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# Aboriginal and Torres Strait Islander HACC Funding Models

## Project Report

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hacc
home and community care
A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM
PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

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| **Terminology used in this report** | |
|---|---|
| **ACCO** | Refers to Aboriginal Community Controlled Organisations which are funded by the Department of Human Services to provide HACC services. |
| **HACC activities** | Refers to the range of HACC activities funded by the HACC Program in Victoria, namely: Home Care, Personal Care, Property Maintenance, Meals, Respite, Planned Activity Group (Core and High), Allied Health, Nursing, Service System resourcing and Flexible Service Response. |
| **Indigenous** | The term Indigenous in this document refers to all Aboriginal and Torres Strait Islander individuals, communities and groups. |
| **ACCO HACC service / program** | A HACC service operated by an Aboriginal Community Controlled Organisation and funded by the Department of Human Services HACC Program. |
| **Mainstream HACC agency** | A non-government organisation operating a HACC service funded by the Department of Human Services eg. local government, community health, or hospital. |
| **Koorie Specific HACC Service** | A HACC service operated by an ACCO or a mainstream agency, which is funded by the HACC Program to specifically target Indigenous people. |

# Executive Summary

Viable and sustainable Aboriginal Community Controlled Organisations (ACCOs) in partnership with culturally sensitive and appropriate mainstream agencies are essential to:

- increase and improve the up-take of Home and Community Care (HACC) services by Indigenous people,
- ensure Indigenous people access equitable and appropriate HACC services, and
- improve the health, well being and quality of life for elders, people with a disability and carers.

The pre-requisite for any effective HACC service is adequate resources for governance, management, administration, infrastructure, assessment / care management and partnerships.

The low levels of funding received by the majority of ACCOs make it difficult to adequately resource and maintain these management and infrastructure functions. For example, fifteen (15) of the 23 ACCOs funded to provide Koorie specific HACC services received less than $150,000.00 in 2004/2005. The majority of the ACCOs were not funded for sufficient hours of Home Care to employ a full-time worker.

The impact of relatively low levels of HACC funding is compounded by the fact that most ACCOs receive small amounts of funding from multiple programs within the Department of Human Services. For example an ACCO may receive funding from Disability Services, Drug Treatment Services, Child Protection and Family Services, Juvenile Justice and Youth Services, and Mental Health. The level of funding from these programs is often insufficient to employ full time staff and adequately fund management and infrastructure functions. Unpublished DHS data shows:

- ACCOs often receive less than $100,000.00 per annum from DHS program areas. In fact many programs provide funding of less than $50,000.00 per annum.
- That when comparing average amounts of agency funding with the total number of funded activities by agency type (local government, non government, community health and ACCO), ACCOs receive the lowest average amount of agency funding.
- Average funding per activity is $72,268.00 for ACCOs, compared to $268,550.00 in non-government organisations, $160,359.00 in community health services and $146,680.00 in local government organisations.
- That it is not untypical for an ACCO to receive funding from more than eight (8) DHS program areas to deliver more than 20 activities.
- While most of the other DHS Program areas fund for one two activities, the HACC Program often splits a relatively small quantum of funds into six to eight service activity types.

Estimating the cost of delivering HACC services to Indigenous people was difficult and indeterminate due to difficulties obtaining accurate costing data from Aboriginal Community Controlled Organisations within the Project parameters. However the costing data which was collected and analysed, as well as anecdotal evidence from the mainstream agencies that

participated in the Project indicated that the cost of delivering HACC services to Indigenous people appeared to be higher than the provision of services to non-Indigenous people.

The Koorie HACC service system has evolved in an ad hoc way and could be improved. The Koorie HACC service system is characterised by a range of models, many of which do not appear to be effective or to represent value for money. Typically ACCO HACC services operate in relative isolation and tend to replicate the broader HACC services (i.e. provide a broad suite of HACC services) rather than build upon and complement the local service system. There is also a clear disparity between agencies receiving Koorie specific HACC funding to deliver HACC activities and those agencies funded for a service coordination role. Clearly service coordination models are simpler to manage, require less infrastructure for reporting and quality, have lower overheads and less complex staffing arrangements.

The majority of mainstream agencies provide HACC services to few or no Indigenous clients and significant work is required to make these services culturally sensitive and attractive to Indigenous communities and families.

**Project Conclusions**

Significant redevelopment of the current funding arrangements is required to achieve the intent of the Victorian government's policy commitments to Indigenous health and ACCOs, in particular its stated goal to "Build capacity in Aboriginal organisations to develop quality services and partnerships to meet community needs" and stated strategy that "the Department will support the viability and sustainability of ACCOs funded by the Department and their ability to provide good quality services[1]".

