. The problems are real and they are even harder to deal with in the home when you have violence and aggression, but it is possible.

We have been aware that there has been a problem for many years. With a number of other home care providers, we have done a large amount of research into what drives their need and how to care for them better. We have just started a pilot project in one of our northern areas looking at how we might actually better provide this care. It is complex. It is difficult. Some of the challenges are significant. We have analysed the issues. We think there is a solution and we are trying to see if it really is a solution.

Senator LEES—What is that solution around? Is it around more support for carers?

Mr Bradshaw—It is around being able to respond quickly, being able to appropriately deal with complex issues, particularly mental health and violence related issues, where you often have staff working alone in the house and you need to make them safe. It is access to psych support, medical support—making sure their medications are right—and it involves a significantly higher level of coordinator input so there is somebody basically on the case all the time. Having a much more stable range of carers going into the house is important, so a lot more energy goes into identifying the behaviour of the person and what their needs are. Often aggression is a product of frustration, so it is important to understand that and get the right carers to match the needs of the client. Then we try to keep that stable so you do not have change.

Senator LEES—This morning we heard of a new model of day care; a far more intensive day care support service for older people. It sounded a bit like child care. You drop the elderly person off—or they are picked up by bus at 8.30, eight o'clock, or whatever, in the morning—and a full range of services is provided. Perhaps physiotherapy or podiatry services are provided, as well as a meal and various recreational and other sorts of activities. Have any of your organisations looked at that extended provision of day care services?

Mr Bradshaw—We have not. We do it in the community and the home.

Mr Ridge—We do not have any services like that.

Mrs Evans—We did try and link up with one of our local services, but our residents really were not welcome because they are different to the other attendees. They became ostracised and then did not want to come any longer.

Senator LEES—Thank you.

Senator HUMPHRIES—I want pick up on those last questions about homeless people. I assume that the sort of people you are talking about, Mrs Evans, are, but for their mental illness or dysfunction, quite likely to be capable of living in their own homes or in some other non-residential setting. Is that what you are saying to us?

Mrs Evans—Yes. It is usually long-term homelessness. It is not just a week; it is over a number of years. It is usually related to substance use and misuse, so it is more than just having a mental illness. Those two are linked. They have probably lived itinerantly for a number of years, so even to get them back into stable housing takes quite a long time because they are not used to that. In a lot of cases, they have burnt their bridges. No real estate agent will look at that. It takes a lot of time and effort to actually get them back into a stable environment. We have been quite successful with some people with a lot of effort, I think as Ross said. It is just the amount of time and effort that you need to put into that, and obviously that needs to be resourced.

Senator HUMPHRIES—They sound to me like services that the state government should be funding and resourcing. These are people who may not be in aged care facilities if they were not mentally ill or otherwise facing these problems. Are there any moves during the context of this election campaign to get focus on this issue?

Mrs Evans—I would love it if there were. Many of them are prematurely aged. There is always a difficulty trying to get either state or Commonwealth services to pick them up; they tend to bounce backwards and forwards before someone picks them up. From the point of view of Commonwealth services, they will be seen for a short time and then have to flick back to the state services. Then you have to send in another referral and wait a while for that to be picked up again. It does make it difficult having the two types of services, state and Commonwealth. The Commonwealth at least does provide those services. At least we can have them assessed by aged care and get them picked up by the services. From that point of view, the Commonwealth probably does better than the state.

Senator HUMPHRIES—The Baptistcare submission picks up an issue, which has been picked up in a number of other submissions, about the need for the accreditation agency to allow its services to move out into the marketplace. The suggestion is that, rather than having one agency, there should be a variety of agencies that could accredit and people would be able to deal with one or more of those agencies rather than a single agency. It is a fairly consistent theme that comes through from a number of aged care providers. I am not quite sure why it is seen as so attractive by the sector. I know that in other sectors of the economy attempts have been made to outsource accreditation. Those attempts have been met with some resistance and there is some controversy surrounding those developments, although it is probably fair to say that they have been successful overall. Given that there is a concern about consistency of standards and getting best practice and so on, what is it about the marketplace that in this sense is seen as being so attractive that the sector is looking to that model rather than to the present one-agency model?

Mr Ridge—I guess the government encourages us, in a sense, to ‘deregulate’—if I can use that term—and yet we are dealing with an organisation that is not forced to be competitive in the marketplace. We have a commitment to work with the agency, and that is what we want to do. We want to work in partnership with the Commonwealth and all of our stakeholders, and the agency itself is a stakeholder. From our point of view too, we feel that gives us more options. We are not only in aged care but also in programs involved with the mental health sector. That is an area where we know that by 2008 there will be standards. We are involved in the disability care sector, where already we work with standards and are subject to a monitoring process. We are in a couple of other community programs as well as being in aged care in the community, and we are looking forward to having something that will enable us to have a form of continuous improvement there. As an organisation, we feel that is an added dimension that would be desirable. It would enable us to work with a continuous quality improvement requirement process that would go across all those programs and services.

