Wintringham

Productivity Commission: Caring for Older Australians

Interim submission

July 2010

Wintringham

Overview of Wintringham's work with the Elderly Homeless

Wintringham is a secular, not-for-profit welfare company providing an extensive range of advocacy, support and aged care services to elderly homeless men and women, and to financially disadvantaged elderly people who are at risk of homelessness.

Wintringham provides support and services to over 1100 elderly men and women each night, the majority of whom are homeless or at risk of becoming homeless. Wintringham has five registered aged care facilities (including Ron Conn Nursing Home which is the first high care nursing home for homeless people in Australia), manages 440 CACP, EACH, EACH-D, and CDC packages, has an extensive outreach and advocacy team, and through its subsidiary Wintringham Housing Ltd, owns or manages approximately 500 older persons housing units.

Working exclusively with financially disadvantaged older people has given Wintringham a unique perspective on issues associated with homelessness and the aged, and the policy implications of an ageing population.

The other defining feature about Wintringham is that it is a uniquely Australian organisation whose various models of service delivery have been developed and refined here without the "benefit" of copying or attempting to transplant overseas housing or aged care service models.

The vision at the start of Wintringham was simple: the company would be a social-justice organisation that would care for older homeless people upon whom the aged-care industry had turned its back.

Named in memory of an old homeless man "Tiny" Wintringham, the company was created as a direct result of the frustration at seeing elderly homeless men and women living and dying at night shelters, unable to access Commonwealth funded aged-care services.

What was concerning at the time was that this apparent discrimination was coming from aged-care organisations that were Commonwealth funded and, in the main, enjoyed not-for-profit status with generous tax concessions. It is also worth noting that most of these providers also had strong affiliations with various religious bodies. We will have more to say about the need to reform the tax status of many providers in the aged care sector later in this paper.

Wintringham was therefore founded on a very real sense of anger: anger that a Commonwealth welfare system could be twisted and contorted to allow organisations to refuse homeless clients.

A key part of Wintringham's success in dealing with problems associated with the elderly homeless population is that the company has remained a single-focus organisation, deeply rooted in social justice values. Our view of social justice is that it is a basic and fundamental right and should not be consequential on the personal values or religious beliefs of a worker or an organisation. So, for Wintringham, older homeless people have a right to decent aged-care services and housing simply because they are Australian citizens. This clear focus, combined with the absence of a peak industry body that immediately identifies with our client group, has led Wintringham to itself become closely involved in advocacy and policy development.

Issues affecting the aged homeless population intersect with a wide band of policy frameworks that we have found to be both an advantage and a disadvantage. We do not have the benefit of being easily compartmentalised into a single program and so generally do not have the advantage of being part of a major lobby group.

The advantage that this creates is that rather than relying on a peak body to take an interest in the special needs of a relatively small number of people, Wintringham has developed its own lobbying processes. Not having to argue for the needs of the industry as a whole or to defend many of the industry practices that we may not necessarily approve of, frees us to discuss how generalist policy impacts on elderly homeless people and how these largely unintended consequences can be alleviated. The remainder of this submission will attempt to respond to some of the issues that the Productivity Commission will be working on.

> *A well known private boarding house near the centre of Melbourne's CBD was 'home' for Peter. The house was a warren of endless tiny rooms with many emitting a suffocating stench of urine, faeces (both animal and human) and rotting food reminiscent of third world squalor.*
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> *Peter's bank passbook was held by the proprietor to ensure payment of rent and recovery of claimed past debts. Peter lived in fear of the owner but saw no alternative to his present accommodation. Typical of many destitute frail elderly inner city men and women, Peter lacked any vision of a different world. His history of physical abuse and resultant lack of self confidence meant that not only did he accept whatever the owner offered, but more importantly he did not allow himself to think of a better life.*
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> *Peter slept on a stained 'second' hand mattress with no sheets and an army blanket. The boarding house, like all of the others, was populated by frail elderly men and occasionally women, many of whom had an acute alcohol dependency which rendered them particularly vulnerable to landlords who 'gave' them booze as part of their negotiated rent. These aged people lived their last years in squalor and degrading conditions that most people would never contemplate their family pets having to endure. Other residents were intellectually retarded or damaged young people, and those with a psychiatric impairment. They shuffled around the buildings, vulnerable to alcohol and drugs, virtual economic prisoners to landlords who prey on them.*

> *Peter lived entirely apart from the aged care sector. He died shortly after our outreach worker found him and before he could receive any services.*

It is of fundamental importance for the Productivity Commission to realise and address the fact that the aged care industry has failed the elderly homeless. While it is understood that the Productivity Commission has not been asked to investigate the homeless persons' service system, an understanding of the failings of the way society has addressed the problem of homelessness may provide an insight into how the aged care system needs to be reformed so the poor and the homeless can access its services.

Homelessness is the end result of a social system in decline. Night shelters, with their large resident populations of physically, psychiatrically, and intellectually disabled people who have little or no external supports, living beside desperate, lonely, and at times, violent young men, are a public manifestation of that chaotic decline.

