Wintringham

Head Office
136 Mt Alexander Road
PO Box 193
Flemington Victoria 3031

T 03 9376 1122
F 03 9376 8138
E admin@wintringham.org.au
I www.wintringham.org.au

ACN 007 293 478

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The Secretary
Senate Finance and Public Administration Committee
PO Box 6100
Parliament House
Canberra ACT 2600

To Whom It May Concern:

Re: Inquiry into funding, planning, allocation, capital and equity of residential and community aged care in Australia

The sole purpose of the establishment of Wintringham was to enable homeless elderly people access to aged care services that the rest of the community takes for granted. Nineteen years later, our focus has not changed. We actively seek out the disadvantaged, the homeless, those living in caravan parks, boarding houses or at risk accommodation. We have developed expertise in providing appropriate care for clients with difficult behaviours and those who are socially marginalized. As a result, Wintringham has developed a reputation as a provider who can meet the needs of each individual client, even on occasions when other service providers have been unsuccessful or unwilling to provide care.

The issues facing the aged and homelessness can only be addressed through the aged care system. Homeless services are not able to provide long-term, viable solutions. The aged care system, however, is mostly focused on meeting the needs of mainstream society and in particular middle-class women, with family support, aged in their late 70's and above. While a series of Governments, Ministers and associated staff have been extremely helpful to Wintringham, the fact remains that the aged care system must bend to meet the needs of the elderly homeless. As such, the problems we face are not necessarily those of the industry as a whole.

We are the organisation of choice for those who are financially and/or socially disadvantaged. However, the majority of our clients do not easily sit under the tag "socially and/or financially disadvantaged". Many are in fact destitute and many marginalised and isolated. As such, they have few resources at hand to assist them purchase the provision of aged care services. In these terms purchases are not just limited by financial means. There are those, for example, without accommodation resources. It is very difficult to supply a Community Aged Care Package (CACP) to a client of "no fixed address". Alternately there are others who do not have the ability or anyone to support them through a complex health system to receive appropriate referrals. Many of our clients have not seen a GP in years, their first contact with Aged Care Services is often during hospitalisation following an emergency admission.

Our greatest concern, however, is the lack of any sorts of social support systems. Many of our clients have neither friends nor family. In these cases, the entire "burden of care" falls to the aged care provider and staff. Aged care funding is simply insufficient to meet the cost of providing this level of care to a significant number of clients. As a result, aged care services providing for the older homeless face higher operating costs to be met with a lower income than mainstream service providers. This is an unintended consequence arising out of the rigidity of aged care funding. It equally applies to capital funding, where services such as Wintringham, struggle to build much needed new facilities without any significant number of accommodation bonds to meet the high capital costs.

We write with regards to the current inquiry into Aged Care in Australia. In particular, we are concerned that:

a. in many instances current funding levels are insufficient to meet client care needs;

b. the current indexation formula is inappropriate when used to assess the actual cost of pricing aged care services to meet the expected level and quality of such services;

c. there is an inequity in the notion of a user pays system which sees many of those poorer members of our community left unable to "purchase" adequate care from our aged care system.

d. we are unable to fund new capital developments

CURRENT FUNDING – COMMUNITY AND RESIDENTIAL CARE

Aged care funding is provided in distinct silos. Funds are limited to specific amounts dependent on care recipients meeting certain, established funding criteria.

A prospective care recipient's access to services and therefore access to funding is determined by the Aged Care Assessment Service (ACAS). ACAS are the sole source of referral into aged care programs, each team operates slightly differently to the other, teams determine the service level required by the prospective care recipient and make the appropriate recommendation.

There is no direct, apparent link, however, between the criteria the ACAS teams use for their assessment, ACFI assessments and the siloed funding linked to each assessment and made available to provide appropriate care. We have repeatedly found that a client's care needs are far more complex and so - far higher and more expensive to provide than their assessed funding level. In other words, while we agree that the client meets the assessment criteria and they have been correctly assessed as per the ACAS guidelines, we have many clients:

- who enter residential care under a Low Level Care Assessment and then are immediately classified under ACFI as requiring a High level of care
- who enter our CACPs service with multiple care needs (strictly speaking these needs do fit into the CACP criteria) but the funding to provide care to meet wide ranging client care needs does not exist in this program
- who are discharged from hospital to our high care facility (with a high care assessment) but also with very high level care needs which again cannot be met by the highest ACFI funding. It could be argued that these clients would fit into a much higher care category than any currently in operation.
- similarly those who we admit to our EACHD program, who are safe to remain in the community provided they obtain help to dress and undress, wash or shower, supervision to eat their meals and medication management on a daily basis. Again, funding cannot stretch to cover this level of care.