Mrs Evans—I have a contrary view to Ken’s. We have a multitude of services as well. We took the decision to run all our programs on the aged care standards. With all the new ones coming in, we just cross-reference to those standards. We have found that having one specific standard—and we use the aged care one—is much easier for us. Having worked in other sectors, I think it is very confusing when you have a number of standards, so you really need to stick with one. I have found that to be very helpful, from the point of view that the aged care standard is very structured, compared to others.

Senator HUMPHRIES—The cynic in me can foresee a day down the track when a new system comes into place and there are a multitude of providers of this accreditation process, and then we may get stakeholders coming to an inquiry like this in a few years time, saying: ‘People forum shop. They go to the agency that gives them the quickest okay for what they are doing. Standards are dropping, because there is no one body laying down the law in respect of all the standards that have to be applied in the sector.’ Maybe that is overly cynical, but I am not sure how to engineer an outcome that does not allow that to happen.

Mr Bradshaw—I think you can separate standards and the audit process. I think it is essential. ISO standards worldwide are maintained, but they can be audited by a number of accredited entities. That is a critical thing. In our remote health centres, we operate under hospitals standards. In our residential facilities, we operate under aged care standards. In our DVA work, we operate under DVA standards. In our community care, we operate under community care standards. All of those standards should continue to exist. The question is: how do you get audited for them? Currently we are audited by ISO, the department of health, DVA and the Aged Care Standards and Accreditation Agency. That is the bigger issue.

So we have adopted a single standard, the ISO standards, for our audit, but that still means we get audited in our residential care. It would be possible for the ISO audits to cover off the residential standards, because, when they audit us, they audit the residential to ensure that we are complying with the residential standards. One of the things that you have to do in ISO is comply with the standards appropriate to the service you are delivering.

The funder probably should never surrender standards, because that defines what you are requiring for your money. The question is: do you assure yourself that the money you are laying on the table is getting the outcome that you want. The answer is: firstly, you have standards that describe what you want, and, secondly, you have a process of auditing it. The audit can be conducted by multiple entities. The standards should be prescribed by the person doing the funding.

Mr Ridge—I will just add to that, if I may. Ross has just qualified one comment I was going to make. This is an opportunity, a forum, for us to say that we are also alert—maybe overly so—to the issues of just having one body that audits us and then also has other interaction with us in terms of training and education and what their role is. I guess there is a perception that we are a bit worried about that, because we would love the agency, if we are to live with the agency, to provide training and education on the accreditation process—not necessarily to go down the path that it appears to be taking. Rightly or wrongly, we do see that as a bit intimidating, and I guess that is also linked to the lack of choice. I am just being perfectly frank. We work well with the agency; we have a commitment to them. But this is an opportunity just to share something about which I think I would be speaking on behalf of a number of others.

Senator KNOWLES—Ken, can I also ask you about your comments here on the residential classification system with respect to those residents with dementia and psychiatric issues.

Mr Ridge—We are waiting with bated breath to see what the new RCS funding tool will be. There are lots of rumours, although I think it is now becoming reasonably apparent that two or three models will be trialled and piloted, and that is great. We should not jump too far ahead of ourselves, but we do hear the term, ‘It’s cost neutral.’ There is a bit of a worry in terms of whether that in fact will enable us to meet our then requirements in relation to the mix and whether that will create limitations of choice. There may also be some pluses, but I am not sure. At this stage, there is a concern that we may not be able to meet specific needs.

Those of us who are in other programs are becoming very aware that more people who are ageing do have a mental illness, and they are coming into our facilities. Their needs are very different to people who have dementia, for example. Also, we are involved in disability programs and very conscious again that people coming in with disabilities have been under the state system and used to a different model of care to what we will be able to provide for them under the current delivery of funding. We may be overly reading those things into this, but at this stage there has not been a lot of information for us to see where this is heading, apart from the fact that it is going to be cost neutral—that is what we are hearing. Since I wrote this, which was last year, there has been a bit more information, but that is my response.

CHAIR—The committee has heard evidence on a number of occasions now about difficulties with the complaints process. We have heard that some residents are very fearful to complain about issues within nursing homes and, as a result, often do not complain. And, when they do complain, we have heard evidence that there are often very subtle forms of retribution and that they are seen as troublemakers. As CEOs of your organisations, do you see this as a problem? Are your internal complaints process mechanisms adequate and what are you doing about them? Based on the evidence that we have heard, I am satisfied that there is a problem. I have not yet formed a view about the extent of the problem. I just want to get a view from the CEO level about those issues.