The provision of adequate resources for governance, management, assessment / care management, administration, infrastructure, and partnerships to support service delivery is essential. The majority of ACCOs receive comparatively low levels of funding from a range of program areas, and this makes it difficult to adequately resource and maintain these functions.

Adequate funding for governance, management, assessment / care management, administration, infrastructure, and partnerships is therefore a cross-program responsibility. DHS program areas need to work together to address program and funding fragmentation issues, with a view to better coordination to strengthen the viability of ACCOs.

The DHS HACC Team should:

i. Initiate a cross-program review of DHS funding to ACCOs, with the aim of improving coordination between program areas and ensuring sufficient resources are available to adequately resource management and infrastructure functions.

[1] Victorian Aboriginal Services Plan (2004). Department of Human Services.

A refocusing of current HACC funding and a redevelopment of the Koorie specific HACC service system is required to:

- Achieve 'value for money' from the $6 million of Koorie specific recurrent HACC funding.
- Ensure Indigenous people have access to, and benefit from, a choice of quality HACC services.
- Strengthen the ACCOs' ability to provide sustainable and viable HACC services, and to build and maintain effective partnerships.
- Support the viability and sustainability of Koorie specific HACC services provided by mainstream agencies.
- Increase the effectiveness and accountability of mainstream agencies in delivering services to Indigenous people.
- Build a strong platform for meeting the current needs of Indigenous people as well as managing future demand.

Given that it is unlikely that significant growth funding from HACC will be available to substantially increase the resources needed for adequate management and infrastructure functions, the HACC Team at DHS will need to:

ii. Examine how the HACC output based funding model can be more effectively applied to adequately fund the essential functions of management, infrastructure, assessment / care management and partnerships. This could be done through:
    - A review of the effectiveness of the Koorie specific HACC funding in each region to establish whether it represents value for money and is delivering improved outcomes for Indigenous communities.
    - Prioritising future growth funding to support the resourcing of HACC management and infrastructure functions (HMIF) in those ACCOs with a service delivery focus. The consultants suggest that DHS conduct a small number of action research trials to test the effectiveness, outcomes and actual cost of establishing HMIF, which effectively and efficiently support ACCO HACC services.

iii. Work with all agencies funded to provide Koorie specific HACC services to:
    - Determine the most appropriate service model to meet current and future needs of the community. This may involve some agencies considering shifting to a service coordination model or a combination of service coordination and service delivery, especially where there are relatively small Indigenous communities.
    - Clearly define the role and responsibilities of all agencies in meeting the needs of Indigenous clients across the HACC service system and within the aged and disability service system more broadly. This may involve agencies restructuring or narrowing the range of activities delivered, and developing clear referral pathways.
    - Establish formal partnerships across the HACC and aged care service systems to ensure Indigenous people access the range of services required.

iv. Develop a planning and funding approach for Koorie specific HACC which complements the 3 year HACC planning and funding cycle and ensures funding is equitably distributed, and that all Indigenous communities benefit from Koorie specific HACC funding (see conceptual framework in Attachment 4).

v. Undertake further investigation of the real costs associated with the delivery of HACC services to Indigenous clients in both ACCOs and mainstream agencies. The Models Project was only able to collect and present indicative costing information, however more accurate costing information would assist with future planning and funding decisions. To obtain reliable costing information, DHS should consider undertaking an action research project which assists ACCOs and mainstream agencies to establish financial systems which can be used to track and monitor the real cost of delivering services to Indigenous clients.

vi. Develop a strategy to increase the capacity of mainstream agencies to meet the needs of Indigenous HACC clients through culturally sensitive service provision and culturally appropriate models of care, this may involve:
    - Implementing a cultural auditing process (such as was undertaken by HACC funded agencies with the Cultural Planning Tool) which enables agencies to reflect on the cultural sensitivity of their policies, procedures, practices and systems.
    - The provision of training in cultural awareness and culturally sensitive communication for both management and HACC workers.
    - Assistance to establish formal partnerships between mainstream HACC funded agencies, ACCOs and Indigenous communities.

## Recommendations

### Recommendation 1.

The DHS program areas which provide funding to ACCOs jointly work together to:

- Examine the impact of low level, fragmented cross-program funding on the viability and sustainability of ACCOs.
- Develop a more coordinated funding approach to ensure sufficient resources are available to support governance, management, administration, infrastructure, assessment / care management and partnership functions.
- Develop business rules to guide future DHS funding of ACCOs.
- Provide adequate levels of funding to resource:
    - The management, governance and infrastructure functions needed to operate effective services including reporting, quality, human resources management, planning, service development, financial management, community development and partnerships.
    - Assessment and Care Management, to ensure that all Indigenous clients are properly assessed and linked into the full range of services needed.
    - The establishment of partnerships between ACCOs and mainstream HACC agencies.

