Wintringham

IHACPA: CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN RESIDENTIAL AGED CARE SERVICES 2024-25

WINTRINGHAM SUBMISSION

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WINTRINGHAM: PROVIDING CARE TO OLDER PEOPLE WHO HAVE EXPERIENCED HOMELESSNESS

Wintringham is a not-for-profit welfare company that works to house and support impoverished men and women aged 50 and over who are experiencing or at risk of homelessness. Wintringham currently operates in Victoria and Tasmania.

INTRODUCTION

Wintringham appreciates the opportunity to provide this response to the Independent Health and Aged Care Pricing Authority (IHACPA) *Pricing Framework for Australian Residential Aged Care Services 2024-25 Consultation Paper*.

Wintringham's model of service delivery is fundamentally different from most other aged care service providers. With a dedicated focus on supporting older people who have experienced homelessness we endeavour to live up to our motto of providing "A Home 'til Stumps" which means that from the time one of our outreach workers contacts a vulnerable aged person, we aim to care for that person until their death. Wintringham has developed a range of housing options, and extensive support services including community aged care and NDIS, as well as a number of residential aged care homes. Our model utilises State and Commonwealth funding to provide high-quality housing and care outcomes to older disadvantaged citizens regardless of whether they live in country regions or metropolitan suburbs.

WHO WE ARE AND WHAT WE DO

Guided by principles of social justice, Wintringham has a single mission to provide dignified, high-quality care and accommodation to those who are financially and socially disadvantaged, and particularly to men and women aged 50 and over, who are experiencing homelessness, or at risk of homelessness.

Our organisation operates an innovative and integrated range of programs providing a continuum of care that includes assertive outreach, social housing (862 units, all with housing support), in-home aged care (940+ packages), National Disability Insurance Scheme (NDIS) core supports and support coordination, a registered Supported Residential Service (SRS), and eight residential aged care sites (353 beds) with each verified as a specialised homeless service. With over 1,000 dedicated staff, Wintringham supports well over 2,000 clients each day in Victoria and Tasmania.

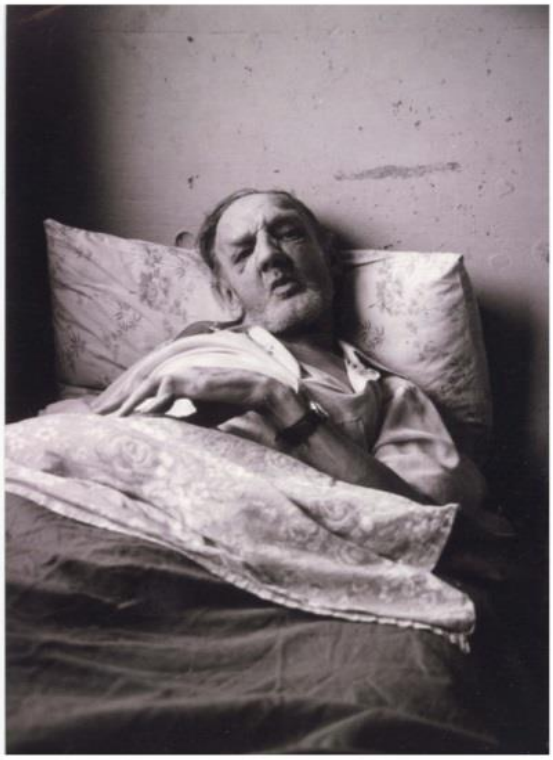
Wintringham's pioneering work with older people experiencing homelessness has received national and international recognition, most notably when in 2011, the United Nations awarded Wintringham their Scroll of Honour, the highest accolade awarded by UN Habitat and the first time it was given to an Australian organisation.

HOW WE CAME TO BE

At the time of the commencement of Wintringham in 1989, elderly homeless people lived and died at night shelters that were run by a variety of charitable services and funded under the Supported Assistance and Accommodation Program (SAAP), a Federal Government multi-lateral funding agreement with the States and a separate bi-lateral agreement with each individual State.

