AMAROO
VILLAGE

PRODUCTIVITY COMMISION SUBMISSION

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TABLE OF CONTENTS

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Caring for Older Australians
Productivity Commission
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Submission to the Productivity Commission Inquiry into "Caring for Older Australians" 2010

1. INTRODUCTION

Australia faces significant challenges in caring for current and future generations of elders as the population of older people rapidly swells, with higher consumer expectations concerning quality and choice of care options. There is an anticipated increase of our frail-aged who will be experiencing neuro-degenerative and other complex high care needs requiring 24/7 residential care, coupled with the projected reduction of an available workforce willing to work in the aged care industry.

If we are to overcome these daunting challenges then some comprehensive overhauling of the current model is urgently required. In fact, we believe that whole new models may well be needed to meet the 21st century consumer demands together with service provider sustainability.

We welcome the Productivity Commission's inquiry into Aged Care as this is a very important matter that has largely been neglected by previous and current governments, who over recent years have had a number of extensive reviews and reports written from which numerous recommendations have been made, however, that's where prospect for any change has ended.

Governments have lacked the courage to bring any wide sweeping changes due to fear of the polls and it seems Department of Health & Ageing bureaucrats have vested

interests to maintain the status quo which clearly has some severe 'cracks' in the system. These need to be fixed and it seems that the Rudd-Gillard government has deferred this overdue repair job to the Productivity Commission.

Our greatest concern is that the recommended outcome of this inquiry may become all too hard for the newly elected or re-elected government to implement. Notwithstanding, it is critical that changes are made

Amaroo Care Services Inc, trading as "Amaroo Village" is a community-benefit charitable organisation that provides a range of affordable senior's housing options to some 597 residents of which 173 are in our two residential caring centres located in Gosnells, WA. With 36 residents living in ILUs at Denmark on WA's south coast, the remaining 388 residents live in ILUs at Gosnells. The organisation is due to turn 40 in August 2011.

2. MODELS OF CARE

2.1 Residential Care

From the dreadful morbid large multi-bed wards of the old C-Class Hospitals being the end-of-line medical solution for the feeble or demented frail aged, we have progressed to attractive resort style Caring Centres offering single rooms with ensuites, with access to communal lounges and dining rooms creating a lovely homely environment for our contemporary frail aged.

These modern caring centres offer secured areas, activity therapy rooms, hairdressing salons, allied health therapy rooms and often more such as cafes, theatre rooms, and landscaped gardens with water features etc.

Regardless of the amenities offered, basic design and function standards have to be met through a complex certification system. Furthermore, the quality of care is periodically measured against strict accreditation standards. Indeed residential aged care is one of the most highly regulated industries within the human services sector. All this of course, significantly adds to the cost burden.

Divided into low and high Care including 'secured care' within both, there is also now the Extra Services option available. Extra Services is mainly offered to high care residents with financial means by providers who are keen to obtain a moderate to high accommodation bond, where in normal circumstances they would not be permitted to ask for a bond. Sometimes the accommodation and services may be more appealing but many times there is little difference except for the separation of the 'up market' section.

The reasons why aged care providers see that we must continue building these fabulous residential care facilities (RCF) include:

a) consumer expectations;
b) family/ community demand;
c) provider competition; and
d) an element of future proofing

While the cost to provide any caring centre that meets contemporary and regulatory design specifications has escalated to the point that they are no longer affordable, particularly in WA where the building of new residential care places has almost stopped, leaving the State some 2400 bed places short of where population planning ratios say we should.

Since the Dept of Health & Ageing (DH&A) introduced the new funding tool, Aged Care Funding Instrument (ACFI), there has been a clear shift towards the higher end of the Low-High range, therefore there are more residents being admitted into high care than low care.

The reasons for this include:

a) admitting low care has generally become financially unviable;
b) within 4-6 weeks of admission, the health status of low care residents usually improve; and
c) providers are 'cherry picking' selecting highest scores and moderate workload.

Paradoxically, accommodation bonds assist aged care providers to raise capital loans to expand their bed places or build new facilities, yet in most cases low care residents are no longer a financially viable proposition?

Over the past decade, residential aged care while the quality of accommodation and daily living and care standards have continued to improve, the ability to make ends meet has disappeared for many providers, with only 35% managing to retain a small surplus according to Stewart & Brown. Nationally this equates to an average shortfall of $12 per resident per day. This situation is certainly not sustainable.