### Recommendation 2.

The DHS HACC Team evaluate the effectiveness of the new Service Coordination /Assessment and Care Management models (in both ACCO and mainstream agencies) as an alternative approach to HACC service delivery. This may involve tracking and evaluating a

selection of models and disseminating findings to the DHS Regional staff, VICACD, ACCOs and mainstream agencies. Possible models for evaluation include:

- The new Bendigo and District Aboriginal Cooperative Access and Referral Worker.
- The Information and Referral Worker position at the Western Suburbs Indigenous Gathering Place.
- The HALO model operating in the cities of Whittlesea, Hume and Darebin.
- A mainstream Service Coordination and Referral worker model in operation in the Southern Metropolitan Region (there are currently 4 such models operating in this region).

**Recommendation 3.**

The DHS HACC Team recognise the importance of Assessment and Care Management in the delivery of HACC services to Indigenous people, and ensure that all ACCOs with a service delivery focus, have sufficient funding to effectively and efficiently perform their assessment and care management role. This could be achieved by prioritising Assessment and Care Management in new recurrent funding or through the rationalisation of existing activity funding.

**Recommendation 4.**

The DHS HACC Team work with a selection of ACCOs and key mainstream agencies to track and quantify the additional costs associated with the delivery of culturally sensitive HACC services and models of care for Indigenous people. An action research project involving the Shire of Gannawarra, Latrobe Rural City Council and/or the Swan Hill Rural City Council and a small number of ACCOs should be considered.

**Recommendation 5.**

The DHS HACC Team works with each of the Aboriginal Community Controlled Organisations to:

- Conceptualise the most effective role for their HACC program over the next 5 – 10 years (service delivery, service coordination, or a combination of both).
- Revise HACC targets and funding set out in the Funding and Service Agreement to reflect the future role of the organisation’s HACC service.
- Define the role of Koorie specific HACC services within the broader service system.
- Identify resources required to support adequate governance, management, administration, infrastructure, assessment / care management and partnership functions.
- Build partnerships with mainstream agencies to ensure that Indigenous people have access to the full suite of HACC (and Aged and Disability) services in their local area.

**Recommendation 6.**

The DHS develop a strategy to assist mainstream agencies to:

- Review their HACC policies, practices, procedures and systems to ensure they are culturally sensitive.
- Develop models of care which are culturally acceptable and effective.
- Build relationships and partnerships with ACCOs and /or local Indigenous communities.

The DHS should consider adapting the Cultural Planning Tool for use by mainstream agencies, to facilitate their reflections on current practices, procedures and systems and guide them to implement any changes required to develop culturally sensitive services.

# 1. Project Background and Methodology

## 1.1 Project Background

The Department of Human Services engaged Effective Change and PQ Associates to undertake the Aboriginal and Torres Strait Islander HACC Funding Model Project in 2005 (hereinafter referred to as the project). The aim of the project was to develop a resource to assist the Department of Human Services (DHS) and Aboriginal Community Controlled Organisations (ACCOs) to determine the most appropriate option(s) for funding and delivery of HACC services to Indigenous communities.

The project was conducted by Juliet Frizzell and Tony Chamberlain between March 2005 and March 2006. The project was managed by Lois Brown and Calvin Graham from the DHS HACC Program and supported by a Steering Group comprised of Lena Morris, Chairperson Victorian Indigenous Community Aged Care and Disability (VICACD), Deidre King, Deputy Chairperson VICACD (until May 2005), and representatives from DHS including Jeanine Jacobson, Monica Pfeffer, Pam Oakley and Catherine Griffiths.

## 1.2 Methodology

The consultants completed a range of tasks for the project, including:

### 1.2.1 A Review of Relevant Literature, Research and Policy Documents

The consultants:

- Reviewed a range of research reports related to:
  - Indigenous health and models of care.
  - HACC unit pricing and costing models.
  - Health and well being issues for Indigenous communities.
- Considered a range of Victorian and Commonwealth government policy documents, including:
  - The Victorian Aboriginal Services Plan (2004).
  - The Victorian HACC Program Manual (2003).
  - National Strategies of Improving Indigenous Health and Care (2004), Office of Aboriginal and Torres Strait Islander Health (OATSIH).