Mr Bradshaw—I think making a complaint when you are in a vulnerable position is always difficult. You can imagine lying on a table, waiting for your surgery, and you notice that the surgeon has not washed his hands. Do you raise a complaint or not? It is a critical question, isn't it? It is very hard because, in the end, a lot of residents and clients in our environment are on their own. They ask themselves, 'What happens if the complaint does not get received well or what happens if I complain?' The cohort of people currently receiving care are not complainers, if you know what I mean. Their culture is acceptance. Encouraging people to raise issues is a challenge always. If you can imagine that there is one ounce of retribution somewhere in the system, it would be felt a thousandfold because of the vulnerable nature of the residents. So getting people to raise issues of concern is a major challenge.

In our organisation we have a specific person who is a client advocate, and that person can receive information directly from clients and manage it through the organisation as well. They are the first point of call. They hear complaints raised through any complaints agency—we have a Commonwealth one, a state one and a number of organisations that represent people. The starting point is the difficulty that vulnerable people face with raising a complaint and getting over that in their mind. Quite often, they may have a fear of retribution and it would never be actualised, but the fear is enough if you are on your own and do not have a choice. The biggest challenge is really creating an environment for people to feel safe to raise the point.

Mr Ridge—We work very hard at encouraging residents to verbalise. We also have what we call a continuous improvement log, and we encourage residents and their family members to make use of that. That is difficult because, when you visit a site, most of the people who want to come will be encouraging in their remarks.

We would love to think that we could eliminate that perceived fear. Certainly, I am not aware that anybody would actively pursue that sort of retribution. We are very aware, and want to act immediately, if there is any suggestion that any of our staff may be acting inappropriately in how they care for and respond to the care needs of a resident. You are asking me a question I find very difficult to answer, because it is not in our ethos, obviously, and I do not think it is in anybody's ethos. I am sometimes amazed that there is that perception, because we do our very best to encourage residents and family members—who would be more inclined, most probably—to take up an issue for their residents. Certainly, in our organisation—I think in most organisations—there is an opportunity for people to deal directly with the board, me or a senior manager. We would like to think that an issue can be dealt with locally, and people do make use of advocacy services and the Commonwealth complaints resolution scheme. When people enter our facilities they are certainly made aware of opportunities and avenues and the fact that these provisions are made available for them.

CHAIR—Mrs Evans, you are probably in a slightly different situation, but do you have a comment to make?

Mrs Evans—I would add that we are very aware that the majority of our clients do not have anyone to advocate on their behalf, either relatives or friends, so it is very important for us to ensure that their complaints are heard. I suppose we go over the top, from the point of view of trying to have a generic internal complaints system that covers all our services so that, if you make a complaint, it is to someone else; it is not just to the aged care facility, which helps in airing those complaints. We, like Ken, deal with it internally, but we are very aware that we have to be honest about complaints because there will not be a family member who will complain. I do not know of retribution and I certainly have not heard of that in other services.

Senator McLUCAS—I will follow that up a little further. It has been put to us that the complaints resolution unit should be taken away from the government; it should become an independent agency, because there is a perception by consumers and service providers that it is too close to government. I do not know whether that has crossed your mind in the past as being appropriate.

Mr Ridge—No.

Mr Bradshaw—No.

Senator McLUCAS—Mr Ridge, you talked about the nexus between disability and ageing. I think you were saying that it is difficult for a person to traverse the two systems. Is that what you were saying, and can you give us some practical examples of that?

Mr Ridge—Yes, I can.

Senator McLUCAS—Why does it not work?

Mr Ridge—I think there is an opportunity for us to work together, both from a state perspective and a Commonwealth perspective. As I have already mentioned, we are in the state government program of providing care for people with disabilities. We have a residential facility that is very old. Currently, there are 11 residents living in that facility. It is recognised that that facility is no longer adequate to meet the needs of the people who have an intellectual disability who live there. We are faced with relocating those 11 residents. One thing that we thought might be a solution that we might be able to do—not just for these people, as we relocate them, because they are now significantly older; many of them have been there for many years—is have community aged care packages that we could use as a means of delivering care to people, particularly people with intellectual disabilities, in their existing homes, whether it be a group home, duplex or whatever.

We saw this as a possible solution that we might be able to work towards as we endeavour to relocate these people. We made an approach to the state government here, with whom we are working, and they in turn made an approach to the Commonwealth office here. We were not at the meeting, but the response that we were given was that there appears to be little scope in the Aged Care Act for the two bodies to work together to come up with a solution that may see something like that being a new initiative within an existing program. So that is an example we had towards the end of last year which I put to Minister Bishop as an opportunity that maybe her department could have a look at.

Senator McLUCAS—What is the average age of these 11 people?

Mr Ridge—They are in their seventies.

Senator McLUCAS—But they cannot get aged care services—they are getting disability funding?

