Wintringham

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"A Home Until Stumps": How have policy changes over the past 20 years affected the elderly homeless?

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In the 1980's, elderly homeless men and women lived and died in night shelters unable to access mainstream church managed aged care services.

Twenty years ago, I was working in one of these shelters. When I moved out to set up Wintringham, I knew as much about the aged care system as most of you probably do – which is probably not very much. This was both a disadvantage in that the system was so different to SAAP and the people working in aged care were so unlike anyone I had met in homelessness, but also something of an advantage in that not knowing how things worked freed me from some of the traditional models of aged care.

There is no question that Wintringham has been something of a success: we now employ about 250 people and provide care or support to over 750 elderly people each night. But is this success a reflection of the generally

improved conditions for the elderly homeless over the past 20 years, or is it something more associated with Wintringham itself and policy environment that existed at the time of its formation?

Before trying to answer that question, I want to make the point that it is in the area of policy formulation that truly significant changes to the lives of homeless people can be effected. In spite of the occasional good outcomes that we as homeless workers sometimes experience, when the euphoria of a realising that just for once a really positive outcome has been achieved in part because of your intervention, I have become convinced that without structural change effected through policy development, individual wins or losses as a direct case worker are almost meaningless.

Getting the wording changed in a subclause of the aged care act to include how a particular aspect of the Act impacts on the aged homeless can result in many millions of dollars flowing into direct improvement in the conditions that the aged homeless must live under. With these resources, homeless workers can have genuine and long lasting impact. These small policy changes come about because of hours and hours of lobbying, writing, direct representation and meetings. It is this realisation that makes me so disappointed with the efforts of our various peaks and industry representatives in aged care, housing and perhaps homelessness.

What were the shelters like 20 years ago? Well for a start they were huge – in Australia it was not uncommon to have more than 200 people under the one roof, but still small compared to many US examples where buildings sometimes sheltered over 1000 a night.

Homelessness is the end result of a social system in decline, and night shelters with their large resident populations of physically, psychiatrically and intellectually disabled people who had little or no external supports, living beside desperate, lonely and at times violent young men, was a public manifestation of that chaotic decline.

While at times we all could imagine living in a night shelter if we absolutely had to, none of the people I worked with could ever imagine what it must be like to live there if you were elderly and frail. Yet many elderly people did in shelters, in fact surveys of night shelter populations in the 1980's suggested that up to a half of the residents were aged. In fact it was this permanence of the resident population that prompted the SAAP Redevelopment which was eventually to lead to the types of services that most of you probably work in today.

The first major change that I have noticed in the past 20 years is that today, senior aged care bureaucrats in Melbourne and Canberra are aware of issues affecting the elderly homeless. This was not the case in the 1980's. On one occasion in 1987, after having a pretty solid discussion about the desperate plight of the elderly homeless with someone from the Department, I was informed that "there are no elderly people in homeless person's night shelters, because if there were, I would have known about it".

In retrospect, this story is almost amusing, but I do not believe that his deplorable ignorance was solely his fault. The primary responsibility lay with the managers of these night shelters who had not made him aware of the issue and who had not advocated on behalf of their elderly clients. In fact when Wintringham commenced services, these same homeless

service providers were generally resistant and uncooperative, forcing us to become increasingly reliant on the support and goodwill of bureaucrats working in aged care. In many respects, this situation has not changed much over the years.

Winning the interest and then support of senior bureaucrats has been one of the most important changes relating to any positive impact we might have had in policy development. It is an unfortunate fact that none of the peak industry lobby groups working in aged care appears to be remotely interested in the elderly homeless. The national aged care peak (ACSA) is particularly at fault in this matter.

Service providers working with the elderly homeless can therefore expect no support from their peaks and must do all the lobbying on their own and fund this lobbying from their own resources. The only peak I have ever known to actively support the elderly homeless is the Catholic Health Australia led by Francis Sullivan.