### 1.2.2 Consultations with Key Stakeholders

A range of key stakeholders were consulted for the project including:

- Representatives from Aboriginal Community Controlled Organisations (ACCOs) with HACC services.
- Staff from DHS regional offices, in particular Pam Oakley, Ruth Reading and Will Hanrahan.
- Representatives from DHS Central Office including Monica Pfeffer, DHS Strategic Projects and Ian Vague, Resource Allocation Unit.
- Key stakeholders from mainstream agencies with Koorie specific HACC services, including Steve Tong and Samantha Parsons-Fenton from Latrobe City Council and Carol Wandin from the Gannawarra Shire Council.

- Managers and staff involved in new and emerging Koorie specific HACC models, including Leanne Brooke, Colleen Marion and Dr Chris Watt from the Western Suburbs Indigenous Gathering Place, Joanne Badkey CEO, Bendigo and District Aboriginal Cooperative (BDAC), Michelle Stoter, Loddon Mallee Region Aboriginal Development Officer, and Mandy Bathgate, HACC Aboriginal Liaison Officer (HALO) Project Manager.
- Representatives from the Royal District Nursing Services (RDNS), including Lindy Spuur from Head Office and Dot Campbell, Trish Dalton and Joan Kikos from the RDNS Homeless Persons Project.
- Local Government representatives for costing data.
- Other stakeholders including: Clare Hargraves, MAV, Katherine Wositzky, MAV CEGS Worker, Lena Morris, Chairperson VICACD, and Odette Pagan, Director HACC Unit, Queensland.

### 1.2.3 Mapping Current Koorie Specific HACC Services

The consultants mapped the current Indigenous specific HACC service system. This involved a review of 2004/2005 Koorie specific HACC funding, and consultations with agencies (ACCO and mainstream). A range of information was collected and documented including: HACC target group size, funding and targets, number of reported HACC clients [HACC Minimum Data Set (MDS)], catchment area, service models and viability issues. A report was produced in May 2005 outlining the findings entitled *Summary of Current HACC Funding, Clients, Catchments and Models*, a copy can be found in Attachment 1 of this report. The findings of this report were considered by the Steering Group and used to select 6 models for further detailed analysis.

To gain a better understanding of the match between Koorie specific funding and the location and size of Indigenous communities, a series of maps was also produced. These can be found in Attachment 3 of this report.

### 1.2.4 Utilisation of HACC Services by Victoria's Indigenous Communities

The consultants reviewed the reports and documents which describe the utilisation of HACC services by Victoria's Indigenous communities. The documents reviewed included:

- The *Victorian Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Project* reports (Phases 1, 2 and 3).
- *Who Gets HACC: A Statistical Overview of the HACC Program in Victoria 2002/2003*.
- The Department of Human Services' *Aboriginal Service Plan Key Indicators Report (2004).*

### 1.2.5 Financial Analysis

The purpose of the financial analysis was to inform the project about funding and cost options by analysing current funding arrangements and service costs for a selected range of HAAC service activities - General Home Care (HC), Personal Care (PC), Property Maintenance (PM), and Planned Activity Groups (PAG).

The approach adopted was to compare the actual funding and service costs of the selected service range for both mainstream and Koorie agencies. The costing model (refer

Attachment B) adopted was the model used in the report on Finding The Unit Cost (1995) and also in the Home and Community Care Unit Cost Survey (1997).

Two mainstream agencies (one metropolitan and one regional) and two ACCOs (regional) were identified to participate in the analysis.

### 1.2.6 Examination of Selected Models in-depth

The consultants undertook a more detailed examination of 5 new and innovative models, and the RDNS Homeless Persons Program. The following models were examined:

- Bendigo and District Aboriginal Cooperative (BDAC), Access and Referral Worker position.
- Darebin/Hume/Whittlesea, HACC Aboriginal Liaison Officer (HALO) position.
- Gannawarra Shire Council, Koorie specific HACC services.
- LaTrobe City Council, Koorie HACC Community Development Position and Elders PAG.
- Royal District Nursing Service (RDNS), Homeless Persons Program.
- Western Suburbs Indigenous Gathering Place, Information and Referral Worker position.

## 1.3 Acknowledgments

The authors of this report wish to thank Lena Morris, Lois Browne and Calvin Graham for their work in managing the project. We would also like to acknowledge the four agencies that participated in the financial analysis and recognise the extensive time and resource commitment they made by providing detailed financial data for use in the project. These agencies have not been named as sensitive financial information about their HACC program is presented in this report.

