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Ms. J. Thomson
Senior Research Officer
Senate Finance & Public Administration Committee
SG.60.
Parliament House.
Canberra. ACT. 2600.

Via E-Mail: Jane.Thomson@aph.gov.au

23rd March 2009

Dear Ms. Thomson,

**Re: Request for further information from the Senate Committee investigating funding, planning, allocation, capital and equity of residential and community aged care in Australia**

At the public hearing on 20th February, Ms Helen Small and myself presented information additional to our previously submitted written evidence relating to some of the difficulties that Wintringham faces in providing quality residential or community based aged care services to older homeless people.

This present submission is in response to a Question on Notice to Wintringham in which we were invited to provide supplementary information relating to specific issues effecting the provision of services to older homeless people, and in particular the method in which recurrent funding is determined and how it impacts on our client group.

We would firstly reiterate the fact that the Aged Care Act is primarily intended to meet the needs of an aged client who typically is an 85 year old female from the middle classes who receives some level of support from her family. In no way do we wish that statement to be seen in any pejorative sense, but simply as a descriptor of many of the recipients of aged care services.

Wintringham clients on the other hand are more likely to be 50-65 years of age, from a working class background and who have little or no family or friends providing support. Additionally, many of our clients, in part because of their homeless lifestyle, have significant behavioural problems some of which have arisen as a result of an alcohol related brain injury. In

consequence, many exhibit unrestrained behaviour resulting from a lessening or loss of inhibitions or a disregard of cultural constraints.[1] These behaviours have very little in common with dementias such as Alzheimers and present very different and difficult care issues for our staff.

In addition, it has been demonstrated that homeless populations have a higher rate of serious morbidity and premature mortality compared to the general population, with westernised countries reporting an average age of death between 42 and 52 years [2]. For this reason, Wintringham has long advocated that homeless people over 50 years should be eligible to receive aged care services and in a recent written statement Minister Justine Elliot restated that right.

Finally, the complete lack of social support, which is the lot of many of our clients, creates additional pressures on support services to take on tasks that would usually fall to family and friends.

When referring to the special needs of the older homeless, we are referring to these four key factors:

- inadequate or inappropriate housing
- normal conditions related to ageing experienced at a younger age,
- unrestrained behaviour linked to mental health illness and/or dementias associated with brain injury caused by alcohol abuse
- social isolation or lack of any form of social support.

The importance of understanding this clear distinction, between mainstream aged care recipients and those elderly homeless people who receive care from Wintringham, cannot be overemphasised. In almost every aspect of the Aged Care Act, it is apparent that there are significant problems or issues that have to be faced if dealing with a client group that is so manifestly different.

Of all the different issues that Wintringham faces in trying to provide care for elderly homeless people within the confines of the Aged Care Act, the most pressing problem is the way that recurrent **residential care subsidies** are calculated.

Unlike a simple and non-targeted per bed payment, aged care recurrent subsidies are paid to providers on a multi-level system which is closely monitored and audited by the Department. Providers must demonstrate that they are providing appropriate levels of service to address what is potentially a wide range of client needs. It is also important to note that these various needs are categorised by the Department in a sliding funding reimbursement formula that requires providers to demonstrate appropriate care responses and rigorous documentation.

It is apparent that these range needs and range of expected responses reflect the profile of a typical mainstream elderly person and the expectations of their family and community. They do not reflect the more independent and isolated lifestyle of the homeless.

To reduce the issue down to a simple comparison: the expectations of a typical family is that their elderly parent in residential or community care will receive services as and when required,

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[1] 2008 Report to the Minister for Ageing on Residential Care and People with Psychogeriatric Disorders.
[2] World Health Organisation – Europe, Health Evidence Network (2005) How can health care systems effectively deal with the major health care needs of homeless people?

and that they have the right to directly lobby or query management if the care is not satisfactory. The elderly homeless on the other hand have very little or no expectation of services, are reluctant to compromise their independence, usually have no one to lobby on their behalf, and are invariably fearful of any consequences if they do complain. Additionally, many of them will exhibit behavioural characteristics that any mainstream or generic recurrent instrument will struggle to accommodate.

In short our clients want less but need more, whereas for many clients in the aged care system perhaps the reverse is a more accurate description.

Designers of a recurrent funding instrument therefore have a huge task in designing a system that is generic enough to accommodate the vast bulk of the elderly people who will be using it, and still be flexible enough to address the needs of the elderly homeless.

It is Wintringham's submission that the previous recurrent funding instrument, the RCS, did allow for an appropriate level of flexibility, but that the new ACFI in its current form, does not.