Amaroo Care Services Inc was allocated 24 Low Care places in the 2008-2009 ACAR when some 1208 residential care places were offered and only 530 of them were applied for. These were to be used to extend our low care RCF from 81 to 105 places. We already have the land available to expand.

Several architects have provided suitable concept designs with floor plans and elevations together with total project cost estimates. The average price has been $250,000 per place, and this reflects actual outcomes on recent projects completed in the Perth metropolitan area during 2009. At this price, together with the inadequate funding this project remains "unaffordable".

A survey of 'baby boomers' demonstrates a strong preference for independent or solo accommodation, as opposed to communal or shared facilities, yet 42% will be reliant on the aged pension while 38% will require a part pension to assist their daily living. Here we may have a situation of desire for a product or service today that these same prospective consumers will not be able to afford in the future?

2.2 Community Care

Evolving from the domiciliary services provided by the local district nurse and assistants, State and Federal Governments jointly funded the Home and Community Care (HACC) program that provided a range of support services to the frail aged and disabled.

The services offered included:

a) Home help
b) Meals on wheels
c) Gardening
d) Transport
e) Day centre activity
f) Personal care

HACC was funded by Federal and State Governments, administered by the State and usually tendered out to a diversity of approved community care providers.

Since the Aged Care Act 1997, we have seen the expansion of community care services (the Federal Government through the Dept of Health & Ageing) with Community Aged Care Packages (CACPs); and in more recent years Extended Aged Care in the Home (EACH); and then Extended Aged Care in the Home Dementia (EACHD).

Many of the community care providers started with HACC and continue to do so. We have also seen many residential care providers allocated with CACPs, plus a few specific retirement village operators. Overall, there have been few very large providers but many more smaller providers.

In more recent years there is anecdotal evidence that the DH&A have been attempting to consolidate the community care sector of the industry. The larger providers are winning increased allocations of CACPs, EACH & EACHD while the smaller ones are generally not being allocated very much more (if any) at all. Furthermore, for any existing residential care provider not already providing community care and attempting to obtain some CACPs and/or EACH in the ACARs, it has been nigh impossible.

This has certainly been our experience at Amaroo, where we have 173 residential care places operating in Gosnells, an excellent reputation as a quality aged care provider, four (4) attempts to secure CACPs in last 5 years have failed to yield any. Several other similar organisations to Amaroo have also shared a similar experience.

At Amaroo's Gosnells village, there are some 388 retirees residing in Independent Living Units (ILUs). With an average age of 76, there are some 29 of our ILU residents receiving some level of community care, (mostly CACPs) from 11 different community care providers. The carer from one of these providers has been travelling from Mandurah to Gosnells, a distance of approx 70kms (each way) for just two clients. Now that's efficiency, isn't it?

Many of our ILU residents ask why is it that Amaroo cannot provide these same CACPs, when we have the resources on hand to extend a community care service through the two (2) RCFs we have operating. We patiently wait for the opportunity.

When Amaroo is allocated the CACPs and possibly the EACHs that were applied for in the 2009-10 ACAR, our considered catchment area for qualifying clients includes our ILU residents and goes beyond the village and into the City of Gosnells and adjacent catchment areas. Again, we wait.

Several years ago, each client received on average 6 hours per week for a CACP, then as the demand for CACPs increased, compliance regulation increased, and funding levels failing to keeping up with actual costs, the average weekly hours per client has been reduced to just 4 hours (this includes travelling time to and from the client).

Demand for CACPs has escalated due to the fact that many of the clients are not able to secure a residential care place and this service provides assistance to the spouse or family member providing most of the client's daily living and personal care needs. Government policy and funding constraints have essentially deferred admissions into a RCF.

While deferring admissions into RCFs may be a means of cost-saving to the Federal Government, this policy actually shifts costs to the State Government because the community care client is hospitalised more frequently, so too is the incidence that the spouse carer is admitted to hospital.

There is also a human cost with this indirect policy in that the spouse carers often 'burn themselves out' sometimes with tragic outcomes in looking after their partner at home beyond their capability because they cannot secure a residential care place when needed. CACPs and EACH certainly have their place in our modern society as an alternative care model, however there comes a time when the client requires 24/7 care and with current bed shortages in WA, spouses and families are being stretched to the limit with associated consequences.

2.3 Supported Living

Supported or assisted living is where the older persons have secured a villa or apartment through a life-lease or rental from a organisation that operates retirement villages and is an approved aged care provider. Often, CACPs and EACH is available through the organisation, however where they are not the support services have been or are offered on a fee for service basis. The latter is found more in wealthy areas.