In addition, the project consultants would like to thank the representatives from the agencies sited within the report who willingly gave their time and information about their service and model of care, including:

- Darebin /Hume/ Whittlesea HALO Project.
- Gannawarra Shire Council.
- Latrobe City Council.
- Western Suburbs Indigenous Gathering Place.
- Bendigo and District Aboriginal Cooperative.
- RDNS Homeless Persons Program.

# 2. Koorie HACC Context

The Victorian Koorie HACC service system:

- Is underpinned by a range of Victorian and Commonwealth Government policies.
- Receives more than $6 million in recurrent HACC funding annually[2].
- Has a target group of between 5,900 and 11,000 people[3].
- Delivers services to nearly 2,000 individuals every year[4].
- Is supported by 38 Koorie specific HACC services and mainstream agencies[5].

## 2.1 Policy Context

The operation of HACC services in Victoria is governed by requirements of the Victorian HACC Program Manual and the HACC National Service Standards. In addition, the Victorian government sets out its commitments, goals and strategies for improving Indigenous health and well being, in the Victorian Aboriginal Services Plan. The Aboriginal Services Plan states "HACC services must be delivered in ways that are culturally appropriate and responsive to the needs of people from Indigenous backgrounds". In addition, the Plan states that:

- Aboriginal and Torres Strait Islander people should have access to culturally appropriate and sensitive services.
- Wherever possible, Aboriginal and Torres Strait Islander consumers should have the choice of services delivered by Aboriginal Workers or Aboriginal Community Controlled Organisations.
- The government will help to build the capacity of Aboriginal Community Controlled Organisations to deliver services to their communities, in their own right or in partnership with mainstream organisations.

## 2.2 Funding Arrangements

The Victorian HACC Program allocates approximately $6 million in recurrent funding to Koorie specific HACC services[6] each year. This funding is allocated to forty-one (41) agencies, of which thirty-eight (38) agencies deliver either HACC services or perform a Service Coordination role. Twenty two (22) ACCOs receive in excess of $4.25 million and sixteen (16) mainstream agencies receive in excess of $1.2 million to deliver Koorie specific HACC services. The remainder of the funding is held by DHS regions, used to fund VICACD and the Regional Koorie HACC Networks or expended on specific projects such as the Aboriginal and Torres Strait Islander Service Directory (a project of the Northern Division of General Practice).

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[2] Home and Community Care (HACC): Recurrent / Fixed Term Recurrent Activities (2004/2005).
[3] The minimum estimated size of the Aboriginal and Torres Strait Islander HACC Target Group was calculated by adding the number of Aboriginal and Torres Strait Islander people 45 years and older to the estimated number of Aboriginal and Torres Strait Islander people under 45 years with a disability. The maximum was calculated by multiplying this number by two. The doubling is in response to the under-reporting of Indigenous status in the census and research provided by ACCOs about the actual size of the Indigenous community in their catchment area. It should be noted that not all people in this target group would need or want HACC services.
[4] Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Project Victorian Report.
[5] Home and Community Care (HACC): Recurrent / Fixed Term Recurrent Activities (2004/2005).
[6] Koorie specific recurrent HACC funding $6,072,272.00 (2004/2005) and $6,136,378.00 (2005/2006).

## 2.3 Target Group and Health Status

The size and nature of the Aboriginal and Torres Strait Islander HACC Target Group is not well known or understood. The *Victorian Aboriginal and Torres Strait Islander HACC Needs Analysis Project Report* estimated that in 2005 there were between 5,976 and 11,952 Aboriginal and Torres Strait Islander people in the HACC Target Group living in Victoria. A breakdown of the size of the HACC Target Group by DHS region is set out in the table below.

| Estimated Size of the Aboriginal and Torres Strait Islander HACC Target Group | | |
|---|---|---|
| **Region and LGA** | **Size of Aboriginal and Torres Strait Islander HACC Target Group** | |
| | **ABS** | **Estimated** |
| Northern Metropolitan Region | 852 | 04 |
| Western Metropolitan Region | 852 | 956 |
| Eastern Metropolitan Region | 1704 | 1,136 |
| Southern Metropolitan Region | 775 | 1,550 |
| Gippsland Region | 4183 | 1,438 |
| Grampians Region | 8366 | 760 |
| BSW Region | 16732 | 5,844 |
| Loddon Mallee Region | 33464 | 11,6886 |
| Hume Region | 66928 | 128,57484 |
| **Victoria** | **133856** | **12,986,0582** |

Source: Victorian Aboriginal and Torres Strait Islander HACC Needs Analysis Project Victorian Report page 14.

## 2.4 HACC Utilisation

Available evidence suggests that Indigenous people suffer a greater burden of ill health than the rest of the population. The poorer health and well being of Indigenous communities has been well documented and results in a higher likelihood of them needing health service including HACC[7].