The result of this poor representation is that while individual organisations such as Wintringham who directly lobby politicians and bureaucrats may occasionally receive positive outcomes, because the industry is generally not calling for reform there are no structural improvements in the way services are funded and delivered to the aged homeless. We even have had instances where the national aged care peak (which represents mainstream providers) have in the past argued against our proposals to bring more money into services for the aged homeless.

Without a doubt, the single most important development over the past 20 years is that any organisation contemplating working with the elderly

homeless will do so through the Commonwealth Department of Health and Ageing and will generally eschew SAAP funding. Although I no longer have figures from 1985, approximate current budget figures for SAAP (annual budget of $300m) and Aged Care (annual budget of $7 billion) are probably still representative.

Apart from the financial logic of working through DoHA, there is also the ethical position of ensuring that aged homeless people access the same level of care that other elderly Australians can expect. Wintringham's position is that we have always argued that our clients are aged and homeless, and not homeless and aged. This is not merely semantics, but generates a whole new paradigm that has enormous implications for the funding of services to our aged homeless clients. If we say a person is homeless and aged then it seems appropriate to provide for that person within a homeless persons service system such as SAAP. If on the other hand we say that primarily the person is elderly then it seems self-evident that they should be part of the aged care system and that their care should be resourced by that system. By aligning ourselves with the far better resourced DoHA, we also entered a system which is clearly better at understanding the needs of elderly people than SAAP is.

As strong as this point is, it was even stronger 20 years ago. In common with all the different profiles of homelessness, those working with the elderly homeless are constantly in need of quality and affordable housing for their clients. With aged care, the problem was partly overcome at least in the residential care field, with funding available to construct high and low care facilities (or what used to be known as hostels and nursing homes).

I say “was” because 20 years ago, there was a Commonwealth program that funded organisations who wanted to build residential services for low income elderly people who required care. This program was known as the Variable Capital Funding Program. Without going into the complexities of aged care funding, residential care is generally a user pay system. Elderly people requiring 24 hour residential care pay a Bond often of many hundreds of thousands of dollars, which in large part, is repaid when the resident dies or leaves the facility. These massive bonds are used by the organisation to fund the building of the facility.

20 years ago, the Government recognised that not all people could afford to pay bonds, and so funded on a sliding scale according to how many Financially Disadvantaged People an organisation intended to provide services to. In Wintringham’s case, because all of our clients were homeless and impoverished, the construction of our first three aged care residential facilities were largely funded by the government.

Then in 1997, the Government introduced its Aged Care Reforms, and abolished this capital program. Without any doubt, this has been the most significant policy decision affecting the aged homeless made in the past 20 years. Although the Government has come up with a variety of adjusting recurrent funding formulas to compensate organisations wishing to work with the elderly homeless, nothing has ever come close to providing the needed money to build new facilities, which cost over $100,000 per bed plus land. Indeed analysis by Wintringham demonstrate that although we work with some of the most needs-intensive clients in the aged care sector, we routinely receive anything up to $20 a day ***less*** per resident in total subsidies. Not much of an incentive to keep going.

The situation is so serious, that it is difficult to see how any new provider could enter the aged care sector with an intention of providing for the aged homeless if they did not have other forms of capital available to them.

Recently the Government is showing signs that it is slowly beginning to reintroduce a limited capital program, and in the recently completed tender round Wintringham received $5 million to assist with the development of a new facility in Dandenong. While we are of course delighted with this success and do not wish to be critical of a program that we are the beneficiaries of, I remain concerned that other homeless services did not get funded.

My concern is that grants that are distributed from a very small pool, and that depend on the support of the Minister of the day, are not going to resolve any structural problems associated with providing care to aged homeless people.

Aged homeless people desperately need a return to the days when there was some surety in the system: when there was a capital program that enabled providers such as Wintringham to develop new services.

The solution is quite simple: the Aged Care Act needs to recognise the elderly homeless as a Special Needs Group, and there needs to be a highly targeted capital funding program attached to this Special Need.

From a Community Care perspective, elderly homeless have probably fared better than they have in the Residential Care program, if for no other reason, than the fact that there is no capital required to deliver this

care. The DoHA target many of the allocated packages in the CACP program to the financially disadvantaged elderly, allowing for specialist organisations such as Wintringham and the Salvation Army to further refine the allocation to the homeless or to those elderly people who are at risk of becoming homeless.

A related initiative in the last 20 years has been the development to the ACHA program (Assistance with Care and Housing for the Aged), which I am an unashamed enthusiast of. The program is tiny and has experienced no net growth since its inception, but has achieved with some providers, a remarkably consistent result in helping prevent homelessness amongst the aged and in assisting isolated elderly people in accessing the aged care system. Unfortunately the program lurches from one budget cycle to another with the threat of closure always hanging over its head. Hopefully one day it will be recognised for the great work which it can and often does achieve.

It is also worth noting that a significant development in ministerial responsibilities and portfolio allocation has had an impact on the ability to influence policy development affecting the elderly homeless. Up until the early 1990's, the Minister responsible for Aged Care was also the Minister responsible for SAAP. The Aged Care Minister therefore was receiving direct advice on matters affecting the elderly homeless, primarily through her CACH (Commonwealth Advisory Committee on Homelessness). As a result, her and her advisors were routinely informed about the often, unintended consequences on the homeless of changes to the Aged Care Act. Importantly, because of the dual ministerial responsibility, senior bureaucrats from FaCS and DoHA were obliged to know about issues outside of their department.

Unfortunately, these portfolio responsibilities were separated in 1998 and as a result the Minister for Ageing is now unlikely to be as well informed on issues effecting the elderly homeless. As a result, the onus is directly on providers and peak bodies to ensure that the Minister and her advisors are informed.

This paper has concentrated on Commonwealth responsibilities for the obvious reason that aged care is a Commonwealth responsibility.

State policies however do also impact on the elderly homeless through such programs as SAAP, Community Connections Program, and HACC. Of particular interest however is its responsibilities in relation to the provision of affordable housing, which like SAAP, is heavily influenced by the funding agreements it makes with the Commmonwealth.

A matter of concern in recent years has been the introduction of Segmented Waiting Lists in Victoria and similar forms of targeting in other States. Moving from a universal housing program to one that is aimed at the most disadvantaged inevitably means that less housing resources are available for low income people who are not in crises. While the battle to include the elderly homeless within Category I of the Segmented Waiting Lists was won, the numbers of low income elderly people who must wait for a crises until they can be considered as a priority for housing, is a major concern.

Similarly, I am disappointed that the State does not appear to be recognising the needs of the elderly homeless in the creation of its new Housing Associations. Contrary to its earlier statements, the State has not

appointed any organisation with experience in providing for the elderly homeless. Of equal or greater concern is that the Housing Association model will require organisations to raise capital through borrowings. With community housing margins as thin as they currently are, the only way these new Housing Associations will be able to service such loans will be to generate profits through accommodating a percentage of people who are able to pay higher rentals.

How this can advantage the elderly homeless has yet been explained.

Conclusion

By almost any account, it is possible to say that services to older homeless men and women have improved dramatically since the 1980's. Aged homeless men and women are very much seen as being eligible to receive services from the aged care system as a matter of right. As a result, SAAP service providers are increasingly seeing that their role with aged homeless people as a referral into the aged care system.

In spite of this improvement, there is one qualification that is so serious and of such magnitude that it overshadows all of the other improvements – and that is the lack of capital funding available to construct aged care facilities for the elderly homeless. In spite of the best efforts of a number of people, including notably Professor Warren Hogan in his recent Government funded review of the aged care industry, the capital funding environment of 2005 does not resemble 1985.

From a purely personal perspective, this failure to replicate the conditions of 1985 has the clear implication that I would probably not be able to establish Wintringham today.

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