It perhaps also needs to be stated that the seemingly obvious fact that the social class a person is born into appears to play a major role in determining whether a person becomes homeless or not.

To an average person living in the community, the concept of homelessness is vague at best or, if pressed, entirely unimaginable from a personal or family perspective. To live on the streets, to scavenge for food, to be sick and unable to get care, to be subject to bashings and random terror of gangs, police, or from other homeless people, is simply unimaginable. As difficult as it is for the public to contemplate what life must be like if they were homeless, few could begin to imagine what it must be like if the homeless person was the age of their parent or grandparent.

Yet elderly and frail men and women make up a significant number of homeless people. The most recent Counting the Homeless figures from the 2006 Census showed that of the 105,000 people who were homeless, 18,000 were over the age of 50. This is a staggering figure for such a wealthy country as Australia particularly given the sophistication of the aged care sector.

The stories of the brutal conditions that elderly homeless men and women endure are numerous. Anyone who has worked with homeless people can describe violent and frequently fatal attacks that largely go unreported and un-investigated. This remains one of the most tragic and inexcusable faults of our society that, at a time of their life when they are most vulnerable, elderly and frail homeless men and women can expect little or no support, sympathy, or services.

> *Jeff was a homeless old man living at a homeless centre in Melbourne in the 1980's. His incoherent ramblings and regular verbal outbursts, while annoying to many of the residents, was generally tolerated by most of the people who had lived at the Gordon any length of time.*

A combination of his refusal to accept any form of treatment or help, and a complete failing of the public health system to assist staff at Gordon House, meant that Jeff wandered the building ranting to himself and occasionally to others.

I came across Jeff one afternoon on the 3rd floor of the building, being held down by three men while a young woman bashed him. He had annoyed the wrong people.

The Homeless Elderly Population and the Aged-Care System

A primary concern for Wintringham is that elderly homeless people have not readily been assigned to a policy environment where their needs can be addressed in a structural and consistent way. While a few individual organisations working with the elderly homeless population have had success in alerting the decision makers in Canberra to this policy vacuum, it can hardly be said that the industry as a whole is concerned with the needs of aged homeless men or women.

With the door to aged-care services effectively closed to the elderly homeless population, remaining options are indeed bleak. The most common outcome is premature death – often in the most appalling circumstances. Before death comes, a variety of frightening and totally inappropriate accommodation options are available, including government funded not-for-profit homeless services, substandard rooming or boarding houses (some so violent that outreach workers will only enter in pairs or with police escort), or rooms above hotels, euphemistically known as pub tops.

With some notable exceptions, there are a wide range of "gatekeepers" who appear intent on making it as difficult as possible for homeless people to access mainstream services.

Interestingly, a study tour in 1993 confirmed that what was happening in Australia was, to a significant degree, being replicated in Sweden, Denmark, United Kingdom, and the United States. The extent of this selective rationing of resources is nothing new.

In the early 1980s, large homeless persons' night shelters existed in most Australian capital cities. In all of these shelters, frail and elderly men and sometimes women co-existed with much younger and frequently violent tenants. Few if any of these older tenants were able to gain access to the aged care system.

My own epiphany about the injustice of elderly people living in a night shelter came about through a series of events involving some of our clients.

> *One Friday night before leaving Gordon House, I helped our community nurse take two men to the Prince Henry Hospital, both of whom were suspected of having heart problems. At the hospital we became involved in a lengthy*

argument with the Triage who at first refused to take the men and then only extremely reluctantly agreed that they should at least be checked.

After leaving them at the hospital, my wife and I took my parents to a performance of Circus Oz. Coincidentally, during the performance, my father had a heart attack. We managed to get him out of the circus tent, into a taxi and then to St Vincent's Hospital. He stayed at St Vincent's for about 10 days where they performed all manner of tests while he recuperated in the private patient section of the hospital. Dad went on to live for another 9 years.

When I returned to work on Monday morning, I was told that the two homeless men I took to Prince Henry's had both been discharged from the hospital about an hour after I took them in, and were both found dead in the shelter the next morning. One of the men in particular had died a terrible death. He was found in the morning jammed between the bed and the wall in a tangle of sheets, faeces and urine as he hopelessly struggled to his death.

Why was my aged father treated so well and these men so badly? Was it just that he had private health insurance, or was it simply because he was not living in a homeless shelter?

Two days following this incident, while talking to a colleague at Gordon House, I was told that "James" was back.

James was typical of many of the old men at Gordon House in that we knew very little about him or the circumstances that had led to him living in a homeless persons' night shelter. What we did know was that he was a quiet and shy man who kept to himself, and in the chaotic conditions of Gordon House, he was known only because he had lived there a long time.

Following a fall, he was taken to hospital where both his arms were placed in plaster casts. Typically the hospital did not notify us when they discharging him and, as he had no contact with any family member who would have insisted that he receive some rehabilitation services, he simply returned unannounced to Gordon House.