The cause of the financial discrepancy between the RCS and ACFI is not necessarily the care categories or the process required to demonstrate appropriate levels of care provided, but lies instead in the weightings and resultant dollar values attributed to the various categories. While the Department has maintained that the total dollar value of the national recurrent subsidies under the new ACFI regime will be the same as RCS, Wintringham can see a clear and demonstrable reallocation away from the care issues associated with homeless clients. We can notice a diminution of recurrent funding in excess of 30% - a figure which is clearly unsustainable for Wintringham.

A report from the designer of the ACFI, Dr Richard Rosewarne, concluded that:

"What is clear is that the type of resident supported at Wintringham is highly atypical of the general residential aged care population in both low and high care".

While it needs to be acknowledged that the Department is working with Wintringham to further investigate this issue and hopefully to resolve it, I would ask that the Senators take note of the crisis that Wintringham faces as a result of the introduction of ACFI. Regardless of whether ACFI works well for the industry as a whole or not, the point we would make is that it is not suited to delivering services to the elderly homeless.

The issue then arises: what is the appropriate method to ensure that ACFI can be used by both the Department and Wintringham to ensure that services are provided to homeless elderly people in a manner which enables Wintringham to remain financially viable?

Wintringham would certainly not argue that ACFI should be substantially changed to enable a relatively small section of the residential aged care community to be accommodated. The system was designed to meet the needs of both the Department and the industry and if it is seen to be doing that, we would not argue for changes on our behalf.

We would alternatively argue that a way needs to be found to make ACFI work for the homeless, and it would appear to us that the simplest and most effective way of introducing an alternative is to create a "Homeless Supplement" that would be added to the ACFI.

The Rudd Government has recently announced as part of its White Paper on Homelessness, "The Road Home", that they will amend the Aged Care Act to include homelessness as a Special Needs category. The recognition by the Government that aged care services working with the homeless encounter difficulties not experienced by the aged care industry as a whole, is justification for the creation of a "Homeless Supplement" as a means of ensuring that ACFI can be made viable for Wintringham.

Wintringham would not be seeking to make a profit from such a supplement but would be asking instead that the value of the supplement be the equivalent of the difference between the indexed value of funding received from the RCS as at 2008 and the value of funding under ACFI. The purpose of a "Homeless Supplement" would solely be to ensure that Wintringham was not disadvantaged by the introduction of ACFI.

We would ask that the Senate Committee recommend that organisations who provide residential services to the elderly homeless, such as Wintringham, are not disadvantaged by the introduction of ACFI and that a Homeless Supplement be introduced to ensure that any funding loss arising from ACFI is recouped.

The actual dollar amount of that Homeless Supplement will need to be worked out with the understanding that the value of the supplement should be the difference between earnings from ACFI and those under the previous RCS. These figures are still being compiled but it would appear after nearly 12 months of operation that the figure is approximately $25 per resident per day to cover a loss of about 30% funding.

With regard to **community care**, although funding is not ACFI related, the recurrent funding process encounters the same problems for homeless service providers as it does for residential care.

The recurrent funding tool seeks to provide funding for community based services in the Extended Aged Care in the Home (EACH), EACH Dementia and Community Aged Care Package (CACP) programs, but as is the case with residential care, the funding tool for community care is not sufficient to cover the additional needs of homeless and isolated older men and women.

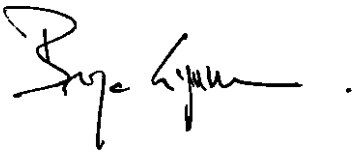
Homeless elderly people are particularly vulnerable in a community setting. Not only do they have to worry about the constant threat of violence or theft in many of the temporary accommodation settings they find themselves in, but they entirely lack the funds to purchase basic requirements. For our CACP workers, finding the resources to provide for even the most basic necessities such as sheets or linen, basic cooking implements or even the staff time to protect and advocate for their residents in disputes, presents a constant problem.

In fact, it can well be argued that the recurrent subsidy gap in community care is more significant than it is in residential care, if for no other reason than residents in care are both physically safe and receive normal necessities and basic luxuries, whereas in the community homeless clients are invariably isolated and extremely vulnerable.

We would argue that the identified 30% gap in residential recurrent funding is replicated in community care and that as a result an appropriate Homeless Supplement should be paid (only) to those community care providers who work with the elderly homeless.

Should you require any further information or clarification on any item discussed above, please do not hesitate to contact me

Yours sincerely



Bryan Lipmann, AM
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