According to the *Aboriginal and Torres Strait Islander HACC Needs Analysis Victorian Report* the 'Adjusted HACC MDS' for the 2003/2004 reporting period, indicates that 0.89% (1,939 individuals – unduplicated count) of all HACC recipients were identified as Indigenous people. This data suggests that Indigenous people accessed HACC services at a level equivalent to or greater than their proportion of the total population. That is, the percentage of Indigenous HACC recipients is between the ABS population estimate of 0.6% of the total Victorian population and the estimated size of the Indigenous population (used in Phases 1 and 2 of the Aboriginal and Torres Strait Islander HACC Needs Analysis Project) of 1.2% of the total population. However, the utilisation of HACC by Indigenous clients varies considerably within and across regions.

The report analysed the 'Adjusted' HACC MDS and found that for the 2003/2004 reporting period (based on a duplicated count):

- 36% (815 individuals) of Aboriginal and/or Torres Strait Islander people accessed HACC services from an ACCO HACC service.

[7] Productivity Commission. *Overcoming Indigenous Disadvantage: Key Indicators* (2005).

- 13% (292 individuals) of Aboriginal and Torres Strait Islander people accessed HACC services from a mainstream agency with 'Koorie Specific' HACC funding.
- 40% (913 individuals) of Aboriginal and Torres Strait Islander people accessed HACC services from a mainstream agency.
- 10.5% (237 individuals) of Aboriginal and Torres Strait Islander people accessed HACC services from the Royal District Nursing Service (RDNS)[8].

The data indicates that the RDNS (with 237 HACC clients) was the largest single provider of services to Aboriginal and Torres Strait Islander people during the 2003/2004 reporting period, followed by:

- Victorian Aboriginal Health Service (142 HACC clients).
- Goulburn Valley Health (118 HACC clients).
- Gippsland East and Gippsland Aboriginal Cooperative (98 HACC clients).
- Rumbalara Aboriginal Cooperative (91 HACC clients).
- Aborigines Advancement League (66 HACC clients).
- Gunditjmara Aboriginal Cooperative (57 HACC clients).
- Aboriginal Community Elders Service (45 HACC clients).

While the HACC MDS suggests that mainstream agencies play a significant role in the provision of HACC services to Indigenous people, further analysis suggests that only a small number of mainstream agencies actually provide services to more than a handful of Indigenous clients.

The report concludes that overall, mainstream agencies appear to be performing poorly with regard to Indigenous people, and significant work is required to make these services attractive to Indigenous communities and families. This is particularly important in those areas where there are few or no ACCO HACC services available such as the Hume, Eastern, Southern, Gippsland and Western regions.

## 2.5 Need and Service Gaps

Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Project (Phases 1, 2 and 3)[9] found that:

- The overwhelming majority of Indigenous people prefer to access HACC services, particularly in-home and social support (PAG) services through an Aboriginal Community Controlled Organisation (ACCO). Their preference is for reasons of Cultural Safety, as well as a reluctance to access services through mainstream agencies because of issues of distrust, fear, shame, cultural barriers, and fees.
- Where an ACCO HACC service is not available, the majority of Indigenous people consulted indicated they would consider accessing a HACC service through a mainstream agency, if the agency and its service models were culturally sensitive and appropriate[10].

[8] Aboriginal and Torres Strait Islander HACC Needs Analysis Victorian Report (May 2005) p. 30.
[9] Aboriginal and Torres Strait Islander Communities HACC Needs Analysis report (Phase 1,2 and 3).
[10] The Report recommended that the Department of Human Services develop and implement a strategy to increase the up-take of HACC services provided by mainstream agencies by Indigenous people.

- While the Indigenous HACC target group is relatively small, the group has high and complex needs, is younger than the overall HACC Target Group and is growing exponentially[11].
- The Indigenous HACC target group has unmet needs and there are service gaps across Victoria.

## 2.6 Service System

The project mapping exercise identified 38 different models operating in Victoria. The current system and models for the delivery of Koorie specific HACC services has evolved over time in an ad hoc way. The service models adopted by the ACCOs and mainstream agencies funded to provide Koorie specific HACC fall into two main categories:

- Service Delivery.
- Service Coordination.

A detailed analysis of the current Koorie specific HACC service system can be found in section 3.5 of this report and in Attachment 1. Summary of Current HACC Funding, Clients, Catchments and Models Report.

[11] Population data and projections indicate that the number of Indigenous people entering the HACC Target Group will increase by more than 50% between 1996 and 2006 and continue to grow exponentially over the next 20 years.