I only learnt of this from a casual comment from one of the booking clerks and immediately went up to see James. I found him sitting on the end of his bed, with his head hung low and dressed in only an old dressing gown he must have had for many years. I talked to him a while and tried to find out how he was. Still furious with the hospital for dumping him and realising that with both arms in casts he was left virtually disabled, a thought suddenly occurred to me.

"James", I asked. "How are you wiping yourself?" Using his mouth to pull up the sleeve of his dressing gown, he showed me the casts that went down to his fingers. Both casts were covered in faeces: unable to use his fingers to hold

> *toilet paper, James had been forced to wipe himself by dragging his cast over his now red and inflamed anus. Such is the life of an elderly homeless man. The nurses, doctors and social workers responsible for his discharge must have known that James would require intensive personal support for many weeks, yet they dumped him back in a homeless night shelter.*

Elderly men and women were dying with alarming regularity and we seemed powerless to stop it. Hospitals refused to help or did so under great duress, while access to aged-care services seemed blocked. Referrals to aged-care assessment teams were futile as they regularly refused to come to the shelters and, if they did come, made it clear that our guys were either too young to be eligible or that they would not "fit–in" to a residential aged-care service. These and other stories were some of the reasons for the establishment of Wintringham, a specialised, non-religious, not-for-profit welfare company that works with the elderly homeless population. It was the reluctance of the existing service system and the people who worked within it that provided the impetus and sense of urgency needed to create an alternative way of looking at a very old problem.

Older age and homelessness: shifting the paradigm

A more satisfactory and equitable answer to the seemingly unrealistic position of requiring workers in homeless services and government-funded homeless service programs to provide for the elderly homeless population is to change the paradigm in which they work: to insist that it is not the responsibility of homeless programs to cover the needs of the elderly homeless population but is, in fact, the clear responsibility of the nation's aged-care program. **We need to stop thinking of aged homeless people as being *homeless* and elderly: what we should be saying is that they are *elderly* and homeless.**

The difference is not semantic: it involves a whole new paradigm of thinking about providing for the aged homeless population. If people are seen as homeless then some could say that it is entirely appropriate that they are accommodated in a homeless persons' centre. However, if they are viewed primarily as being elderly and their homelessness due to a variety of circumstances, then people will come to see that they should have the right to access the same level of residential aged-care services that the rest of the aged community expects.

The aged-care industry, both private and welfare, makes little or no effort to advocate on their behalf. As a result, the only advocates for elderly homeless people are often workers within the homeless agencies, who are themselves beset with funding crises that invariably make it extremely difficult to address the needs of the elderly. For all the discussion concerning the "tidal wave" of older people advancing towards most western societies and the need to find creative and affordable ways that society can provide for their care, virtually nothing is said about the extreme poverty that some of these people will inevitably find themselves in. For example, what will be the consequences for both these elderly folk and society in general if a

housing shortage and inability to access appropriate aged-care services forces impoverished people into homelessness?

Shifting the paradigm so that elderly homeless people are seen first and foremost as being elderly will have immediate implications for any major policy review affecting the homeless population (and most notably in the White Paper on Homelessness that was an initiative of the Rudd government). Wintringham has argued that the solution to providing care for the elderly homeless population lies not in improving the response of homeless service programs to elderly people but lies instead in improving access for the homeless elderly population to the much larger and better resourced aged-care program.

However, there are problems with simply transferring the responsibility of providing services for elderly homeless people to the existing aged-care sector because experience has demonstrated that the general health-service field has been manifestly unable or unwilling to adequately meet the health needs of the homeless population.

Instead, what is needed is a mechanism whereby homeless elderly men and women can gain access, not necessarily to mainstream services, but to mainstream funding sources. In this way, organisations such as Wintringham can develop under the general umbrella of the aged-care industry using mainstream resources to develop highly-specialised services and skills appropriate for a group of elderly people who are not necessarily representative of the general elderly population.

The Aged Care Act was designed for the care needs of the general population's elderly parents – it was not intended to meet the needs of the homeless. While it is also true that the Act was not designed to exclude the homeless, recognition now needs to be given to reframing the Act to enable the homeless to gain easier access to services.

The primary difficulty in providing services to the homeless is that it is extremely difficult to make such services financially viable. As such it acts as a disincentive to aged care providers who may be considering providing services to the elderly homeless.

Neither the DoHA Capital or Recurrent funding models are suitable for the elderly homeless

- **Capital**

The aged care industry builds new residential facilities through proceeds derived from a combination of Accommodation Bonds and Special Service Bed rates, both of which are unavailable to providers who choose to work with the aged homeless. Furthermore, companies like Wintringham are unable to borrow capital funds to build new facilities because the absolute poverty of our clients precludes the ability to service bank loans of any substance.

In order to construct desperately needed new residential facilities for the elderly homeless, we are therefore entirely dependent upon the occasional good will of government decision making for limited one-off capital grants.