The services offered comprise of a whole range of support including:

a) Cleaning & laundry;
b) Meals;
c) Gardening;
d) Transport & shopping;
e) Personal care; and
f) Nursing care.

Within a fairly close proximity, it is much more cost effective to deliver these services without the travel and time costs.

Furthermore, the resident (or a third party) has paid for their accommodation and continue to pay for their daily living expenses.

This removes a significant cost burden to the Government and therefore the tax-payer.

Supported living is currently a hybrid model where it involved Government funded CACPs and EACH largely limited to a few approved pilot sites or good fortune that the village operator is also a community care provider.

This supported living model certainly needs better support from Government to enable its extended use, therein utilising the environment where the resident receiving the assistance has and is already paying for their own accommodation and daily living expenses, often to a standard higher than in a normal RFC.

While the concept could work well in most retirement villages, current known examples suggest that it would work best as a low care model, however if there was a group of special apartments located close to a central nursing control centre, residents in need of the lower to middle range of high care could be safely managed with the appropriate resources. This needs to be explored and used to its best advantage for the resident.

Notwithstanding, a concern for retirement villages in undertaking this supported living service would most certainly be the threat of any encroachment of more and overbearing regulations.

3. FUNDING – REMAINS INADEQUATE

Given that aged care funding has not kept up with actual costs of service provision over the past decade, aged care providers are struggling to keep the doors open and certainly in WA the building of new places has all but stopped as actual costs outstrip all sources of revenue.

Nationally, only 40% of RCFs have produced an operating surplus over past 2 years with a reported average shortfall of $12 per resident per day. WA has been experiencing inflationary pressures higher than other States of 3.4% CPI to 2.9% CPI, yet there is no mechanism to allow for any compensatory adjustment. Little wonder that no-one is investing in residential aged care anymore?

Currently there is no objective basis for setting fees and subsidy levels for the provision of aged care and accommodation under the Aged Care Act 1997, which includes the meeting of the competitive remuneration needed to attract and retain the skilled staff that is needed to care for the increasing number of frail aged people with increasingly complex high care needs.

Revenue to cover the cost of *daily living expenses* in residential care (otherwise known as the basic daily care fee) is linked to a percentage (84%) of the single aged pension, (non-pensioners "self funded retiree's" pay a slightly higher fee) which is designed to support a basic standard of living for older persons supporting themselves in their own homes. All residents of aged care facilities, pensioners and non pensioners alike are required to contribute towards their living expenses. While this provides a base-line, it removes choice from those who can afford to pay more except if they choose to go into an 'Extra Services' facility.

The current subsidies for *care and support* in residential care (otherwise known as the basic care subsidy), as embodied in the ACFI scales and income tested fees, are historically based and are subject to minimum wage adjustments under the peculiar COPO system. COPO assumes that wages in all sectors are offset by productivity gains and uses this flawed assumption that the aged care sector has the same ongoing capacity as all other sectors to achieve productivity gains through labour substitution.

The basis for setting of *accommodation* subsidies and prices remains uncertain with the exception of bonds in low care and extra service places. This means for most, the current accommodation prices are totally inadequate to support new capital investment for high care residential services built to contemporary design standards, therefore the industry has no capacity to expand the service in spite of the growing demand.

Current subsidies for *community care* (CACP, EACH & EACHD) under the Aged Care Act 1997 were originally set to the mid points of the former RCS classification for residential care and since then has only been adjusted in accordance with the COPO system meaning that funding has lagged behind, leaving providers with no other option but to reduce the average hours of delivered care for each recipient.

Generally, more consumer choice needs to be built into future arrangements. This would not only improve the flexibility, quality and responsiveness of services, but would allow greater competition and provide a more evidence-based and transparent approach for evaluating performance, setting care fees and subsidies in aged care.

A major improvement would be to separate aged care costs between *care and support*, *accommodation and daily living expenses* within any future funding models. The fees charged and subsidies received could then reflect the actual costs of providing care and support against accommodation and daily living expenses.

While the former may be tied to ACFI or its successor, accommodation is tied to the resident's or recipient's ability to pay against their assets etc. If a resident cannot afford to pay the true market rate to cover the cost of accommodation, then the Federal Government pays either the full or partial amount on their behalf.

Consider the fact that all through an adult person's life, he/she essentially provides their own accommodation and daily living, so why should this change when they get into aged residential care?

We believe this would release much needed funds to provide capital expansion with more beds to meet growing demand for the necessary capital expansion required for both residential care.

Since the introduction of ACFI in 2008, combined with the ACAT assessments predominantly classifying almost everyone as high care, (even when they clearly are not high care), together with the increased numbers of CACPs allocated at about the same time, there has been a significant shift away from low care admissions to residential care.

Financially, this has been a disaster for many low care facilities with prospective residents denied a place within a residential care facility simply because their ACFI score does not attract sufficient funding to pay the actual costs, hence we are seeing some bed vacancies.

Unfortunately, accommodation bonds are limited to low care facilities with the exception of 'Extra Service' places, yet low care is an area that is experiencing a diminishing demand for residential care places because providers essentially have to 'cherry pick' to stay viable. Selecting some that meet specific criteria means that many others with needs are overlooked.

Whatever form accommodation bonds are to take in the future, the difference between low and high care as far as assessing accommodation needs, should definitely be removed. With ACFI as the funding measuring tool, there is no need to have a separation of low and high care at all. This means that accommodation bonds would apply to all future admissions and for those who could not afford to pay a bond, would pay an accommodation charge.

Acknowledging that Governments of either persuasion have been reluctant to introduce accommodation bonds for high care, it is an imperative that they rethink the issue and develop a strategy that ensures a sustainable source of capital funding to replace tired stock; expand existing facilities; and/or build new facilities.

Clearly, the current funding system does not ensure services will be available to support older people in the future. Costs of care delivery are rising faster than funding for aged care principally due to the ongoing application of COPO indexation which most often provides less than a CPI increase. Take for example the 1.9% adjustment for 2009 where WA's CPI was 3.4%, then 1.7% in 2010 when we are expecting another CPI of at least 3.5%. The maths just don't add up?

Utility costs within WA, including electricity, water and gas have risen significantly over past 2 years as a consequence of a massive catch-up to cover the real costs in government providing them. Over the past 12 months, water rose by 17.7%, sewerage rose by 4%, electricity rose by 17%, gas rose by 7% and the emergency service's levy rose by 18% The increased costs for utilities alone far exceeds the 1.7% COPO increase for 2010.

Due to the rigid regulation of care fees and subsidies, aged care service providers are unable to pass these costs onto consumers, even assuming that they had the capacity

to pay. Interestingly, when an individual is able to pay more than the standard care fee, the Federal Government 'claws back' the difference by reducing subsidies for the person.

Without any doubt, COPO has become totally irrelevant to reflecting escalating costs which impact the delivery of quality aged care services. COPO reveals an administrative policy that has failed to keep abreast of 21st century requirements and the Department of Health & Ageing can no longer hide behind it.

The previous government provided the conditional adjustments payments (CAP) as a temporary patch for residential care in recognition that costs were completely outstripping funding provision under COPO. Fortunately it was acknowledged as an essential funding top up to prevent financially stressed provider organisations closing.

Clearly CAP really needs to become an integral part of the aged care baseline funding, removing any future threat to remove it. Furthermore, where it was previously omitted from Community Care, it should be added without delay.

Sadly, the Dept of Health & Ageing has used CAP to extract specific information within a certain timeframe, when the funding is now critical to just keep the doors open.

A Thought Bubble – "the Aged Care Annuity"

Alternative funding models may well replace the accommodation bond with *"the aged care annuity".* Briefly, this works in conjunction with an increased or uncapped accommodation charge that consumers should be able to purchase an aged care annuity (effectively a refundable lump sum deposit) from the provider for an amount of their choice. This annuity would be government guaranteed and provide the same pension benefits as currently exist in relation to accommodation bonds.

The annuity would attract a predetermined interest return, either agreed between the provider and the resident or, alternatively, at a rate set by the government at the time of entry.

The aged care provider would offset this interest return of say 8.5% against the resident's accommodation charge and in this way, depending upon the size of the annuity purchased, a resident could potentially reduce their daily accommodation charge to zero. There would be an understanding that upon departure, the full value of the annuity would be returned to either the resident or their estate with the possible exception of a predetermined retention depending upon the value of the annuity, say 0 - 3.5% per annum to cover a minimum contribution towards the capital cost for their accommodation.

If applicable, this retention amount would be set either by the provider or government at time of admission and remain so until the resident was discharged. The retention rate would be reviewed annually to ensure that for new admissions, it actually retained relativity to current market forces.

Accommodation charges could also vary in accordance to the type of accommodation. For example a single room with an ensuite could be say $60.00 per day, whereas a

single room with a shared bathroom, or a twin shared room and bathroom only $45.00 per day. This would better differentiate the various levels of accommodation available as well as provide affordable choice options.

Everyone knows that "one size doesn't necessarily fit all", yet that is what the government has forced upon residents and providers alike, with the exception of "Extra Services" which tends to promote a clear 'them and us' social perspective. Currently, both the accommodation charge and the daily care fee are fixed regardless of whether a resident is placed in a shared room or single room; whether they have a scenic view or not; whether they have a menu choice for each meal or not etc.

Accommodation and daily living costs need to be separated out from care and support, therein enabling improved consumer choice dependent upon the residents ability to pay for additional options.

4. WORKFORCE - COPING WITH A DIMINISHING WORKFORCE

It is widely acknowledged that the demand for aged care workers will increase significantly as a consequence of the ageing population.

The aged care industry's biggest challenges today and in the future after funding levels is the work force issue. Our existing workforce itself is ageing and the workload has become much heavier. To attract younger and stronger workers, we need access to funding that allows us to offer more competitive wages, otherwise I can see the day when we will have to close down.

Indeed, during 2008, we went through a period that our dependency upon contract agency staff grew to 35% and during this time the facility registered a record number of official complaints and investigations. This in turn brought further stress to an overworked team of employees trying their utmost to provide the best possible care we could to our residents. To rectify this, we began closing beds down when residents were discharged in order to reduce the workload to suit the size of our stable workforce.

Contract agency staff may fill up a blank space on a roster however experience shows that a provider is paying top money for additional bodies to be on the floor that have little commitment to the residents, team or organisation. It would be far better to be able to afford to pay higher and more competitive wages and retain our own workforce.

Fortunately, we have reduced our dependency on contract agency staff to 6.35% and all 173 beds are occupied with 78 names on our waiting list.

While it is acknowledged that the Federal Government has been attempting to recruit and train more medical, nursing and allied health professionals to work in aged care, they are barely keeping up with workforce retirements. Furthermore, how many of these

qualified professionals will choose to remain in aged care when they can earn 14% more, working in public hospitals.

Again, adequate funding to offer competitive salaries and wages is urgently required.

WA is heading into another time of a 'boom' economy driven by the resources sector and such is likely to last for at least a decade. If we have a repeat of what occurred in 2008, we can expect to lose staff that will be attracted by wages that we just cannot compete with.

The WA Chamber of Commerce and Industry has identified serious labour shortages that will inevitably impact upon the aged care sector attributing the problem to:

a) The economic conditions in WA meaning that the aged care sector cannot compete with other sectors for labour;
b) An undersupply of aged care residential places, causing pressure on public hospitalsd, themselves requiring staff;
c) Changing social and demopgraphic trends requiring additional paid care for the aged population;
d) An ageing workforce;
e) The relatively poor image of the sector making attraction and recruitment difficult; and
f) The increasing number of administrative, regulatory and compliance burdens being placed on an already stretched workforce.

While aged care workers may have a passion for their work in making a difference for the elderly they care for or support, it remains a sad indictment upon our social values when an entry level zoo keeper attracts a base rate of $19.50 per hour for tending to animals while an entry level personal carer or support worker only attracts $15.90 per hour for providing care to our elderly in accordance with a new Australian industry award that came into effect during July 2010.

Existing funding arrangements for aged care limits the capacity for employers to offer competitive wages. The COPO indexation formula has not maintained parity with salary and wage increases in any way, shape or form. A comparison reveals that COPO delivered a 21.6% overall increase in subsidies from 1996/97 to 2009/10, while ordinary time meetings for adult females (the majority of the health workforce) increased 62% during the same period. For too long, the Federal Government has relied upon the goodwill mission of the aged care industry.

Other emerging concerns are associated with the changing ratio mix of nurses to personal carers within the aged care workforce and the inadequacy of 'fast-tracked' training courses being offered by Registered Training Organisations (RTOs).

Currently some 76% of residential care beds are occupied by residents receiving high care. There are obvious benefits in terms of improved care outcomes for aged residents that come from registered and enrolled nurse involvement in the residential setting, particularly at end of life care, however the nurse numbers employed are diminishing due to basic market forces.

Frequently we receive applications from newly qualified personal carers who have been 'fast-tracked' through a 2 - 4 week Certificate 111 course who really have little idea of what they might be required to do on the job, having had insufficient course work and practical experience. The variance in quality of the training differs so much between RTOs and the industry requires greater consistency. Clearly a Certificate 111 and 1V should equate to same standard.

5. COMPLIANCE - TOO MUCH REGULATION

Australia's aged care system is extensively regulated with respect to quality, quantity and price. Residential aged care is highly subsidised by government and provides limited capacity for residents to influence the delivery of their aged care services.

We have no problems with the Minister for Ageing insisting that Australian aged care providers offer the highest quality of care possible to the frail aged persons in our care, just as long as the DH&A is prepared to pay the cost of providing this care.

The Aged Care Standards & Accreditation Agency (ACSAA) seems to be raising the bar each year and their expectations in an environment where staff shortages prevail and dollars are tight, place an extraordinary challenge upon aged care providers who are forced to invest large sums of their revenue on the effort to maintain accreditation status in order to continue operating.

At the end of the day, one must ask if any of this 'compliance' expenditure improves the quality of life for our residents?

There is the expenditure for specialised staff to prepare for the next visit or review, then there is the exorbitant fee demanded by the Agency for the service they think they are providing. Without any competition, the Agency remains the big winner.

Also, with the introduction of the CAP, came the additional expense associated with the conditional requirement for the aged care provider to produce audited general purpose accounting statements. Such may satisfy the DH&A bureaucrats but really doesn't add any value to the resident's care. Furthermore due to the many different interpretations, general purpose accounting has failed to produce the measurement consistency that was sought.

Our point here is the significant additional expense in time and money associated with compliance has eroded much of the value gained by the CAP funding. Each year compliance costs increase substantially more than the fee adjustment received. This expenditure erodes the sum that we need to spend on care.

The gate keepers for the frail aged either entering into either the residential or community care streams is the Aged Care Assessment Teams (ACAT). Herein lies a serious problem. While the ACATs are funded by the Federal Government, the operational personnel are employed by the WA public hospitals.

Generally, there is a conflict of interest in that the ACAT has their first loyalty to their employer, who incidentally requires them to move out the 'bed blockers' ASAP so they tend to tell an aged care provider what they think we want to hear to achieve the desired discharge. All too often, someone that has been classified as 'high care' can be found to be at the bottom end of 'low care'.

ACAT personnel need to be employed by the Dept of Health & Ageing, and they definitely need to be conversant with ACFI for better outcomes.

6. CONCLUSION

So that we may move forward, we may need a clean sheet of paper that provides the policy framework to offer Choice, Access and Sustainability for both the consumers and providers.

As demand for aged care services increases to meet the needs of Australia's ageing population solutions need to be found to ensure that our elderly will be able to access a quality service provider of their choice.

For this to occur, the aged care industry requires adequate levels of funding that are adjusted to reflect the State CPI movements to ensure financial sustainability. This would then enable the providers to offer to:

a) Pay competitive remuneration to employees;
b) Attract new employees (professionals and support)
c) Refurbish RCFs;
d) Build new RCFs (extend them and/or replace them);
e) Replace plant and equipment;
f) Extend community care hours; and
g) ***Keep the doors open***.

With an ageing population comes the realisation of a diminishing workforce and taxation revenue base, there is a critical need for a rethink about how we are going to resource aged care in the future. This is why we are suggesting 'a clean sheet of paper'.

There is merit in revisiting the Medicare levy and perhaps increasing it to cover aged care in future, for our future generations of the frail aged in need of care. Already, a significant cost to Medicare is the medical and hospital treatment for people over the age of 65, so it seems as if a recent report/recommendation produced by KPMG for the Bethanie Care Group really needs some consideration.

This paper has been written in good faith that the contents be considered with all the other submissions to provide the Productivity Commission with sufficient material and evidence for those involved to be courageous and make sound recommendations for a better way forward.

We then look to the Federal Government to have the courage to take the industry forward and continue to nurture the needs of Australia's elderly.

Numerous reviews conducted over recent years have consistently highlighted the same issues and the need for structural reform but very little has ever happened to alleviate the stress that the industry continues to be under.

Should you wish to discuss these matters further, the CEO would be pleased to hear from you.

Yours sincerely

David Fenwick
Chief Executive Officer

27 July 2010

COMMON ACRONYMS USED

ACAR	Aged Care Annual Round
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
CACP	Community Aged Care Package
CAP	Conditional Adjustment Payment
COPO	Commonwealth Own Purpose Outlay
CPI	Consumer Price Index
DHA	Deptartment of Health & Ageing
EACH	Extended Aged Care in the Home
EACHD	Extended Aged Care in the Home with Dementia
HACC	Home and Community Care
ILU	Independent Living Unit
RCF	Residential Care Facility
RCS	Resident Classification System
RTO	Registered Training Organisation