# 3. Project Findings

## 3.1 Effective HACC Services

**The pre-requisite for any effective HACC Program is adequate resources for governance, management, administration, infrastructure, assessment / care management and partnerships. Many ACCOs do not receive adequate levels of funding to establish and maintain these functions.**

HACC is a complex and technical program, with a range of diverse service activities, reporting requirements, quality standards and legal requirements. Sustainable HACC programs must be underpinned by the following:

- Effective management and adequate infrastructure, including sufficient resources for human resource management, service development, planning, reporting, quality and continuous improvement.
- Adequate assessment and care management capacity.
- The capacity (resources, skills and time) to build and maintain formal partnerships.

Many of the ACCOs currently funded to provide Koorie specific HACC services do not have sufficient resources to establish and maintain these critical functions.

### 3.1.1 Management and Infrastructure

Only a few ACCO HACC programs have a dedicated manager position or even a part-time manager. The majority of programs have a HACC Coordinator (many of whom work part-time) whose focus is primarily service delivery and whose role usually includes some direct service provision or assessment. Even in the larger ACCOs, the employment of a Manager (Aged and Disability/HACC) is only possible by pooling funding from a range of program areas eg. Disability, CACPs, NRCP. These managers often undertake some service delivery or assessment role. In other organisations the HACC program is managed by the CEO such as the Aborigines Advancement League, Goolum Goolum Aboriginal Cooperative and the Bendigo District Aboriginal Cooperative (BDAC).

During 2004/2005 of the 23 ACCOs that received HACC funding:

- 35% received less than $100,000.00.
- 30% received between $100,000.00 and $150,000.00.
- 13% received between $150,000.00 and $250,000.00.
- 22% (5 agencies) received more than $250,000.00.

Across the HACC program, it is an accepted standard that agencies allocate between 18 – 20% of total HACC funding to cover overhead costs. Within ACCOs the amount of total funding allocated to overhead costs is often higher, at around 25%.

### 3.1.2 Assessment and Care Management

Assessment is the entry point into the HACC service system. The *Victorian Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Projects (Phase 1 and 2)* highlighted the importance of assessment and care management in the delivery of HACC services to Indigenous clients. In particular, the reports noted that there are significant and unique complexities involved in assessment and care management of Indigenous clients, including:

- Poorer health status and lower life expectancy.
- Burden of disease.
- Stolen generation issues.
- Cultural and community disconnectedness.
- Living arrangements and life style factors.
- Mental health issues.
- Family and community links.

Currently Assessment and Care Management is poorly funded in the ACCOs[12]. On average, ACCOs receive less than $10,000.00 for Assessment and Care Management and 10 ACCOs receive no funding at all. The Gunditjmara Aboriginal Cooperative for example receives funding for Meals, Home Care, Personal Care, PAG, Property Maintenance, Respite and Volunteer Coordination, but no funding for Assessment and Care Management.

The importance of this function within ACCO HACC programs must be recognised and adequate funding should be a priority for future HACC growth funding.

### 3.1.3 Partnerships

The HACC service system requires agencies to establish partnerships to ensure that clients can access the full suite of HACC services, as well as other commonwealth and state funded aged and disability services they may need. For example, local councils have established partnerships with community health services to link clients into allied health services or health promotion activities, and socially isolated allied health clients are often referred by community health staff to local Planned Activity Groups or to Councils for in-home services. Carers may be linked into carer services for respite, education or other support services.

The project found that there are only a few established partnerships between mainstream agencies and ACCOs. Consequently in many areas there are few if any referrals between ACCOs and mainstream services. Where partnerships exist, this is often due to the provision of specific funding and resources such as the HALO project, the Program and Services Adviser Koorie Assessment in the Loddon Mallee, and the Koorie HACC Planning project in Gippsland.

The lack of partnerships between ACCO HACC Programs and mainstream agencies is a weakness in the current service system. ACCO and mainstream agencies consulted for the

[12] There are many examples of small amounts of funding for Assessment and Care Management, eg. $6,736, $1,347, $7,284, $3,569, $6,526, $6,516, $1,393. Ten (10) agencies received no funding to provide Assessment and Care Management).

project indicated an interest and willingness to form partnerships, but were primarily constrained by a lack of time, knowing where to start and knowing who to approach. The Victorian HACC Program through its CEGS Strategy acknowledges that additional resources are required to enable ethno-specific agencies to build and maintain partnerships with mainstream agencies. A similar approach would be beneficial for the Koorie HACC Program.