As a result of Wintringham's lobbying and the consequent commitment of the Rudd Government through its White Paper on Homelessness ("The Road Home"), capital funding has been pledged for 4 aged care facilities over the next 4 years. While this is welcome news, it is clearly insufficient, particularly if the Government wants to meet its objective of reducing homelessness by 50% in 2020.

Wintringham regrets the abolition of the Variable Capital Funding program which was removed during the Aged Care Reforms of 1997. Under this program a variable capital subsidy was provided which was dependent upon the proportion or number of financially disadvantaged people that the new facility would target. The first three aged care facilities that Wintringham constructed were financed through this program.

We would recommend either the reinstatement of the Variable Capital Funding program or an expansion of capital funding available under the Road Home initiative. It is important however that the funding be 'quarantined' to services that undertake to provide for the homeless or those at risk of becoming homeless, as Wintringham has been made aware that in at least one instance, capital funding has been made available in the past to organisations that have not honoured their undertaking to target the homeless.

- **Recurrent (ACFI)**

The ACFI in its current guise acts as a powerful disincentive to any provider wishing to care for the elderly homeless. While this outcome is clearly an unintended consequence of the reform, it is nevertheless a major concern to Wintringham and increasingly to other homeless service providers as the full extent of the relative disadvantages are becoming known.

Wintringham has provided DoHA with a wealth of information and case studies demonstrating the problems we are facing with ACFI.

Principally, ACFI was not designed to meet the needs of our client group. In 2007 the designer of the ACFI model, Professor Richard Rosewarne noted:

"What is clear is that the type of resident supported at the Wintringham Port Melbourne facility is highly atypical of the general residential aged care population in both low and high care (diagnosis evidence was often found in the ACAS ACCR forms with alcoholism and acquired brain damage commonly diagnosed. Cognitive impairment or memory loss was also more common than a dementia diagnosis). Residents in this facility have significant behavioural support issues and accommodation and social support needs but have generally quite low activities of daily living dependencies and low levels of complex health care needs.

The current RCS funding is achieved by higher ratings in the ADL RCS items and Medication and Complex Health areas than would be expected. This is a function of the methodology used with RCS that relies on documentation and care provided to validate claims. The ACFI in contrast relies on the assessed care needs relating to their underlying impairments."

Subsequent analysis by both Wintringham and DoHA has revealed that there is not a simple cause for the failure of ACFI to adequately reflect the cost of providing for homeless particularly those with alcohol related brain injuries, nor is there a simple remedy. Behavioural issues , which resulted in high overall RCS claims, are not able to be claimed at the same rate under ACFI. Behavioural issues require vast amounts of staff time and patience, these care requirements then 'leech' into the care provided in the other two ACFI domains, to an extent, governing how care is provided overall. The three ACFI 'silos of care' do not allow this to occur – for example, should resident be reluctant to shower, this is classified as a behaviour and can only be claimed in this silo. Under RCS, this behaviour leeched out into the ADL category and was able to be claimed in both areas. In addition, in comparison to the other two ACFI silos (ADLs and Complex Health Care), the ACFI the Behaviour 'silo' is poorly funded and cannot be easily adapted to acknowledge the high cost of catastrophic behaviours.

The following case example of a current resident at Wintringham is a real example of the problems we have with ACFI

> *Jason has a very significant brain injury which results in extremely violent outbursts which have seen him oscillate between homelessness and a variety of care facilities all of which have been unable to cope with his behaviours resulting in his eviction.*
>
> *Through setting a strict regime of routines that Jason was comfortable with, Wintringham has successfully provided for his needs within the aged care program and importantly given him a safe home – probably the first time this has happened to Jason.*
>
> *In spite of this apparent success, Jason's temper flairs violently if he perceives that he has been wronged. Usually this will occur if there has been an unintentional change to his routine.*
>
> *On one occasion, when Jason's medication was not provided to him at the agreed time, he became violent and charged our young (female) worker. Terrified, she retreated into a staff room. Jason punched his way through the glass door and was only subdued when the police arrived. Three divisional vans, 7 police and 3 cans of capsicum spray were needed to bring Jason under control. Jason is not the kind of client the aged care industry usually sees.*

> *Upon an internal investigation as to what prompted the outburst, we discovered that Jason had become violent because we had failed to change the clock in his room when day light saving finished, thereby confusing him as to the real time. When Jason's routine was disrupted, he lacked the cognitive ability to see anything other than his rights had been violated.*
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> *Wintringham calls these events "catastrophic" but they can all be managed and usually prevented. By having a routine in place that keeps Jason calm, staff are able to effectively work with him in a relatively safe environment. Jason requires nothing more than a regular routine – but he requires a regular routine for all ADLs, Medication and Complex Health Care needs.*
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> *Under the RCS system, the routines that we developed for Jason were claimable under a wide range of RCS Questions, but under ACFI the only claim that can be made is a 'Low' claim for the one off violent outburst and the claim is only applicable to the ACFI Behavioural Domain.*
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> *It is also worth noting that if, on the other hand, Jason had a mild form of Alzheimers' that presented itself as gentle confusion that required hourly minor prompts from staff, these interventions would be eligible for a 'High' claim under this same domain.*

The RCS system was by no means perfect, but Wintringham was able to make it work for a client group that it was not designed for. We are unable to do this with ACFI – in fact statistical analysis provided to DoHA by Wintringham demonstrates that by the end of next year if there is no resolution to our recurrent funding problems, we will be losing in excess of $2 million per year. This is clearly unsustainable.

