Elderly Homeless Men and Women: Aged Care's Forgotten People

Bryan Lipmann, AM
Chief Executive Officer, Wintringham

Abstract
In spite of Australia having an aged-care system that provides a wide range of residential and community-based, aged-care services to elderly men and women, which are appropriately monitored and audited, homeless people have historically found it difficult or impossible to access those services. It remains an appalling blight on the aged-care industry in general, and the social work profession in particular, that this apparent selective exclusion of the most vulnerable of elderly people should continue with little or no comment, criticism, or action.

This is a policy commentary rather than an academic research paper, and aims to alert readers to the plight of elderly homeless people. The paper provides some insight into the life of an elderly homeless person, it describes the interaction between elderly homeless people and the Aged Care System; discusses services provided by Wintringham, a welfare company specialising in providing aged-care and housing services to aged homeless people; and explores some of the policy responses suggested by Wintringham.

The Homeless Elderly Population: The Problem Identified

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 (Lipmann, 2006).[1]

Nobody can work with elderly homeless people without feeling overwhelmed at times. The degrading conditions in which many live and the constant violence to which such circumstances give rise, together with the lack of resources to meet the seemingly endless crises that have to be met, makes even the most optimistic worker feel, on some days, that it is all futile. The large night shelters in Melbourne have now all closed, although many frail and elderly homeless people continue to live in private boarding and rooming houses, where conditions, if anything, are worse than the shelters. Shelters still exist in other Australian states and certainly in most large cities around the world. While many cater to large numbers of people, a typical night shelter provides dormitory accommodation for about 200 men each night in rooms where up to 50 men will sleep. In New York, the most current estimates place 34,776 people in the shelter system (Kolker, 2008). Of course, this figure bears no resemblance to the actual numbers of homeless people, which is many times larger than the number of people seeking shelter accommodation. For example, in Australia the 2006 Census estimated that over 110,000 people were homeless on any given night.

For the average person 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; in fact, surveys of night-shelter populations in the 1980s suggested that up to a half of all residents were older aged, a figure that can only have increased over time. In Australia in 1985, the Federal Department of Housing and Construction estimated that 40,000 people slept outdoors and 60,000 people were housed inadequately, many of whom utilised the night-shelter system (Coopers and Lybrand & Scott, 1985).

To cope with life in a night shelter requires coping skills that many frail-aged people either do not possess or are unwilling to risk. However, the alternative can be even more dangerous. While Australian winters are relatively benign compared with those experienced in North America or Europe, frequently it is not just hypothermia that threatens homeless people; it is violence from other street dwellers that presents the most risk (Ballintyne, 1999).

Jeff was a homeless old man living at Gordon House 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.

Jeff was found 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 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.

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, 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.

Sometimes, an appearance of independence only masks intellectual or psychological disabilities. At times, an apparent complete withdrawal from mainstream society and a reluctance to accept any assistance has dramatic consequences.

Some years ago, on a cold and wet Melbourne winter's night, an elderly homeless man was brought into the shelter I was working at. A young couple had been driving past an inner suburban park and had happened to notice the old man standing near a tree in the

> *rain. Although he refused their help, he nevertheless was somehow bundled into their car, and delivered to the shelter. The couple then drove off, apparently satisfied with their Good Samaritan deed.*
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> *The old man was clearly distraught and trying to calm him, I gave him a chair and squatted on the floor beside him. He wouldn't (or couldn't) talk, and refused the offer of food or a bed for the night. His clothes were torn and in spite of being many layered, threadbare. My eyes happened to fall on his legs and there I saw what once must have been a horrible wound on his leg. His sock disappeared into the wound that was now covered with an angry scar, only to reappear some inches later.*
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> *He obviously had not received any dressings for the wound, or changed his socks during the long process of healing. What horrors lay under the skin could only be imagined.*
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> *I stood up and went off to call someone to get a nurse or doctor to the shelter. When I returned a minute or so later, the man had disappeared and gone back into the night. We never saw him again.* (Lipmann, 2007)

As horrific as this story is, it represents a fairly common experience for people who work with homeless older people. Whether it is a product of a sense of maleness that one should stoically bear illness or ailments, or whether it has been learned by experiencing rude and dismissive hospital staff, reluctant to work with homeless people, the effect is the same. Older men, and to a lesser extent older women, often refuse to go to hospital, saying that is where you die. Inevitably, they wait so long that when they are eventually admitted it is to an emergency ward where their prophecy often becomes self-fulfilling.