It seems that many clients referred to care are presenting with increasingly complex care needs and greater acuity of care in each ACAS and funding referral category (ie CACPs, EACH, EACHD, High or Low Residential Care). In addition, each referral category has a funding limit which many clients exceed on admission. This does not start to take into account the clients already on the program whose care needs gradually grow higher and higher.

Case Study:

Mr B was recently diagnosed with terminal cancer. He has lived in one of our mixed care facilities (formerly called a Hostel) for many years and wishes to remain there until he dies. Mr B required monitoring on a 15 minute basis during waking hours and every hour overnight. He required help with all ADLs. He had a PEG tube in situ, but continued to choose to eat by mouth and needed constant supervision to ensure his safety during mealtimes. In addition, Mr B had hospital appointments on an almost daily basis. A staff member was required to accompany Mr B to all appointments, wait with him while treatment was obtained and then accompany him back to the facility. Overall, Mr B consumed up to 6 hours of one to one staff care each day for the last

months of his life. There is no level of funding available under ACFI that can cover this level of care. Mr B died in hospital last night (17/11/08).

We hope that consideration could be given to a review of current funding categories:

- **that a CACPs PLUS funding category be created to meet the needs of CACPs clients requiring a higher level of service**
- **that an EACH and EACHD PLUS category be created to meet the needs of EACH and EACHD clients requiring a higher level of service**
- **that the three ACFI domains and resulting ACFI categories be extended to acknowledge the higher care needs of some extremely complex clients**

Of special concern to us is the ceiling on funding available to provide care to those with difficult behaviours. We pride ourselves on our ability to manage those who other providers have found too hard, but the maximium residential ACFI funding is currently $29.17 per day for residents who meet the criteria applicable for 'the highest level behavioural care needs'. This small level of funding makes it difficult to purchase specialist opinion that is of benefit when providing care. For example, a neuropsychiatric report can cost anything from $650 to $2,000. This equates to 22 to 68 days of total funding just for this purpose. This low level funding also makes it extremely difficult to meet individual care needs.

Case Study

Case One: Ms A

Ms. A is a resident at our high care facility. Ms. A came to us from an alternate service provider. She has been diagnosed with Bi-Polar Disorder which is poorly controlled by medication. Her medication regime has been reviewed on numerous occasions – we are assured that the current treatment provides the best possible option with regards to meeting her care needs. During her "highs" Ms. A continually seeks out staff to take her out shopping. She will come along our corridor, loudly calling to all. If she is ignored she simply gets louder. During her "high" periods Ms. A also continually seeks food. We have provided behavioural management training to all our kitchen staff and administration staff as it is these staff members that Ms A targets with her behaviour. Again, the most successful option when trying to help meet Ms A's care needs is one to one intervention by staff for extensive periods of time. Ms A's funding, however, is not sufficient to cover this type of care to the level and extent required by Ms A. As a result, our High Care Manager has often devoted whole afternoons to Ms A and completed site work out of hours at home. We recognise that this is neither a good use of our resources or a fair workload for our Manager.

Case Two: Ms B

Ms B. was admitted to our High Care facility in May this year. She has been diagnosed with an Alcohol Related Brain Injury (ARBI) as a result of excessive drinking over a period of time. While in community care it was not possible to monitor or limit her drinking in any significant way. During the times when she was intoxicated Ms B. was extremely aggressive, she was also incontinent of faeces and urine, Ms B would urinate where she sat on her couch or around her carpeted unit. As a result, Ms B was continually evicted from accommodation. On admission to our High Care facility, where Ms. B's drinking could be monitored, her care needs decreased significantly. Under ACFI assessment criteria, she was only able to receive funding for the behavioural care needs noted as part of her alcohol seeking behaviour. This behaviour, however, was extreme. Ms. B would aggressively seek alcohol from staff and other residents. On many occasions, several hours of one to one staff time was required to divert Ms B from alcohol seeking.

Prior to her Nursing Home admission, Ms B was provided with a CACPs. To ensure staff safety, however, services could only be provided when Ms B was at home and reasonably sober. Care Managers were continually cancelling and re-scheduling services to ensure the safety of our staff. CACPs funding is a set daily amount, allowance is not made within the funding to meet the different care needs of those with difficult behaviours. These clients require far more flexibility in the delivery of their package to allow Case Managers to negotiate care which will both meet the client's care needs and ensure staff safety. In Ms B's case, a normal week of CACPs care often involved 5 hours of scheduled services re-scheduled to different days/times maybe twice in the week. Our package is required to pay for each of these scheduled services, even when cancelled and re-scheduled, resulting in the service paying for up to 15 hours of care per week. We should also add here that we do use our own staff in CACPs due to the difficult behaviours exhibited by

housing, however, it requires lots of additional hours from the case manager helping the client complete application forms and moving in.

Care recipients who have no informal supports require the case manager or staff to provide additional monitoring services and in some cases on a daily basis. In the case of a care recipient going into hospital the case manager would be required to visit the person, liaise with medical staff, ensure that they have clean clothing and personal effects, whereas, this would normally be the responsibility of the family or informal supports.

Funeral arrangements in the case of the financially disadvantaged, have rarely been planned and often there are no funds available to pay for it. Again, the responsibility for this often falls firstly, to the case manager who will arrange the funeral and secondly, to our service who cover the costs.

Many of these above-mentioned problems also exist in residential care. While a concessional subsidy is available for financially disadvantaged residential care recipients, this subsidy is largely provided to fund the financial difference experienced by providers who cannot obtain accommodation bonds to supplement income. The existing subsidy does not take into account the additional responsibilities providers take on when their clients do not have family or friends to help share the "burden of care".

We believe that this further supports the notion of the creation of an additional subsidy payable to those providers caring for residential and community clients with no financial or social supports. This could be achieved through the creation of a special needs group based on homelessness – if a wider definition of homelessness was applied it would include those living in insecure or inappropriate accommodation and those with no known social supports.

INDEXATION FORMULA

Finally, and in common with the rest of the industry, our greatest costs throughout all our services are staff and food. During recent years these costs have risen at 4 to 5% per annum, in response, our funding has grown at 2.5%. We believe that this growing gap places significant stress on services to continually budget and provide care with less and less funding in real terms.

Over the past few years we have developed our own food service to provide meals to our community clients, we hire our own staff rather than entering into brokerage arrangements, we are currently trialling an in-house day program – all this is done to try to ensure financial viability and offset the high cost of purchasing these services externally. In this way we endeavour, with shrinking dollars, to ensure that we can continue to offer our clients the care and levels of service they expect and need.

We hope for a review of the current indexation arrangements so that any increases are linked to increasing pay levels and inflation rates.

CAPITAL FUNDING

Policy settings around the capital funding of residential aged care facilities are based on a user-pay system with residents expected to pay an Accommodation Bond (which can vary up to $500,000+ per resident) which is in part refunded when the resident leaves the facility. Not all residents pay these bonds, but it is presumed that there will be sufficient bond paying customers to finance the construction and continuing maintenance of a new aged care facility.

Clearly, if a provider caters for homeless people, its capacity to raise capital from Accommodation Bonds is minimal. **Wintringham therefore recommends that the Government introduce a Capital Funding program which would contain a highly targeted funding pool to be made available to facilities which undertake to provide in excess of 90% of residential places to the elderly homeless, or those at risk of becoming homeless.**

A similar scheme, titled the Variable Capital Funding Program, was in existence in the 1980's and it allowed for a capital subsidy to be paid to providers on a sliding scale that was dependent

upon the number of Financially Disadvantaged People the provider undertook to provide for. Under this scheme, Wintringham developed the first three of its aged care residential facilities.

Wintringham advocates that either this scheme be re-introduced or, if the capital cost proved to be unacceptable, that the above recommendation of a limited capital pool be reserved for services for homeless elderly.

In the interim, Wintringham would suggest that the existing policy boundaries for the recently announced Zero Interest Capital Loan Scheme be extended to include services for the homeless.

As an organization endeavouring to provide a quality service to people who are financially disadvantaged or have no informal supports we believe that the level of funding is not appropriate to cover these services and hope that the information here is of some help in clarifying and describing the exact nature of our concerns. Please do not hesitate to contact me if you wish for any further information or clarification of any of the issues raised in this letter.

With Regards

Helen Small
General Manager Operations

P: 03 9376 1122
F: 03 9376 8138
E: helens@wintringham.org.au

W:www.wintringham.org.au