These buildings were often violent places where people were routinely assaulted, raped, and on occasions, murdered. It hardly needs to be stated that these facilities were totally inappropriate for frail aged people, yet many of the residents were elderly and in desperate need of aged care services.

Despite the best efforts of social workers at places such as Gordon House in Melbourne, Victoria's largest night shelter, it was almost impossible to have any referrals to aged care residential services accepted, even though these services were managed by church or charitable organisations who received generous tax concessions.



Gordon House could accommodate 300 people each night. We estimated more than half of the residents were over 50 and more than a third were eligible for Commonwealth aged care services. Not one of those residents were in receipt of such services.

It is difficult to explain just how appalling conditions were in these night shelters for the aged, but a simple comparison is that Gordon House provided 20 hours per week of personal care for the 300 clients. Our estimate is that a Commonwealth aged care service catering for 300 people would provide 5,000 hours of personal care. It is important to note that in both instances the clients are the same people - it is the accommodation and resultant eligibility for care that differs.

Given the unwillingness of aged care providers to accept referrals on behalf of elderly homeless people, Wintringham was established to provide this care. The initial reaction from both the aged care sector representatives and the public service was one of resistance, with claims from providers that the problem did not exist, and from the Government, that homeless clients were being provided for via the homelessness service system.

In response to the claim that our clients were homeless and therefore should be part of the homeless services system, we argued that they were not 'homeless and aged' but 'aged and homeless' and should therefore be entitled to aged care services. This argument was not simply semantics but signaled a new paradigm in viewing the rights of the older people experiencing homelessness. The representation was successful and eventually funding was approved for Wintringham to develop 3 aged care facilities for elderly homeless people.

50 YEARS AND OLDER: HOMELESS PEOPLE AGE PREMATURELY

Working with older people who have experienced prolonged periods of homelessness, presents unique problems for service delivery. The incidence of premature ageing among this group is high and many people present with very complex care needs. Negative experiences with health or community care providers may have left them mistrustful and with a general reluctance to accept services.

Wintringham's model of care has been developed in direct response to these 'special needs' of our client group. Many clients who have been, or who are experiencing homelessness arrive at Wintringham in very poor health, undernourished, traumatized or so 'battle hardened' that they are difficult to communicate with. It is not unusual for our clients to have had a very disconnected and isolated life with little or no contact with family members.

The Australian Institute of Health and Welfare recognises that within a homeless population, 'older people' are commonly defined as those aged 55 years and over[1]. Based on our own experience working with older people who have experienced homelessness, Wintringham defines older people as those who are 50 years and older. Premature ageing is caused by the disproportionately high rate of preventable diseases, progressive morbidity, and premature death prevalent in the homeless population. This can mean that a person is 'older' at 40 or 50 years of age. It makes a key difference to service provision if we recognise a client as aged and homeless, rather than homeless and aged.

Wintringham clients select, use and evaluate their aged care experience differently to mainstream older Australians. This is because people who have experienced the marginialisation and exclusion from services, that our client group have, don't often react in the way that is expected and usual for the mainstream. Drivers for accessing and choosing the right aged care provider are often around the need for safe and secure accommodation. Promises of respectful care that allows them to keep living their life are critical.

Quality care must be driven by the needs and desires of the people receiving that care, understanding that the experience of our lives shapes our values and what our best life looks like. How our residents define good care, or bad care, needs to be reflected in the standards and in the way the standards are measured. We cannot assume that all older Australians want the same things, in the same way, from their aged care providers.

[1] AIHW Older Australians Web Report, https://www.aihw.gov.au/getmedia/a49cf1b5-0a25-46a1-804b-ef38fa805af4/Older-Australians.pdf.aspx?inline=true

RESPONSE TO THE CONSULTATION PAPER

Utilise the expertise of specialist providers

IHACPAs role in delivering on-going advice on the costing and pricing of residential aged care will be critical to the long-term sustainability of the sector. Considering that the aged care program is designed around the needs of a 'typical' client that is very different from those people that Wintringham cares for, it is critical that IHACPA hear from a specialised homeless service provider.

When considering the breadth of expertise required for providing advice to IHACPA, we wish to emphasise that knowledge just around elderly people who are socially and financially disadvantaged is not sufficient, as while all elderly homeless people are financially disadvantaged, not all financially disadvantaged people have experienced homelessness. Homelessness, particularly for the elderly, brings with it a range of trauma and life-threatening events that socially or financially disadvantaged persons would not normally experience.

Wintringham would welcome an opportunity to become a member of the Interim Aged Care Working Group (and the Aged Care Advisory Committee when it is established) and bring our expertise as Australia's largest specialised homeless provider.

Recognise the overall costs of providing services to people who have experienced homelessness

Wintringham clients have different support needs when compared with mainstream residential aged care. Some key differences are:

- Age, gender and length of stay
    - the average age of people living in residential care is 85 years.[2] The average age of people entering Wintringham is 68 years.
    - The current average length of stay at Wintringham is 5 years, this compares with an average length of stay across Australian RACs of 30 months.[3]
    - 70% of Wintringham residents are male compared with the national average RAC occupancy of 35% males.
- Financial disadvantage – 82% of Wintringham residents meet the 'Homeless' criteria. This means that residents have very limited access to funds and often need assistance to manage their limited funds; 32% of residents have a court appointed financial administrator.
- Living on the margins – People present with complex histories of abuse, trauma and chronic disconnection from mainstream society. They are reluctant to trust, fearful of authority and often have learned responses and behaviours that make it difficult for them to adjust to living within a RACS community. A calm, consistent, supportive approach by skilled staff is required over many months to develop rapport and trust. This is often a period of multiple mandatory notifications of missing residents and sometimes assaults.
- Lack of family connection – 68% of Wintringham residents do not have a nominated person that they can rely upon to assist with banking and personal shopping, attendance at medical appointments and provide advocacy and support when needed. Wintringham staff fulfil this role.

[2] https://www.aihw.gov.au/reports/australias-welfare/aged-care
[3] Australian Institute of Health and Welfare Aged Care Data 2017.

- Poor Mental Health – the incidence of serious psychiatric illness is greater at Wintringham. 50% of RACS residents are receiving antipsychotic medication for a diagnosis of psychosis compared to the national mean of 10.2%.

In order to respond to these specific needs, Wintringham has developed a model that cohorts people with similar care needs in cottage style homes and provides a range of staff to best meet the needs of the client group. There is a strong emphasis on choice and independence, meaningful recreational therapeutic support and connection with community.

It is widely acknowledged that the aged care system also relies on the work undertaken by a huge unpaid workforce comprising family and friends, or the ability of residents to purchase additional supports privately. If we flip this over though, this same system greatly disadvantages those who have no social resources or the financial means to purchase these services. As a service provider, we are required to step into this gap, no matter how simple or complex the problem is.

Another key issue for organisations like Wintringham, relates to Capital funding and how the cost of residential services are financed. Residential aged care beds are usually funded by RADs / DAPs. An impoverished elderly homeless person is unable to pay a RAD / DAP and so cannot make any contribution to the capital cost of their accommodation.

To compound the problem, residential aged care services for homeless people do not make a sufficient surplus to service capital borrowings, so we are forced to rely solely on government grants for all of our housing or residential aged care buildings: grants that are extremely difficult to access as they invariably come from a limited funding allocation.

Wintringham necessarily operate with a cost structure simply not envisaged by the mainstream aged care environment, and prior to the introduction of AN-ACC it was recognised that the ACFI funding tool significantly disadvantaged and was in fact unsustainable for specialised homeless providers. In response, the Australian government introduced the Homeless Supplement and the Viability Supplement in 2014, and increased these supplements by 30% in 2019.

Against our advice and advocacy, these supplements were withdrawn by Government with the introduction of AN-ACC.