### 3.1.4 Impact of Insufficient Funding on Resource Management, Infrastructure, Assessment/Care Management and Partnerships

The impact of insufficient funding for resourcing management and infrastructure has been documented elsewhere in this report. However, insufficient funding also impacts directly on client outcomes, for example:

- Inadequate assessment and care management can result in Indigenous people slipping through the gaps, accessing fewer services than non-Indigenous clients, utilising less hours of service etc.
- Limited partnerships may result in fewer referrals being made and misunderstandings about roles and responsibilities of agencies within the service system.

### 3.1.5 Summary

In summary, adequate resources for management, infrastructure, assessment and care management, and partnerships are essential for any HACC service. The way the funding model is currently applied makes it difficult for ACCOs to adequately resource these functions. As a result many ACCOs struggle to perform these critical functions effectively.

Specific additional funding for small organisations to build partnerships has been acknowledged through the CEGS strategy. DHS should consider whether the knowledge gained from this strategy can be applied to expanding partnerships between ACCOs and mainstream agencies operating in the HACC service system.

## 3.2 Impact of Low levels of HACC Funding

**The low levels of HACC funding received by the majority of Aboriginal Community Controlled Organisations make it difficult to adequately resource and maintain management and infrastructure functions.**

HACC services are funded nationally using an output based purchasing system. In Victoria, ACCOs typically receive small amounts of recurrent HACC funding to provide low volumes of a broad range of HACC activities.

The relatively small size of the Indigenous population does not justify high volumes of service and as a consequence ACCOs often receive small amounts of funding which are insufficient to establish and operate sustainable quality services.

Low levels of funding make it difficult to adequately resource the management and infrastructure functions needed to effectively support the HACC program.

The lack of income from fees and other sources further constrains the ability of ACCOs to enhance and expand HACC services.

### 3.2.1 Low Levels of Funding make it Difficult to Adequately Resource Management and Infrastructure Functions

The total amount of recurrent HACC funding received by most ACCOs (65%) is less than $150,000.00. Low levels of funding make it difficult to adequately resource the management and infrastructure functions needed to support an efficient and effective HACC service. The dilemma faced by many ACCOs is whether to:

- Allocate sufficient funding into management and infrastructure functions, leaving little funding for direct service delivery and possibly not meet the targets specified in their Funding and Service Agreement or
- Direct funding primarily to service delivery, and have insufficient funding to adequately resource management functions, infrastructure, partnerships and service development activities.

Evidence suggests that most ACCOs focus on service delivery. As a result many ACCO HACC services do not have sufficient management and infrastructure resources to:

- Meet reporting and quality assurance requirements.
- Undertake planning and continuous improvement of services.
- Build partnerships with mainstream agencies.
- Redevelop services and delivery models as the needs of the community change the HACC target group increases.

### 3.2.2 The Relatively Small Size of the Indigenous Population often does not Justify High Volumes of Service

The allocation of recurrent HACC funding and growth funding is based on formulas (RREF and WREN) which measure population and need, and attempt to balance competing demands for limited funding. The relatively small size of the Indigenous population often does not justify high levels of funding and volumes of service, and as a consequence ACCOs often receive small amounts of funding which are insufficient to establish and operate sustainable quality services.

Fifteen (15) of the twenty-three (23) ACCOs funded to provide Koorie specific HACC services received less than $150,000.00 in 2004/2005. The majority of the ACCOs were not funded for sufficient hours of Home Care to employ a full-time worker. Other examples of the low volumes of service funded during this period include:

- Aborigines Advancement League (AAL) which received funding for 100 hours of Volunteer Coordination and 313 hours of Respite Home and Community.
- Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) which received funding for 20 hours of Respite Home and Community to the value of $515.80.
- Goolum Goolum which received funding for 540 hours of Home Care.

Low levels of funding and small numbers of targets add complexity and difficulty to managing HACC programs. For example, the ACCOs reported that it is difficult to achieve economies of scale, recruit staff to work part time and meet program requirements such as reporting and quality. In addition, the skills and qualifications needed to provide Home Care, Personal Care, Respite, Group Programs, Assessment and Care Management, and Property Maintenance etc vary considerably, which means that small amounts of funding cannot simply be rolled into full-time or part time HACC worker position/s.

While it might appear that purchasing services from other agencies may be an effective approach to managing small volumes, this approach is often not cost effective either. The following factors affect the ability of ACCOs to purchase HACC services for Indigenous clients from external agencies[13]:

- Management resources are required to negotiate, purchase and monitor external service provision, many ACCOs do not have a HACC Manager to undertake this role.
- Many Indigenous clients will only accept Indigenous workers, especially for in-home services such as Home Care and Respite. