Wintringham

Productivity Commission: Caring for Older Australians

Post Draft submission

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Wintringham

This Post draft Submission from Wintringham should be read in conjunction with our original Submission to the Commission (#195 dated 30/7/2010).

As with our previous Submission, comments in this post draft Submission will be confined to aspects of the Draft report that relate or impact on services to elderly homeless people and will not address industry-wide issues which will be more appropriately covered by our peak body (ACCV) or mainstream providers.

Wintringham has taken every opportunity to stress both publicly and in private conversation with the Commission that our contribution to the debate on the future of the aged care industry is predicated solely on the social justice vision that older homeless people are entitled to aged care services.

While we acknowledge that the Aged Care program was not initially designed to meet the needs of the homeless, we believe that with some relatively small changes that will not dramatically impact on the overall aged care budget, the program can continue to deliver quality services to the aged homeless.

Wintringham would wish to acknowledge that the Productivity Commission has heard the concerns we and others raised in relation to the draft recommendation that the minimum accommodation standards for Supported Residents would be considerably lower than for mainstream aged care clients. We congratulate the Commission for abandoning that draft recommendation and would urge them to similarly review other aspects of their Draft which have the potential to negatively impact on the elderly homeless.

The particular issues that Wintringham would seek to comment on are as follows:

1. **<u>The particular problems facing Wintringham</u>**

We would ask that the Productivity Commission takes note of the particular problems facing Wintringham.

While there are a small number of organisations providing care to the homeless, generally they are either stand alone services with one registered aged care facility, or are part of a larger welfare agency that has the capacity to cross subsidise losses incurred in the homeless service.

Wintringham fits neither of those classifications. We are probably the largest provider of aged care and housing to the elderly homeless in Australia that is under the one

management structure. Additionally, we are a specialist service with no capacity to cross subsidise from other unrelated welfare activities.

Despite the fact that we work with some of Australia's poorest and most disadvantaged clients who frequently present with the most complex (and costly) behaviours, our business model in past years was sufficiently robust to enable us to grow to the size we are today, which is reflective also on the significant demand for services to the elderly poor.

It is a reasonable proposition to say that it has been Wintringham's business acumen which has enabled it to prosper. So saying, however, our limited funding stream means that changes in Aged Care policy which eventually leads to changes in our income, can easily threaten the viability of our organisation. An example of this is the recent changes to the Residential Aged Care funding instrument. As a result of this change, we estimate that we will lose income in excess of $1.5 million per year. We calculate that this represents a 26% loss of our Care Subsidy Income. There is little we can do to cover such a large loss that does not lead to such a marked reduction in services that residents would neither receive quality care nor be tempted to enter one of our facilities. In simple terms, this loss, if not addressed, will force our residential aged care facilities to close.

2. **Recurrent funding – ACFI**

Our concerns with the ACFI are well documented. In summary, our simple position is that we were able to develop and maintain residential aged care services to homeless clients within the RCS system, but are unable to do so within ACFI.

The essential reason for this is that while ACFI appears to satisfactorily cover the costs associated with caring for a resident with Dementia, the behavioural domain does not sufficiently recognise the needs of a resident with behavioural problems associated with brain injury.

A real life example of the inequities of the ACFI system is an elderly woman who is a parent of one of our staff who has dementia related to a series of strokes. She continually and gently touches you with a rapid fire reflex action when you visit. This reflex flickering touch which is mildly annoying and causes no pain to the receiver is classified as Constantly Physically Agitated and results in a D claim in ACFI 9 (Physical Behaviour). Similarly she will constantly murmur and ask to be left alone and is therefore resistant to any ADL care offered. As a result she scores a D on ACFI 8 (Verbal Behaviour – Refusal of Care).

The gentle but repeated actions of this woman can be compared to Mr X who recently erupted in a violent outburst at our Dandenong facility breaking six floor to ceiling pane glass windows after charging them with a large fire extinguisher, terrorising both staff and residents who were inside the room escaping his previous violence. Police arrived in three vans and used half a dozen tins of Capsicum Spray to subdue the man who was then handcuffed to a hospital bed until he calmed down. In spite of this extreme violence, an episode of this nature when it is a once-off incident is not able to be claimed under ACFI.