Mr Ridge—They are currently under disability services. The funding comes from the Disability Services Commission here in the state. It is one of their programs.

Senator McLUCAS—Have they been assessed by ACAT?

Mr Ridge—Some have, yes, but they have been living there for some time and that is their home. This is something on which we have been working with the Disability Services Commission for some time. We have received some funding from them for somebody to come and have a look and see what model of care we could come up with and how we could go about relocating them. We have met with them and their family members, so we have been working our way through a long process. Hopefully, there may be a solution—it is looking more promising at this stage—where we can relocate them to a building. The point I want to make is that there will be greater opportunities with regard to the funding level for some of these people, because their care needs would be greater than that which can be delivered through the current RCS tool.

Senator McLUCAS—It has been put to me that more and more people with disabilities are ageing; not necessarily people with intellectual disabilities—people with Down syndrome, for example—and that, because of the nature of their disability, they age earlier. But, whilst they are exhibiting ageing characteristics, they are still 50, 55 and so they are being funded as people with a disability, whereas in fact they are now at the point where, if they were to undergo an ACAT assessment, they would be classified as someone who should get a CACP or should be assessed as being eligible for residential aged care. But the issue of age is a barrier for them accessing aged care type services, whether they be in community or residential care. Is that a situation that you have encountered?

Mr Ridge—Some of those people are a little older and some are a little younger than the average age I gave you. Certainly we are working with people in the community as well. The comment I really want to make is that there is an opportunity for community aged care packages to go out to people who are currently living either in the community or, perhaps, in a facility such as the one we have. That would address their immediate needs and let them remain where they are rather than relocate them. To answer your question: yes, I think there is. What is happening is that, because people who have Down syndrome or an intellectual disability are getting older, they now have ageing care needs, whereas previously the disability they had was not necessarily related to ageing. Now they have ageing needs as well as their disability.

Senator McLUCAS—I think we have to focus on the individual and maybe call them care needs rather than ageing or disability needs. These are people who need care in a whole range of settings. It is a real challenge, I think. Thank you very much.

Senator LEES—Mr Ridge, as well as the 11 people you mentioned in this specific facility—the people with intellectual disabilities—do you cater for any other people with disabilities in a specific accommodation support service?

Mr Ridge—Not in residential care, but we do have people with physical disabilities that we care for in their own home.

Senator LEES—Do you have any young people with disabilities in any of your nursing homes?

Mr Ridge—I think we have only one. We do not have a lot of involvement, but we understand the inappropriateness of a younger person being in a residential aged care facility.

Senator LEES—Do you have demand for more services, particularly accommodation services, for people with disabilities in Western Australia?

Mr Ridge—I would have to say that we have not experienced that.

Senator LEES—Mr Bradshaw, how about your service?

Mr Bradshaw—We care for them at home. They are part of the project I was talking about earlier—the complex, high-care need client group.

Senator HUMPHRIES—One of the earlier witnesses today, Barbara Horner, praised Silver Chain’s model of early intervention designed to emphasise independence and end people’s dependence. Can you tell us a bit more about how that works?

Mr Bradshaw—Yes. It came about when demand exceeded capacity to supply. One of the things you can do in addressing demand is reduce it. This was in the days when rehab was not favoured in HACC, so we called it the home independence program. We came to the view that independent people have a higher quality of life and need fewer services. So we started a project around the question: how do you help people become independent? One of our observations was that, when a person comes to you and you keep providing them with care, you are in a way contributing to their dependence, because their muscles atrophy, they stay at home and a whole range of things happen as a result of that, particularly in the community care environment, where some people look upon it as a right: ‘I am old now and I do not have to do my cleaning.’

We started the project as a small pilot in our research area. We identified the things you could do that would help a person stay independent. We have a multidisciplinary team that works in an interdisciplinary way. Firstly, we do an assessment of the person and the potential for optimising their independence. That results in a range of activities being implemented. We found—and I think we put some of these figures in our paper—that around 70 per cent of people who come through the program do not need services after six months. These are people who would have got services for the rest of their lives. We are now about 18 months into a long-term study—

because of the linked database we have in Western Australia we can track where people go without identifying them. After 18 months, about 62 per cent of those people still are not getting services.

So what we have found is that, with the right intervention early in the process, you can actually raise a person’s level of independence rather than service their dependence. The outcome is that they do not need care. That is a good outcome for them in terms of quality of life and independence, and it is a good outcome for the system, because you can care for more people with the same amount of money. It does not exactly work under an input funding model, because your cost per hour goes up; even though you are caring for more people, your unit cost goes up and you are seen as less attractive in a per-hour funding system.

We have just been successful in getting AHMAC funding for a five-year evaluation, to compare it with a randomised group over five years and see whether the impact is sustainable. We are so convinced we have now moved it into the area of dementia and we are about to pick it up in our high-care, complex care area. We think there is a lot of potential. It is one of the few win-win situations you get: you get a great outcome for the client, a great outcome for the system—and you can care for more people.