The fierce independence of many of elderly homeless people is a significant reason why they receive so few services. It is not as if workers in homeless services exclude elderly people or deliberately target younger clients. In fact, it is invariably the reverse: many workers feel great sympathy and concern for older people who are homeless. Rather, the problem is one of an overwhelming presence of younger homeless people demanding time and resources; the reality is, workers rarely have time to search out the lonely and isolated members of society, and succumb to a reactive process of dealing with immediate problems. Therefore, elderly homeless people who remain independent and reluctant to seek out services, and who are rarely assertive about their rights in the ways that younger homeless people can and rightly do, become lost to the system. Older homeless people have been described as "feral" in that they become almost invisible to the rest of the community, learning through hard experience that it is often safer and wiser to withdraw and not draw attention to themselves (Lipmann, 2007).

Before any relationship with an older homeless person can begin, the person needs to feel that he or she can trust you. Relationships start over a shared smoke, a footy story, or a joke about someone else. Only later is it sometimes possible to begin to tackle housing or health issues. Faced with the daily problem of trying to meet just a few of the vast needs that are continually presented to them, workers in homeless services often do not have this level of spare time to engage with elderly people. Trying to "make do" in often the most trying of conditions, many workers are similar to homeless people themselves, lurching from crisis to crisis. But, should it be the responsibility of workers in homeless services to take care of the elderly population? Is it reasonable to expect a homeless service system to be able to respond to the needs of aged and frail homeless people?

The Homeless Elderly Population and the Aged-care System

It has been a well-accepted fact for many years that Australia, in common with most other western countries, has a disturbingly large number of elderly people living in poverty. The 2006 Census estimated that 42% of the Australian homeless population was over the age of 35 years (n = 44,300) and, in this group, men outnumbered women by approximately 3 to 2 (Chamberlain & MacKenzie, 2008). What has not been commonly accepted is that many of the impoverished and marginalised elderly men and women became homeless. To the extent that "homelessness" is taught in social work courses, *elderly* homeless people rate barely a mention. Certainly, in the 1980s, there was no mention of people who were aged and homeless. The result of the profession most charged with responsibility for looking after the elderly homeless population not acknowledging their existence, has been that at a time in their lives when these elderly people most need assistance, they have been left to fend for themselves. The consequences of this lack of interest have been many and varied.

A primary concern 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, such as Wintringham, 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. Consequently, few social work students are graduating with "a fire in their belly" to change the living conditions of elderly homeless people. This absence of a clear policy environment has meant that aged-care organisations, which are themselves frequently managed by social workers, can overlook the needs of the aged homeless population and concentrate instead on the more lucrative market of mainstream demand. The fact that the Government has allowed this highly selective rationing of scarce aged-care dollars to continue is only slightly less scandalous than the policies of the not-for-profit aged-care providers who adopt such policies.

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.

We should read again the Universal Declaration of Human Rights. Many of the Articles are relevant to the homeless population but particularly Article 1 ("All human beings are born free and equal in dignity and rights…") and, in the case of the elderly homeless population, Article 25 ("Everyone has the right to …. security in old age or circumstances beyond his control") (World Health Organization, 1948). It is not hard to see how elderly homeless people end up in such circumstances, given what appears to be the prevailing view of graduates of both nursing and social work, namely, that elderly homeless people have no special claim to aged-care services. How else to explain the extraordinary difficulty that our workers face daily in trying to access health or aged-care services for their aged clients? 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 (Lipmann, 1995). The extent of this selective

rationing of resources is nothing new. In the early 1980s, while working at Gordon House, then the largest homeless persons' night shelter in Australia, I saw how hard it was to get elderly homeless men and women living in shelters into aged-care programs. Gordon House was a 300-bed building that provided temporary accommodation to men and women from every conceivable background, from Chilean refugees who had been tortured in their homeland and then abandoned when they reached Australia, to intellectually-disabled men on remand, to young women with drug addictions, to violent and seriously disturbed men. The other group of people who made a profound impression on me was the large number of elderly men and women who were living more or less permanently at Gordon House. It would appear that for many professionally-trained people, the existence of large numbers of elderly impoverished people in a homeless night shelter was not a major concern; nor was it a matter that troubled their interpretation of what their profession stood for. It is difficult to come to any other conclusion, given the extreme difficulty that workers at Gordon House faced in accessing either appropriate medical treatment or aged-care services for their clients?

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.*
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> *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.*
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> *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 later, 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.*
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> *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 Gordon House and, if they did come, made it clear that our guys were 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.

Wintringham: Some Background Information

The vision at the start of Wintringham was simple: the company would be a social-justice organisation that would care for older homeless people on whom the aged-care industry had turned its back. on. The company was formed in 1989, after I received support from Peter Hollingworth, then CEO of the Brotherhood of St Laurence and Peter Staples, then Minister for Aged Care. 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. Referrals to these services invariably failed, usually without any formal assessment by the manager of the residential care service. The elderly persons' address, "Gordon House", was usually sufficient to ensure that the referral was not followed up. What amazed me at the time was that this apparent discrimination was coming from aged-care organisations that were entirely 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. Therefore, Wintringham was 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. It has been that understanding of social justice that continues to ground our work some 20 years later (Lipmann, 2000).

Wintringham's first services were a series of low-care residential facilities ("hostels") in inner Melbourne, all of which provided high-quality care to elderly homeless people in beautiful purpose-built buildings, some of which went on to win a variety national and international awards. Importantly, we were also able to access the nascent Community Aged Care Package (CACP) program, known then as Hostel Options. Having given up on securing any help from local aged-care providers, we were able, with the assistance of Commonwealth bureaucrats , to obtain funding from the Hostel Options program to deliver personal-care services into Gordon House while we waited until the new hostels were built.

Following the immediate success of the Hostel Options program, the number of CACP packages provided by Wintringham began to grow considerably. However, a fundamental problem remained: community home-based care presupposes the existence of a home into which care can be delivered. For that reason, we began to build a range of affordable housing options for our clients, into which care could be provided, noticing in the process that the very provision of safe and affordable housing, with appropriate levels of support, forestalled the need for many clients to go into residential care. This work was augmented by a strong outreach support model, funded by a variety of Commonwealth and state programs, most notably the innovative Aged Care and Housing for the Aged (ACHA) program. However, the demand for residential aged-care beds continued to grow and so, too, did the levels of frailty and resultant care needs. After much internal debate within the company, Wintringham decided to build the Ron Conn Nursing Home, which was eventually completed in 2005. It was the first such facility for elderly homeless people in Australia and we are advised, possibly in the world.

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 the values of social justice. 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 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. For example, issues affecting the elderly homeless population are invariably different from those impacting on most elderly people and so require particular policy responses that are usually of little interest to the aged-care industry as a whole. 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 paper will highlight the background to a few of these policy initiatives.

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 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 invariably 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 recently announced by 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 in the general health-service field they have 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 (Lipmann, 2002). 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.

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.

Savings to the community from providing permanent housing and care

In common with homeless service providers world-wide, Wintringham has many examples of homeless clients who have had numerous admittances to the public hospital system. Often because of the unwelcoming nature of many of the suburban private medical practices towards this client group, homeless people frequently do not receive medical attention for their ailments until an emergency attendance at a public hospital. These visits periodically require hospitalization and become progressively more serious with each successive admission. The financial cost to the hospital service system and emotional cost to the homeless client are both considerable, and largely avoidable (Epstein, Stern, & Weissman, 1990; Rosenheck, Gallup, & Frisman, 1993). It is self-evident that providing appropriate health care to a homeless person in secure accommodation is both considerably cheaper to society and more pleasant to the person than either admittance to an intensive high-care nursing home or to a hospital (Mondello, Gass, McLaughlin, & Shore, 2007).

Ron Conn was a homeless man who lived at Gordon House in South Melbourne in the 1980's. When Gordon House closed down, he moved to Gippsland where he lived in a boarding house, although he frequently travelled to Melbourne to visit an old mate who had come to live at McLean Lodge, a Wintringham aged-care facility.

Eventually Ron accepted an offer to return to Melbourne to live at Atkins Terrace, one of our housing facilities in Kensington. Within months Ron was diagnosed with cancer to which he eventually succumbed.

During his 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 inestimable.

Shortly before his death, I told Ron that we would be naming our new nursing home in his honour.

The need to have the Aged Care Act (1997) amended to make "homelessness" a Special Needs Group

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. Compounding this discrepancy is the fact that most of our clients are or have been homeless and have a variety of poor health and behavioural issues consequent to years of living rough. Public servants in Canberra and a variety of Aged Care Ministers have generally been supportive and prepared to be as flexible as the legislation allows, but they have all faced the same problem we face at Wintringham; namely, that the aged-care program was simply never designed with the needs of the elderly homeless population in mind.

It needs to be said that while this has proved to be an obstacle, it is by no means an insurmountable one. Moving from a relatively small programmatic area such as homelessness, and entering the much larger and better-resourced, aged-care field was a deliberate decision made in full awareness that there would be significant problems in making a mainstream generic program fit the needs of the homeless. In spite of these inherent problems, the logical consistency of arguing that as the homeless clients were elderly they should be eligible for funding, has been generally accepted by senior bureaucrats within the Department of Health and Ageing (DoHA) and various Ministers for Ageing.

A variety of innovative and flexible responses have been created in partnership with DoHA that recognise some of the unique characteristics of the homeless aged population, behavioural issues associated with brain injury, lifestyle choices, and the generally much younger age profile. Most of these and other issues impact greatly on how the recurrent funding tool is interpreted and applied, and here again, DoHA has been prepared to accept arguments proposed by Wintringham relating to the needs of their clients. However, in spite of this flexibility, the fact remains that the Aged Care Act (1997) has been silent on matters relating to the elderly homeless population. As a result, any proposal concerning the elderly homeless population has needed to connect in a sufficiently emotive or plausible way with the appropriate decision makers, so

that a special deal could be done. Clearly, this was an unsatisfactory way to do business: what was needed was to make a structural change to the legislation that would enable and empower the Minister of the day and their senior bureaucrats to address the needs of homeless people.

Some 15 years ago I became convinced that the only way to do that was not to attempt to get support for the creation of a new Aged Care Act, but to argue for the more realistic goal of amending the existing Act to include the elderly homeless population as a Special Needs Group. Perhaps in an ideal world this would not be necessary. We can fantasise that aged-care providers, particularly those with church affiliations, would be keen to seek out the most disadvantaged and to offer them services. Similarly, we might expect that regional ACAS teams would be keen to ensure that elderly homeless people gained access to aged-care services. However, this is not the case. Providers are quick to point out that their residents (or their families) would object to sharing accommodation with homeless people, and ACAS teams are often extremely reluctant to accept referrals, often because the person being referred is under 65 years of age. A common suggestion is that we should try to get services from the Disability sector!

While the Special Needs category would not solve all of the access problems, we felt it would have an immediate impact in that it would legitimise the right of elderly homeless people to access aged-care services. Importantly, it would also remind policy makers each ACAR funding round that the aged homeless population was a special group that needed to be accounted for in the planning process. It would also change the dynamic that currently exists where a provider of aged-care services to the elderly homeless population has to rely on the individual support of people such as the current Minister, Chief of Staff, and Department Head before any deal to ameliorate an aspect of the current Aged Care Act (1997) that might disadvantage his clients. Moreover, because there is nothing in the current Act to allow for special treatment, the power of the Minister to intervene is limited.

Shortly after the election of the Rudd Government, they announced that a White Paper on Homelessness would be developed, and they 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

A variety of government reports over recent years have addressed the increasing problem of homelessness with little positive result. Indeed the levels of homelessness are rising. What makes the White Paper different, and why many workers in the field are optimistic about the future, is the clear indication that the Prime Minister is himself concerned about the problem and wants to find a solution. All of the previous attempts have failed quite simply because there was not the political will to do any thing substantial. Time will tell if our optimism is well-founded, but it is clear that the atmosphere in Canberra is different from past years: we now have a Prime Minister and Deputy Prime Minister who have both committed a significant amount of personal credibility to the issue and who have appointed young and extremely capable junior Ministers to tackle homelessness, and of particular interest to Wintringham, elderly homelessness.

Taxation Concessions

Wintringham has also proposed that there should be a review of the not-for-profit tax concessions enjoyed by many aged-care organisations, which are in direct competition with for-profit businesses. 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.

Conclusion

It is difficult to imagine a harsher political environment in which to establish a new welfare organisation to work exclusively on the needs of elderly homeless people than the environment we have experienced in the past 20 years. Yet, in spite of the difficulty of raising funds for such services, Wintringham has demonstrated that it is possible to manage a highly specialised independent welfare organisation, to run it on social justice principles, and importantly, to not only remain financially viable but to experience rapid growth.

In an ideal world the need for an organisation such as Wintringham would not exist. Unfortunately the world is far from ideal: the numbers of homeless people continue to grow and, in the case of the elderly homeless population, mainstream service providers are reluctant to accept their responsibility to provide care. We have demonstrated that the key to finding long-term solutions to the problem of elderly homelessness is to access mainstream funding. Through the deserts of homeless service funding run rivers of money. To access that money on behalf of your clients it is necessary to look beyond a person’s homelessness to see another member of society with the same rights as anyone else (Lipmann, 2003).

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