There is also the ethical issue of Wintringham agreeing to take some of the most difficult clients in the aged care sector and then being expected to provide for those clients with far less money available that the rest of the industry which studiously avoids such clients.

We understand that the replacement of RCS with ACFI was generally thought to have "zero-sum" implications to DoHA. This being the case and given that Wintringham is now losing money, it is clear that the subsidies that we were able to attract have gone to other non-homeless providers within the sector.

To put the issue quite simply, we want our money back.

We would also caution the PC that any recommended change to ACFI that might solve Wintringham's problems needs to be understood in terms of how the mainstream providers will react. Presumably if there is a loosening of some of the definitions to assist homeless service providers, mainstream providers will similarly make use of these new looser definitions, with subsequent massive budgetry implications for DoHA.

Wintringham would therefore suggest that any resolution to the problems that ACFI presents to homeless services providers be shaped in terms solely of these providers. Homeless service providers such as Wintringham are chronically underfunded compared to mainstream providers. Any redirection of funding to assist homeless service providers should not also flow to mainstream providers whose own problems with funding needs to be addressed as a separate issue.

The amendment of the Aged Care Act (1997) to make "homelessness" a Special Needs Group

A significant start to addressing the fact that the aged care program struggles to provide for the elderly homeless was made in 2010 with an amendment to the Aged Care Act to make homelessness a Special Needs Group, a key component of all Wintringham submissions over the past 15 years.

The aged-care system is clearly designed for mainstream society and not for the elderly homeless population. The typical profile of a resident of a Commonwealth-funded, aged-care residential service is a middle-class, 85-year-old female, with varying degrees of family support. The typical client at Wintringham is a working-class, 65-year-old male, with little or no existing support from family or friends.

> *In one private boarding house, bedding was noticed under a stairwell. The entrance to the stairwell was about a metre square with a small uncovered globe hanging ten centimetres from the 'ceiling' that was about a metre high. It was apparent that someone was sleeping there on a semi-permanent basis. Although the owner denied it, we discovered later that an elderly man was being charged for this 'accommodation'.*

Shortly after the election of the Rudd Government, the Prime Minister announced that a White Paper on Homelessness would be developed, and the Government then proceeded to engage in extensive negotiations with the homeless sector. To the great credit of Ministers Plibersek and Elliot, the White Paper embraced the need to make substantial changes to the way services are accessed by elderly homeless people, and most notably, they announced that the Government would amend the Aged Care Act (1997) to make homelessness a Special Needs Group. It is not overly churlish to add that this was achieved without the support of the aged-care industry.

While the Special Needs category will not solve all of the access problems, we believe it will have an immediate impact in that it will legitimise the right of elderly homeless people to access aged-care services. Importantly, it will also remind policy makers each ACAR funding round that the aged homeless population is a special group that needs to be accounted for in the planning process.

The creation of a Special Needs group for the elderly homeless potentially creates a solution to the perennial problem of a few ACAS teams who show a reluctance to assess homeless clients who are under the age of 65 years.

The Aged Care Assessment Teams

All providers of residential or community based aged care services who wish to receive DoHA funding require clients to be assessed by their regional ACAS teams. As such the ACAS teams act as gatekeepers to the aged care system.

At the time of the formation of Wintringham, we argued successfully that the life experiences of our clients preternaturally age them above their chronological years. Many of Wintringham's clients exhibit health conditions and general frailty of people who would be expected to be considerably older. In this regard, they exhibit some of the characteristics of the more disadvantaged sections of the Koorie population.

Accordingly, Wintringham was assured by the then Minister for Aged Care (Peter Staples) and DoHA that our clients would be eligible to receive DoHA funded aged care services from 50 years of age.

While most ACAS teams have responded positively to having an aged care provider who is prepared to accept referrals of elderly homeless people a fair number of whom have difficult management issues, some assessment teams have resisted referrals from people under 65 years. To these teams, such a person is more properly dealt with via the Disability sector.

This is clearly in contradiction to the wishes of the current Minister and the Department and against the rights of the elderly person themselves. We would ask that the Commission notes the right of homeless people who have aged prematurely, to receive DoHA funded aged care services and that ACAS teams be reminded that age is of itself not a barrier to eligibility. Attached is advice from Minister Elliot.

The role that Housing and Support can play in aged care

The catalyst that drives many of these men and women into night shelters is usually the loss of their housing. In a recent international study that Wintringham co-authored, two-thirds of a newly homeless older population had never been homeless before. The primary antecedent cause was that their accommodation had been sold or was in disrepair, their rent in arrears, the death of a close relative, relationship breakdown, and disputes with other tenants and neighbours. Contributing factors included physical and mental health problems, alcohol abuse, and gambling problems (Crane et al., 2005). The fact is, few elderly residents of night shelters ever "get lucky" and leave for better accommodation.

> *Vivian is an elderly Irish man with Alcohol Related Brain Injury. His ability to look after himself has deteriorated and as a result his accommodations have similarly deteriorated. After being evicted from his privately rented flat, he moved into an inner urban hotel. He then moved to his present*

accommodation in a private boarding house, where his room has periodically been changed as he became less able to assert his rights. His current room is half of a previous bathroom.

The partition wall separating his 'room' from another resident does not reach the ceiling. Vivian most days sits on his bed which is against one wall. From his bed he can reach the opposite wall. There is no window. The only door cannot be opened more than half way and this combined with the lack of space means that a visitor cannot enter the room unless either Vivian gets out of the room first or if he lies on the bed. For food, Vivian relies on the generosity of an intellectually disabled couple who live in a slightly larger room in the same boarding house. He is now too frail to negotiate the steps out onto the street, so cannot either go to the bank or buy food. His bed and mattress are so old and damaged that there is a permanent depression which curls further and appears to envelope anyone sitting on the bed. The fetid smell of the room is completely overpowering even to the most experienced homeless person worker. Throughout the boarding house run unsupervised little children with their voices echoing through the building.

Unlike most aged care providers, Wintringham sees itself as primarily being a housing provider, into which we deliver appropriate aged care services that are matched to the needs of each resident.

It also needs to be stated that the tenants that Wintringham Housing actively seeks out are some of the most disadvantaged elderly people in our community. These tenants generally speaking, are of a different profile to those people living in housing managed by statutory housing authorities of by mainstream community housing providers.

It is the transient lifestyle of our clients who alerted us to the fact that it is the safe and affordable housing that we provide which is the most valued. For many of our clients the housing we provide is the first time for many years that they have a place they can call home. It is difficult to imagine the stress, fear and associated health risks that elderly people are exposed to if they have no place to live. This is clearly in contrast to most elderly people entering mainstream residential aged care who would invariably be transferring from their family home.

The provision of housing to our elderly clients is now seen to be so important to Wintringham that we have created a housing subsidiary, Wintringham Housing Ltd, which has successfully applied to the Victorian Housing Registrar at the Office of Housing to become a Housing Association and therefore eligible for growth funds. We are one of only 9 Housing Associations in Victoria and the only one that is a DoHA registered aged care provider. To date we have approximately 500 older persons units under our management or ownership.

The existence of an extensive housing portfolio combined with extensive Outreach social work teams, and significant CACP and EACH services has assisted us to develop new aged care service models that are based around housing rather than RAC's. We see the housing as an opportunity to redefine "ageing-in-place" as more than simply covering the transition from low to high care. We commence with the provision of housing and delivery of flexible services that will enable the tenant to remain in their housing until death. This is the notion behind our company motto of "A Home Until Stumps".

The housing that the Productivity Commissioner's visited at our Atkins Terrace service in Kensington is one such example. The commonalities of that housing with others under Wintringham's management include the provision of safe and affordable housing, access to personal care and recreation services that are individually targeted, provision of in-house gardening and maintenance services, and importantly, the assistance to help develop a village-like community where tenants support each other.

Wintringham would wish to stress that it is the provision of appropriate support services that enable our housing model to work to the benefit of both the tenant and the community. We reject the common aged care nomenclature of "Independent Housing" believing that all people regardless of where they are living in society, require some level of support. To us the more important issue is to identify what levels of support are required and then how to access that support.

Wintringham draws the distinction between services such as CACP's and the initial identification of the need for services. This latter service is usually performed for elderly people by family members who identify that their mother or father may needs additional support to remain living at home. For homeless clients who have no family to rely upon, it is vital that an outreach support provider can firstly find and win the confidence and trust of a homeless person and then together with their new client identify what types of services are needed, whether that be housing, food, CACP assistance or residential care.

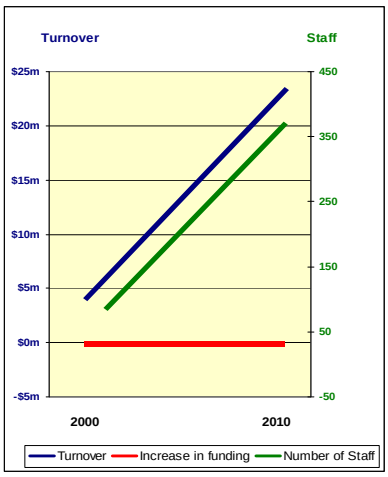
This type of support precedes the actual provision of services and can easily be imagined as seen to be replacing what a family would normally be expected to provide to an elderly parent.

Commonwealth funded aged care support services of this nature do exist and are provided under the excellent Assistance with Care and Housing for the Aged program (ACHA): one of the most innovative and creative programs within the DoHA. While the program has had a substantial impact upon the lives of elderly homeless people, there has been no core funding increase since its inception in 2000 at which time Wintringham was granted two ACHA positions.