Clearly, ACFI recognises the more common behavioural issues associated with Dementia but fails to accommodate other behavioural problems such as those linked to a brain injury.

As was stated in our original Submission:

> *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.*

I would repeat, we are not attempting to gain a financial windfall from the introduction or review of ACFI. We simply want to maintain the level of funding that was available under the RCS system.

Wintringham has worked cooperatively with DoHA to try to find a solution to the ACFI problem and wishes to acknowledge the work of the central office in trying to find a solution. **We would however now wish to propose that the designer of the ACFI, Professor Richard Rosewarne, be engaged by the Productivity Commission to further investigate the problem with a view to finding a solution to the negative and unintended impact that ACFI is having on our recurrent income and consequent viability.**

3. **Block Funding**

We note in the Draft Report that the Productivity Commission has suggested that a Block Funding response may be needed for rural and remote services that are facing financial difficulties.

Wintringham would suggest that the financial problems associated with building and managing services for the elderly homeless are sufficiently complex to similarly warrant such a block funding approach.

Alternatively, thought should be given to removing organisations such as Wintringham from the mainstream aged care program, and contracting with them for a fixed fee, to develop and manage services to the elderly homeless.

4. **ACAS**

A matter of increasing concern to Wintringham is the apparent change in approach from some Aged Care Assessment Services who are adopting a "gatekeeping" role when

addressing whether a prematurely aged homeless person should be assessed for Commonwealth funded aged care services.

When Wintringham was established in the 1980's, the then Minister for Aged Care, Peter Staples, agreed with our observation that homeless people aged prematurely, and that as a result, clients of Wintringham aged care services could be aged 50 years and above. This has remained our policy in the intervening 21 years.

Although there periodically have been problems with individual ACAS workers with this policy, generally Wintringham has been seen by ACAS teams as presenting a solution to one of their major problems: that being what to do with prematurely aged people with behavioural problems which the aged care industry is generally extremely reluctant to provide services to.

More recently however, we have experienced problems with ACAS teams who appear to have taken on a 'gatekeeping' role which suggests that people under 70 years of age should not be referred to aged care services. As this interpretation clearly disadvantages the elderly poor and homeless who prematurely age, I raised the issue with the previous Minister who provided me with a letter validating our approach. This letter was attached to our original Submission to the Productivity Commission.

Of particular concern to Wintringham is our new facility in Dandenong, the Eunice Seddon Home. This facility was built in Dandenong largely because DoHA's Melbourne office advised that this is one of the most disadvantaged areas in Melbourne for elderly people. This was validated both by the evidence we provided at tender and then in the acceptance of our tender at the DoHA ACAR.

Subsequent to the opening of this facility, we are finding it extremely difficult to obtain low care referrals from ACAS despite the great need in the area. Anecdotally, other local providers report that, in spite of many attempts, some local ACAS teams are refusing to assess what we believe are eligible clients. ACAS teams advise that these referrals, on the evidence presented, are inappropriate. We understand that some ACAS teams are now saying they will only assess a 'younger' client (that is under 70 years of age) if the Disability Services division of the State Department of Human Services have assessed the potential client and feel a referral to ACAS is appropriate.

In spite of extensive evidence that there is a substantial number of elderly people in need of low care accommodation, evidence that is substantiated by anecdotal reports, local census figures and our own outreach workers, very few people under 70 are being assessed.

It is worth noting that during the first 15 years of Wintringham's growth, we had extensive waiting lists for all of our residential services. Since that time, in spite of a massive increase in the aged population and a consequent increase in the elderly homeless (the recent Census highlighted that 18,000 people over the age of 50 are homeless in Australia), and no new beds coming on line, we now experiencing vacancies at all of our sites. Our conversations with other homeless aged care providers in Melbourne support this

observation. So if the numbers of homeless are increasing yet we are all experiencing vacancies, the problem clearly lies with the process of gaining admission.

In fairness to the local ACAS team, it is clear that for many of these referrals, the paper work from non-aged care providers such as homeless service organisations, has often not correctly been completed which probably explains the higher success rate when applications are completed with the assistance of trained Wintringham workers. It is apparent therefore that local homeless or housing workers are struggling to correctly complete the referral forms, but it is also saying that the some ACAS teams are taking a very legalistic view as to eligibility and that, for some, it is the process itself that is forming the barrier to access rather than an impartial assessment of care needs. On this basis, I think that the concern of Wintringham workers that local housing and homeless services have simply given up making referrals to ACAS teams has some substance.

A simple solution would appear to be the creation of a national, uniform referral form which contains a tick box section to indicate when the client being referred is under the age of 70yrs but has aged related care needs associated with an impoverished lifestyle (ie those who are homeless or at risk of homelessness). ACAS teams could then be instructed that such applications were mandatory assessments and further could be included in their service targets. This type of response provides a clear instruction to ACAS teams that people under 70 are eligible for aged care services if there is evidence of premature ageing, also, this knowledge could easily be widely disseminated to appropriate referral sources.

5. **Market approach to Aged Care requires safeguards**

It is apparent from the Draft Report that the Productivity Commission has taken a market based approach to reforming the aged care industry. In this respect it has followed similar principles as adopted by the Hogan Review which Wintringham was on the Advisory Committee for.

While Wintringham can accept that such a market based approach is required for the industry as a whole, we would like to express our concern which we similarly voiced to Warren Hogan, that a purely market driven approach requires significant safeguards in order to protect players that cannot equally compete within the market.

We would argue that the elderly homeless are such a group. It is clearly impossible for the homeless to compete equally with the rest of society. With no ability to pay Accommodation Bonds or to meet daily accommodation charges or personal expenses that typical aged care clients or their families can readily bear, a pure market based approach will result in a positive disincentive to providers contemplating the provision of care to the homeless.

While we acknowledge that any distortion of the market should be kept to a minimum, we do ask that the Commissioners acknowledge that providers such as Wintringham cannot

provide for the homeless without access to funds that equate to the revenue and capital received by mainstream providers.

6. The Elderly Homeless are a Special Needs Group

While it is acknowledged that the Productivity Commission was very generous in the time that Commissioners spent at Wintringham visiting our services and chatting to our clients, a reading of the Draft would indicate that they do not as yet have a full understanding of the issues associated with service delivery to the elderly homeless.

The elderly homeless are much more than just a subset of Supported Residents and as a result require different policy responses to address the complexities of their special needs. This was recognised by the Rudd Government when it included the Homeless as a Special Needs Group within the Aged Care Act.

The Aged Care Act and consequent funding program is designed around the needs of someone similar to my late mother who had family support, was receptive to services and was fortunate enough to have a retirement income sufficient to secure high quality aged care services.

The aged care program is not designed to meet the needs of a financially destitute prematurely aged homeless male who has no family or supports, is likely to have a substance abuse problem, and is generally resistant to services.

While a great deal can be written about the differences between two such diverse users of the aged care system, it is clear that in terms of principles of universal access to care, the inability of the aged homeless to provide anything other than their pension, severely inhibits their access to care. This is an important point because if the homeless are seen to be just another subset of Supported Residents, there is a risk that it will be inferred that there is a similar financial cost associated with the care of homeless people as compared to other Supported Residents.

This is generally not the case. Supported Residents are seen to be those people who cannot pay an Accommodation Bond, but there are levels of poverty considerably below this simple definition. There are large numbers of Supported Residents, who in spite of their relative poverty, can enjoy the continued support of family and friends, and can be seen to be quite genteel compared to the many behavioural problems associated with some of the homeless.

The issue of family support is worth noting from at least a financial perspective. A Supported Resident who has such support can be expected to enjoy a range of services including being accompanied to doctors appointments by a daughter or son, the purchase of clothing and personal incidentals and funding of recreational activities to name just a few. Wintringham staff report that for most of our clients none of these supports are available which results in

paid staff being required to perform all the unpaid functions that family would normally provide, including the payment of all incidentals.

These costs are estimated to average out across our services at least $5 a day per resident and as such presents a further disincentive for other players in the market to provide for the homeless. This cost is not part of the Productivity Commission analysis but it should be considered as an example of how our clients differ from mainstream Supported Residents.

We would ask that the Productivity Commission turn their attention to the various aspects of the financial viability of providing care to Supported Residents who are homeless.

7. Capital Funding

The Draft Report is silent on Capital Funding for homeless services yet it is clear that homeless people are unable to pay any Accommodation Bond, no matter how small. Certainly the ability to pay in excess of a $1m Bond as is often the case in mainstream services, is to a homeless service provider a notion so far removed from reality as to be absurd.

What is needed is the creation of a limited capital pool that is ring-fenced around the needs of the homeless, much as was established in a small way with the commitment to capitally fund four services for the elderly homeless that was contained in the White Paper on Homelessness “The Road Home”.

Alternative suggestions that a low interest or interest free loan be provided would not be a realistic option for Wintringham. The absolute poverty of our clients means that Wintringham is unable to borrow and service a major loan. As observed in Point 1 above, additional expenses associated with providing for isolated people who lack any family support, further precludes our ability to service loans.

It has also been occasionally suggested that organisations such as Wintringham should broaden its client base to enable richer residents to cross subsidise its traditional homeless clients. Wintringham has experimented with this model of care at our Williamstown service, and while it has been successful, we would argue that the unique cultural environment of homelessness requires a range of options including specialised services such as those we operate at our remaining residential facilities.

Our existing model works and creates a community where the recidivism of people back into homelessness is almost nil. As such we have created a permanent solution to homelessness for the elderly, an accomplishment which has been internationally recognised. We are therefore keen not to change that model of care simply to accommodate a new funding paradigm.

8. **Trading of Supported Residents**

It was noted in Point 6 above that some policy initiatives addressed at providing for Supported Residents may not be relevant to the Homeless, and may unintentionally create further problems.

The Draft Report recommendation that a Trading Scheme for Supported Residents should be established is a case in point. While it is unclear in some of the specifics of how such a scheme would work, the suggestion clearly has the potential to greatly impact on services to the homeless.

It is not spelt out in the Draft Report, but we presume that the scheme would probably be similar to a Carbon Trading Scheme – which is also a Market based response to a community problem.

A major concern for Wintringham would be how the mechanism would be established to set the price for these places. In the absence of further information we presume that the price would probably be set by the lowest offer based on what it costs to deliver services to a (non-homeless) Supported Resident.

A possible scenario is that an organisation wishing to have no Supported Residents would offer their allocation of Supported Residential (SR) places to an alternative provider who was prepared to provide for SR clients for a hypothetical fee of say $600.

The disadvantage for the homeless however is that an organisation like Wintringham which specialises in homeless SR would say that the cost of service delivery is higher to brain injured behaviorally challenging homeless people and we would require say $1000 per resident which is clearly over the market price. Presumably no one will pay that price.

Again this demonstrates that a purely market driven response fails to take into account the special nature of complex problems associated with services to the homeless. We would suggest that if a Trading Scheme for Supported Residents is adopted, that thought be given to the creation of a mechanism whereby the market determined the base price but that the Government underwrites the additional cost assumed in the provision of care to people with special needs.

9. **Facilitate action on White Paper re improved access to aged care services**

The Rudd Government released a White Paper on Homelessness “The Road Home” which was the first White Paper of their administration and the first White Paper on homelessness in Australia’s history.

Of significance to the Productivity Commission was the inclusion in the White Paper of matters relating to the elderly homeless and their interaction with the Commonwealth Aged Care program. This information was largely sourced from Wintringham and our services were used as a case example of how homelessness and aged care can interact.

A central feature of the White Paper was its efforts to ensure that homeless people were able to access mainstream services. While there is some debate about the efficacy of such an approach, Wintringham argued that while we agreed with encouraging mainstream services to provide for homeless people, we felt strongly that specialist service providers should be able to access mainstream funding sources to supply appropriate services.

We would urge the Productivity Commission to approach the reform of the aged care industry with a view that reflects the aims of the White Paper in that they do not create unintentional blockages for the homeless to access care they are entitled to.

The Aged Care program does not need to be redesigned just to meet the needs of the homeless, but sufficient attention does need to be paid to ensure that some of the poorest and most disadvantaged in our community receive appropriate care.