We were assured that the Base Care Tariff for specialised homeless services would sufficiently compensate for the loss of the Homeless and Viability Supplements. Our expectation is that this Base Care Tariff is not sufficient to maintain long-term financial viability for specialist homeless providers, when considering the additional operating and compliance costs imposed in response to the Royal Commission. We strongly recommend that the National Weighted Activity Unit for specialised homeless services be reviewed and increased accordingly.

Alternatively, IHACPA can recommend the re-introduction of a supplement for specialised homeless services. We note that supplements are still available for other key client groups such as veterans.

Our recommendation aligns with the IHACPA principles of ***Fairness*** and ***Fostering care innovation*** and ***Promoting value***.

The impact of purpose designed buildings on Activity Based Funding

Wintringham directly operates in a Thin Market. Our organisational mission focuses on the very small pool of eligible residents (i.e. those that meet the homeless criteria) relative to all eligible residents in Australia's residential aged care market.

In addition to our Thin Market challenge, to provide a welcoming and fit-for-purpose environment for residents from a homeless background (who often present with significant behavioral issues) requires careful consideration of the built form. 30 years of designing, building and operating residential aged care services has led us to create non-institutional buildings that have fewer residents than mainstream residential aged care homes. They are single level, and typically designed with individual verandahs for each resident, built with 'soft' materials such as timber and situated with a focus on landscaped gardens and outdoor space.

Our residential aged care services are deliberately smaller in size, ranging from 20-beds through to 60-beds across a portfolio of 8 homes. Our model and built form differ significantly from contemporary mainstream design principles of bigger is better, resulting in large scale 100+ bed developments that deliver (1) economies of scale, and (2) operating models where staffing and other costs can easily be scaled up and down in line with resident occupancy. Due to the smaller scale of our homes, it is inherently more challenging to constantly align our direct service cost base with occupancy levels.

For this reason, we strongly recommend that the Base Care Tariff Funding Basis for specialised homeless services, is changed from **Occupied places** to **Operational places**. Consistent with the 24/7 nursing supplement, this rule can cap out at 60 beds per home.

Unavoidable costs associated with care requirements

As documented above, a key feature of Wintringham's psycho-social model of care is the use of qualified and trained Recreation and Diversional Therapists.

The interpersonal problems that arise from cognitive impairment, trauma and mental health symptoms require an individualised and therapeutic response that includes Social Skills Development and experiential learning that allows for successful involvement in all aspects of residential life. To meet our client's complex, diverse and individual support needs, we have established a Therapeutic Recreation program that provides the necessary individualised interventions for assessment, planning and support. This program uses Strength-Based and trauma-informed practice utilising Motivational interviewing techniques that ensure the specialised needs of our clients are met. Our Recreation Therapists oversee a team of Recreation Therapy assistants who hold a Certificate IV or higher. The Recreation Therapy team assess and facilitate care and support designed to meet the individual's mental health, cognitive and social development needs.

In many cases, these roles deliver resident benefits that is equivalent to that provided by direct care staff in a mainstream setting, however these qualified and trained Recreation and Diversional Therapists are currently excluded from the definition of eligible roles when calculating mandatory care minute requirements introduced from 1 October 2023.

Our investment in these specialist roles is a legitimate cost associated with providing high quality care to our resident cohort. As such, we recommend that for specialised homeless providers, Recreation and Diversional Therapists are defined as an eligible staff role for mandatory care minute requirements.

Capital grant funding is critical to support the elderly homeless

While Wintringham recognise that capital costs are excluded from IHACPA's mandate for residential aged care pricing advice, we bring to your attention the critical importance of Government provided capital grant funding for the delivery of services for the elderly homeless.

Put simply, due to the impoverished nature of residents who have experienced homelessness, Wintringham (nor any other specialised homeless provider), are not in a position to build and deliver aged care services without capital grant funding.

Any conversation regarding pricing principles is merely academic if there is no capital to build residential aged care homes for the elderly homeless. As such we encourage IHACPA to advocate for the on-going provision of a Government funded capital grant pool.