During that time Wintringham has grown from what was a reasonably small organisation with an annual turnover of about $4m and a staffing of 80 to a much larger company of $23m turnover and a total staffing profile of approximately 400.

So during the past 10 years we have grown by about 500%.

During that time we have had 0% increase in support funding



Additionally, the level of existing funding is so low that it prevents Wintringham from employing suitably qualified and experienced social workers. The work that is required from these outreach workers is isolated, difficult and at times dangerous and is no place for an inexperienced recently graduated social worker which is all the funding enables an organisation to employ. Wintringham has responded by cross subsidising our current ACHA positions from company funds to enable more experienced workers to be employed.

> *Juliet is a 71 year old woman who was referred to Wintringham by a western suburban housing provider. Juliet lost her long term Office of Housing accommodation in Heidelberg following the death of her husband. She suffers from diabetes type 2, depression, anxiety and claustrophobia.*
>
> *When our ACHA worker met Juliet she had been living in an unregistered rooming house in Yarraville where she had been physically assaulted and sexually harassed by other residents. Juliet was in a highly anxious state and terrified of what would happen to her in the rooming house.*
>
> *Wintringham's ACHA worker was able to secure housing in Essendon and provided interim case management while Juliet waited for a Community Aged Care Package. The Wintringham ACHA program brokered funding to purchase essential items for Juliet such as food, transport and appropriate footwear as recommended by her podiatrist. Juliet also now participates in the recreation activities which were also made possible due to the ACHA program.*

An update on this case study is that Juliet has now been living in her new housing for over a year and has begun to establish connections in her neighbourhood and make friends with neighbours. She is also now a recipient of a Wintringham Community

Aged Care Package which our ACHA worker was successful in securing for her. This package of care ensures that for a relatively low amount of funding, we are able to assist Juliet to remain living as independently as possible.

Importantly, the secure home that she now has and the supports which she receives, have helped her come to terms with the grief following the death of her husband of 45 years that she was feeling when we first made contact with her.

It is clear that Juliet would have either died a homeless woman or been unnecessarily institutionalised if it were not for the intervention of our ACHA worker and the services that she was able to broker.

ACHA is not just a feel good service that throws up stories of how people can transition out of homelessness: ACHA is much more than that. Apart from the positive impact the program has had on Juliet's life, it is a good example of successful public policy. ACHA saves more than lives – it saves public money.

The lack of acknowledgement of the value of providing a relatively inexpensive support program and the quite outstanding value for money that the ACHA program delivers in terms of preventing premature entry to aged residential services or hospital emergency care, is troubling and should be rectified.

We would strongly recommend to the Productivity Commission that the role of Support is recognised and acknowledged for the contribution it makes to the aged care system, and that a program such as ACHA is sufficiently resourced to enable organisations who work with the elderly marginalised, to expand both the range of services they can offer and the numbers of at-risk elderly people they can reach.

Wintringham also recommends that the role of housing is given more emphasis within DoHA and not left exclusively to FaHCSIA. While acknowledging that housing sits within FaHCSIA's responsibility, DoHA should be empowered to broker funds from FaHCSIA for older persons housing, and particularly for those elderly people who are living on statutory incomes who often find it difficult to access housing managed by aged care providers.

We would further argue that this housing be not only reserved for people in financial difficulties, but that a proportion of ACHA and CACP funding be tied to the housing thus ensuring a seamless and cost effective method of providing for elderly people who are at risk of becoming homeless.

Through our service delivery, we see on a daily basis the many benefits that can be achieved if appropriate support is provided in conjunction with housing. One such benefit is the substantial saving to the community through significantly reduced interactions an elderly person would otherwise have with service providers (medical, allied health, police and justice, mental health, crisis accommodation etc) if homeless.

Wintringham has never obtained funding to undertake empirical research on this hypothesis; however our anecdotal evidence suggests that the saving to the community could be up to $100,000 per annum per person after taking into account the capital and recurrent cost of providing housing and support.

> *Ron Conn was a homeless man who accepted an offer to live at Wintringham's Atkins Terrace. Within months Ron was diagnosed with cancer to which he eventually succumbed.*
>
> *During his more than two years of illness, Ron lived entirely at Atkins Terrace, initially receiving simple assistance, through to a Community Aged Care Package and then finally full hospice care delivered to his unit. For two years, as Ron's health progressively deteriorated, he was surrounded by his mates, many of whom would sit in his room all day yarning about the past, and was even reunited with his first girl friend from 40 years ago.*
>
> *Ron eventually died, but spent only his final 2 days in hospital. Wintringham, aided by Ron's indomitable spirit, was able to care for a homeless elderly man simply through being able to provide a home and home-based care. The saving to Ron in not having to endure the misery of hospital or to the community in dollars saved, is significant.*
>
> *Shortly before his death, Ron was told that we would be naming our new nursing home in his honour. It is not inconceivable to think that a significant percentage of the costs associated with building the nursing home were met through savings that Ron provided to the community by remaining "at home".*

Taxation Concessions

Wintringham has for many years proposed that there should be a review of the not-for-profit tax concessions enjoyed by the majority of aged-care organisations, which are in direct competition with for-profit businesses in seeking high bond paying clients and providing Extra Service Beds.