Senator LEES—Have you got some material that you can leave with us? Do have some further documentation?

Mr Bradshaw—I happen to have it with me. I have only brought four copies!

Senator LEES—Can you give us some examples of the sorts of things you do for someone in their own home that will lead to a reduction in the need for services?

Mr Bradshaw—There are a lot of reasons why people become dependent. Firstly, they think it is the only solution: ‘I’m old and frail and can’t do the cleaning any more, so I’ll ring up Silver Chain for home help and they will provide it.’ It is a matter of working with the person. Exercise can be part of it. There is resocialisation; people who withdraw lose their social skills and withdraw more. Therefore, they do not walk, they do not talk and they do not do a whole range of things like that. It is fear. If they have had a fall and gone to hospital they decide that that is not going to happen again and they do not pick up the vacuum cleaner or anything like that. It is medications. With no disrespect to people who prescribe medications, sometimes our clients doctor shop and so on. One medical practice does not know what has happened at the other medical practices. There are those sorts of issues. It could very well be the design of the house. It could be as simple as the chairs being too close together or having their legs sticking out, and they catch the leg of the zimmer frame and over they go. It could be picking up early on that they are in the early stages of dementia and being proactive in intervening with that. There are very simple interventions that have significant outcomes.

It does not require a lot of visits to the home. You telephone the person and talk to them and you talk to the family. Part of the dependency creating model is addressing the concerns of the family that mum needs help. Really, that is associated with their worry about mum; it is not directly associated with mum’s physical needs. You can have services brought into the house to address the concern or perceived risk when really the trick is to manage the risk rather than provide a service to remove it.

Senator McLUCAS—Do you have doctors involved in that assessment process?

Mr Bradshaw—No, we do not. There is an OT, a nurse and a psych.

Senator McLUCAS—Would it fit in with the comprehensive medical assessment work which is essentially happening in residential care?

Mr Bradshaw—It could do.

Senator McLUCAS—You are saying that it is probably a bit medical?

Mr Bradshaw—We funded it from our research funding because we did not want to have too many rules. It is now working and we can operate it well within the current HACC guidelines. It is quite consistent with HACC objectives and guidelines and can be funded. We are looking at a higher level—what we call ambulatory care, which is the whole process around why people go to hospital when they do not need to. That requires medical input to manage the clinical relationship with the hospital, because they will not let them go if there is not a doctor in the cycle. They have to be confident that the clinical management is competent in the community because they feel a sense of responsibility and will only hand it over if they are confident that it is going to be done properly.

Senator McLUCAS—There are liability questions.

Mr Bradshaw—Yes. It is possible at the higher level and that is where we have moved to now.

CHAIR—Thank you very much for your submissions and your contributions today.

[11.50 a.m.]

SHAPLAND, Ms Susan Doreen Penberthy, Senior Manager, Member Services, Mutiple Sclerosis Society Western Australia Inc.

CHAIR—Welcome. The committee will be visiting Fern River this afternoon, and I would like to thank you for that opportunity as I am sure that it will greatly assist the committee in its understanding of the special accommodation needs of younger people with disabilities. While we will be having an informal discussion later today, the committee considered that it would be valuable to place on the formal record an outline of your activities and operations in this field. The committee prefers evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of confidential nature. I remind you that the evidence given to the committee is protected by parliamentary privilege. I now invite you to make an opening presentation to be followed by questions from the committee.

Ms Shapland—The MS Society of WA is a non-government, not-for-profit organisation. We have several avenues of funding. We have some funding through the Department of Health, which funds part of our physiotherapy service and a small component of our social work department. The money that we get from the Department of Health covers about 50 per cent of the expenditure in those areas. We also have some funding from the Disabilities Services Commission. Their funds cover about 70 per cent of the services that we provide and they include what we call an outreach group, which is a bit like a day centre for people with MS where they can come in and socialise and access therapy, computers et cetera. They also fund some short-term parcels of personal care that we can put in as a stop-gap measure for people who are experiencing deterioration or have a coexisting problem at the time such as surgery or a fall or whatever. That is a block funding that we receive annually and can allocate based on need. We also manage individual care packages for people who have been funded individually to receive personal care in their home.

We have a respite facility, a residential respite house in City Beach. That can cater for five people with MS with high support needs. We also have Fern River, a separately funded program which I understand came out of the Young People in Nursing Homes Project, and that opened in 1997. There are six units there with three bedrooms in each unit and we have 24-hour on-site carers providing the care for the now eight residents that live there.

Multiple sclerosis is the most common degenerative neurological condition in young adults in Australia. There is a male-female ratio of one to three, so it is three times more common in women than in men. Traditionally it is diagnosed between the ages of 20 and 50. However, having said that, we have had some people who are 14 who have been diagnosed, and we have some people who have been 65 before they have been diagnosed. Generally, the majority of people are diagnosed by the age of 35. It is quite a complex and variable disease and the presentation can be quite insidious and hard to diagnose initially because of its vague symptoms—a bit of numbness here or some blurred vision there. It can be quite debilitating. It is characterised by an acute inflammatory attack of the brain or spinal cord, which can then have severe consequences. Some people could end up in a wheelchair from the first attack. Other people may have an attack, have treatment with steroids, and then go into a bit of a relapse and may regain fully the sensation or nerve deficit that they lost, or they may be left with a partial deficit.

It does not necessarily shorten a person’s life, so, if you are diagnosed at the age of 20, chances are you are still going to be around at the age of 70 or 75. However, the course of the disease is unknown; it is not predictable. So unfortunately we have quite a few young people who end up looking down the barrel of needing aged care facilities if there is nowhere else for them to go. Not only are there physical disabilities but there is also possibly cognitive impairment. For some people, that is quite noticeable and quite severe and it makes them quite vulnerable and unable to function on their own out in the community. For some of those people, going into an aged care facility is not that daunting because thankfully they are not that aware of their surroundings. But for somebody who has significant physical disability but is cognitively unimpaired it can be disastrous to go into an aged care setting. That is not a reflection on the aged care setting; it is a reflection that based on their age that is not where they should be.

I have a strong neuroscience nursing background. I nursed at the bedside for 23 years in neurosurgery, so I also cared for people with head injuries. We did a great job of saving their lives but unfortunately their fate was to end up in an aged care facility at the age of 17 or 19 or 20. So I have a bit of a vested interest in trying to make sure that there are more options available for people, especially young people, with physical disability. Fern River is a great facility. We are hoping to build another facility like it but on a smaller scale, as in not three-bedroom units. We are negotiating at the moment with disability services to look at a funding model that would facilitate that.

From our perspective, there are over 2,000 people with MS in Western Australia on our member database. We do not necessarily have everybody with MS on our database because some people do not engage with the society for a variety of reasons. Some people have a very mild form of the disease and they are still working and they do not see the need to access our services, so we respect that.

Part of the problem that we have is trying to access personal care to keep people in their home. Most of ours have to go through the disability services combined application process. Unfortunately, there is only a finite amount of funds and often our people are not deemed to be in critical need. The problem there is that because it is a varied disease and people can deteriorate quite rapidly there is no emergency intervention and no hope of them getting funded because they have suddenly deteriorated. They might be in between the rounds, for example. I must admit that I find that a little bit frustrating.

We do not get any HACC funding. I believe that is because we have been disease specific. So in the future we are looking at perhaps embracing other comparable neurological conditions because our carers have the skills to be able to care for people with neurological impairment.

Senator KNOWLES—Such as?

Ms Shapland—Such as some acquired brain injury, motor neuron disease, Parkinson’s disease and post-stroke conditions. A lot of the neurological deficits are the same, whether they are from MS or from stroke. A lot of the other disabilities, such as acquired brain and spinal injury and things, have a quite static course, whereas our people can change from day to day, week to week and month to month. That makes it a bit of a moving target, really.

There are some immunotherapy drugs available now, and some more are coming on to the market, which are designed to reduce the relapse rate. Every time there is an attack with a relapse there is more damage done. They are not suitable for everybody but at least in the future what we will do is push out the time from diagnosis to the onset of significant disability. However, there are always going to be people with a more aggressive form of the disease who are not going to respond to therapy and those people are the ones who we are going to have to always provide some care for.

Senator KNOWLES—I always find MS a fascinating thing. I know two people with it. One is in her 40s and leads a particularly active occupational and social life but has highs and lows. Another lady was diagnosed with it probably 25 years ago—she is probably in her mid-70s now—and has not got any worse. When you say you have over 2,000 people on your register, how many of those people are actually like those two people I described: they have been diagnosed but their symptoms do not seem to get any worse? Are they any likely to get worse?

Ms Shapland—MS is such a variable thing, and it is also an autoimmune disease. There are some people who have two or three attacks. They are diagnosed and then, for whatever reason, their immune systems seem to get on top of it and it goes into a lengthy remission. They are known to have a benign form of the disease. The majority—about 70 per cent—of people with MS will have what they call a relapsing, remitting form of the disease. They have an attack where there is acute inflammation. They get over that and go into remission. Some people might have six relapses a year and some people might go for two years and not have a relapse. The immune drugs that people are now being putting on are designed to reduce the relapse rate by up to 60 per cent per year. So people might get only one or two attacks, where they may have previously had eight attacks. Sometimes those attacks can be minor and sometimes they can be quite significant and hospitalise people.

There are severe forms—for example, people who have a spinal attack and end up in a wheelchair. We have several of people who have been in a wheelchair for a long period of time and everything else seems quite good. They seem to have stabilised. They are cognitively okay, their upper body strength is fine and they seem to manage quite well. The disease baffles the scientists and the medical profession because it is so variable.

Senator KNOWLES—It also makes planning a bit difficult, too, doesn’t it?

Ms Shapland—Very difficult. The other thing is that some of those people have not been on our database. They have been travelling quite well and, all of a sudden, they have a huge relapse. It becomes a crisis then and suddenly we are trying to help them. We have not known them before because they have never come forward. We recently heard from a young 35-year-old woman who had moved from interstate and who is in a wheelchair. Her husband was having to go overseas, and their marriage was breaking up. Unfortunately, a lot of marriages and relationships do not survive because of the issues related to sexuality, to mood swings, to depression and to not being able to cope with the diagnosis. Suddenly she was faced with having to go into a nursing home because she had no family and no-one could provide the care. It is quite heartbreaking.

Senator KNOWLES—She was cognitively okay?

Ms Shapland—She was cognitively fine. I heard you talking about ACAT assessments before. We often have trouble getting ACAT assessments because, ‘Hey, they’re too young.’ Yet, if you want someone to access a hostel or respite—some of people are medically unstable; there is quite a high incidence of seizures in people with MS because plaques are causing scarring in the brain tissue—and the best form of respite for them is a nursing home, they have to have an ACAT assessment. We are finding that becoming an increasingly difficult thing to obtain.

Senator KNOWLES—The main responsibility for providing accommodation for people with disabilities, as you are aware, rests with the state government. What sort of response have you had over the last decade from state governments?

Ms Shapland—This is my third year with the MS Society. I came out of the public hospital system. I know that there was a big focus on young people in nursing homes with a program that I think was run in the nineties. I know that Brightwater set up some great facilities and that Fern River evolved out of that and the closing down of Mount Henry Hospital. From my perspective, yes, there have been some good things done, but in fact it is a growth industry because there was catch-up to do and all the time people are coming through. You only have to go to the head injury wards and the rehab centres to see that you could fill those beds over and over. So I do not know that there is enough growth in those programs. I think there is a real need for more supported accommodation.

Senator KNOWLES—What do you do to promote that?

Ms Shapland—I attended the Young People in Nursing Homes conference held in Melbourne the year before last. Our CEO sits on a disability action group. We lobby and we are engaged with the disability services. At the moment we have had a council donate a parcel of land south of Perth. It is our intention to put some supported accommodation units there for people with high support needs.

One of the other problems is that increasingly people have been encouraged to stay out in the community, and a lot of them would rather stay in their own home, obviously, than go into a nursing home. I have been quite saddened by the number of people who have a significant level of disability and who have small amounts of care. They spend many hours of the day alone and they do not have the support of families. We have had a young woman who, after the carers have showered her, fed her and put her on the couch, is left alone all day until someone comes back and puts her to bed at night. I find that abhorrent; I think that is unfair. It socially isolates people; it cannot be good for their mental health or their physical health. That is a reflection of the fact that there are not enough dollars there. There is a huge demand and I do not think there are enough dollars there to help cater for it. Unfortunately, we compete with the intellectually handicapped and physically handicapped who are born with birth defects. They are always going to be there—and quite rightly; they need the services and the funds as well—but we have these people who also suddenly, through no fault of their own, find their worlds collapse and they are unable to care for themselves. It is quite difficult.

Senator McLUCAS—I appreciate the data and the submission about how you fund Fern River. You say that residents pay for their own expenses—that is, their own telephone, their food—

Ms Shapland—Out of their pension; we budget for them. They pay rent, which is based on the Homeswest scale, of about $188 a fortnight. Most of that money goes into a refurbishment fund so that there is money there if major maintenance or painting or that kind of thing is required. Then there are expenses such as their food, their electricity and their phone.

Senator McLUCAS—They do pay rent, so there is an accommodation charge.

Ms Shapland—That is through their pension.

Senator McLUCAS—Yes. Is that worked out on a proportion of income?

Ms Shapland—It is worked out on the Homeswest scale as a set amount of a pension. Obviously, as we are a not-for-profit group, if there are people who cannot afford it we have means of swaying some of the costs. Our deficit is made up through our own fundraising and donation program so that is why we can sustain our services even though our funding does not meet the services that we provide.

Senator McLUCAS—You may not want to give us this information on the record, but can you tell us what the deficit is that you run?

Ms Shapland—The DSE funding for our outreach groups and our community access nursing is about 70 per cent of the cost that we outlay and for the Department of Health it is about 50 per cent. The Department of Health funds us a small component of nursing and a very small component of social work and physiotherapy because we have a rehab physiotherapy and hydrogym out at Wilson.