Tax concessions are in the main an inducement to the market to enter into an otherwise unprofitable sector. Economists argue that without appropriate tax concessions, business entities working in unprofitable areas cannot generate sufficient surpluses to stay viable.

Thus, tax concessions are in principle targeted at those organisations working with client groups that mainstream business would be unable to provide for. It is clear that many aged-care organisations that receive tax concessions are not working with difficult client groups requiring special services, but are in fact working in mainstream Australian society, competing directly with for-profit business.

We have argued that Commonwealth aged-care capital and recurrent subsidies should be set at a sufficient rate to enable the industry to meet public demand for its services, and that these subsidies should be entirely independent of tax concessions.

Further, Wintringham believes that the granting of tax concessions be reserved for those welfare organisations that work with disadvantaged or handicapped people, whose needs are not being met by mainstream private or welfare organisations. Wintringham has consistently advocated over a number of years that the Government review the current generous tax concessions awarded to not-for-profit organisations, with the intention of developing a graded, concessional taxation system aimed at benefiting those organisations that work with the disadvantaged members of society.

Exit point: a pathway out of homelessness

Wintringham has been able to demonstrate that if services are carefully thought out and designed, and if they are adequately resourced and maintained, it is possible to provide a permanent exit point to homelessness, and that this outcome can be almost universally achieved. This is an outstanding statement but a realistic one. Wintringham endeavours to provide “A Home Until Stumps”: from the time an outreach worker makes contact with an elderly homeless man or woman, we can provide a pathway from the streets into housing (which preferably we own or manage), into which we can begin to provide appropriate levels of community care and support that are packaged according to the needs of each individual person, through to full residential care in one of our Low or High Care Facilities if required.

In spite of initial concerns from the Commonwealth at the time of the formation of Wintringham in 1989, we have almost zero instances of aged homeless people voluntarily leaving our services. In spite of providing for a wide range of people, some with severe brain injury, we find that beneath their sometimes fiercely independent nature, nearly all of our clients are capable of distinguishing between the services we can offer and life on the streets. In the jargon of the market, they are rational consumers. It is important to note that this exit point is not just for the very frail who are physically unable to return to their previous life style, but includes our younger aged clients who are in receipt of either housing or community aged-care services, or both. Many of these clients still struggle with a variety of addictions or disabilities, yet are able to be maintained in stable and permanent housing, and continue to choose to receive these services.

Conclusion

In conclusion, Wintringham would ask that the Commissioners, when reviewing the aged care industry and arriving at suitable recommendations as to how it can better meet the needs of Australia’s rapidly ageing population, constantly bear in mind how

these proposed changes may impact on the most vulnerable of elderly Australians: the homeless.

While we do not ask for a new Aged Care Act that would concentrate exclusively on the homeless, we do ask that when recommending policy initiatives Commissioners constantly ask themselves “are there possible unintended consequences on the homeless” of these changes?

If the introduction of the Aged Care Reforms of 1997 with the abolition of Variable Capital Funding, and the introduction of ACFI in 2009 have taught us anything, it is that well intentioned policy initiatives designed to positively impact on the aged care industry as a whole, can have a devastating impact on the homeless.

Bryan Lipmann, AM
Chief Executive Officer
Wintringham

SUMMARY OF RECOMMENDATIONS

- That the Productivity Commission be aware of the current inequities in the Aged Care system and the difficulties the elderly homeless face in accessing entry to the system.

- That the Productivity Commission considers the impact upon the elderly homeless of any policy recommendations it may make to Government.

- That the Productivity Commission reaffirm the right of the elderly homeless to access DoHA funded services, particularly through the removal of impediments to entry within the practices of some ACAS teams

- That the Productivity Commission recognise that the primary impediment to the further development of services to the homeless is financial. To that end Wintringham recommends

    - That a capital funding pool is established solely for the purpose of resourcing organisations who undertake to provide aged care places to a minimum of 80% homeless men and women.
    - That a recurrent subsidy mechanism is developed to supplement ACFI to ensure that the elderly homeless at least the same level of funding as mainstream clients.

- That the goals set within the Road Home White Paper of halving homelessness by 2020 are addressed through successive ACAR funding rounds and that the Special Needs category for homelessness is used to establish appropriate funding pools to realise those goals

- That DoHA enter negotiations with FaHCSIA to create an allocation of all new social housing stock to be reserved for older people and that DoHA undertakes to attach support packages to this housing stock

- That the ACHA program be expanded and that the level of remuneration for ACHA workers be set at a level that is commensurate with the skills required for the job.

- That the Productivity Commission investigates the taxation benefits that the not for profit aged care industry enjoys, to ascertain whether these benefits are advantaging the most disadvantaged elderly.

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