Senator McLUCAS—I am trying to isolate the costs of Fern River.

Ms Shapland—Fern River is fairly well funded because it is a unique program—it is funded separately—and so is the respite home. They are both well supported by DSE.

Senator LEES—Do you have eight residents now?

Ms Shapland—We have one vacancy at the moment, but we are negotiating to put the eighth person in.

Senator LEES—Is this the only specific service in Western Australia? There are no other beds supported by—

Ms Shapland—For MS?

Senator LEES—Yes.

Ms Shapland—No.

Senator LEES—What happens to many of the other people who are high need?

Ms Shapland—There are quite a few in the quadriplegic centre at Shenton Park. They have very high support needs and they have been unable to either be placed in a nursing home or go back to their homes.

Senator LEES—Are there any in nursing homes?

Ms Shapland—There are some in nursing homes. We have had a look on the database for the ones that we know. At the moment most of them are over 55 or 57. We have taken a couple of young ones into Fern River as vacancies have come up.

Senator LEES—What would be the overall level of unmet need for another facility such as Fern River or the one you are talking about in the south of Perth? How many people would be ready to go into that facility if it was available?

Ms Shapland—The problem there is the funding for it. At Fern River there are costs associated with having staff for 24 hours a day, 365 days a year. Basically it is a matter of people being able to bring funding in that would allow them to live in supported accommodation, because that funding would be attached through the CACP rounds. That is where we experience trouble because of the level of funds. We do not have many people with MS who are successful in the round because it is so competitive and it is a very difficult process. That is not a reflection on DSE at all; it is a reflection on the huge need and the limited funds that they have. It will be an issue and that is why we may have to look at taking on some non-MS clients as well.

There is another model which we have running where we have two units which are owned by Homeswest, or our Department of Housing and Works. The rent is paid to them. The units have been built specifically for people with disabilities. There are two ladies there who have care packages, and we provide 24-hour care as a shared thing, so they have one carer between the two of them. That works quite well, and it minimises your costs. I would also like to have a look at perhaps having clusters of four units, because you get economies of scale then.

Senator LEES—Of the 2,000 people in WA with MS, what would be the rough number of people who are simply not having their needs for accommodation met?

Ms Shapland—Just off the top of my head, we probably have 40 people with quite significant support needs who are living on their own and could benefit from—

Senator LEES—As well as those who are now in the other facilities. I noticed that Fern River opened in 1997; Ellison House, which is for people with Huntington’s disease, in 1998; and Maylands in 1999. What other facilities have opened from 2000 onwards for any group with disabilities which needs supported accommodation in WA?

Ms Shapland—I am not sure. I know that the Cerebral Palsy Association, Rocky Bay, Brightwater and other people have group homes. There are people who are living very well, very comfortably and very well supported in those homes who have quite significant high support needs. They are safe and well cared for, and there is somebody always a buzzer away, so those kinds of facilities are quite beneficial, but I am not sure how many there are.

Senator HUMPHRIES—I am one of the convenors of the Parliamentary Friends of MS in Canberra, although it is a bit of a misnomer—I suppose no-one should be a friend of a disease like MS. I was interested in what the cost per resident per year at Fern River is. Do you have an estimate of that?

Ms Shapland—The total of their packages that comes in annually is about $625,000 for the eight residents.

Senator HUMPHRIES—So that is $85,000 or something like that per resident.

Ms Shapland—Yes.

Senator HUMPHRIES—That is quite a lot higher than what it would cost to house a person in a nursing home. We have this problem then that these packages are much more appropriate for them, but they are more expensive. Of course, the packages are being provided essentially by state governments, and the nursing home is provided by the federal government, so we have that sort of fault line between the two sectors. Have there been any political issues about that in Western Australia? Have people pressed political parties to promise that there will be better funding for these sorts of facilities?

Ms Shapland—The disability action group, which is made up of the CEOs of several of the not-for-profit disability service providers, certainly has had an awareness campaign. They do go out and lobby and attempt to raise the issues, not only accommodation but some of the other issues like incontinence aids subsidies and those kinds of things, at a level where the politicians are able to hear the issues and try and act on them. I think one of the problems is that there is this state-Commonwealth split. That does cause a problem, I think—from working on the ground—in trying to access things, because there is always the temptation to say, ‘That’s a state issue,’ or ‘That’s a Commonwealth issue.’ In fact, I think it would be quite beneficial to have some way of lumping it all in and just making it funds that are available. That is probably very naive on my part.

Senator HUMPHRIES—We might yet see the day where the Commonwealth seizes control of disability and health services generally across the country—you never know; stranger things have happened!

CHAIR—Thank you for your presentation today, and we look forward to the visit.

Committee adjourned at 12.14 p.m.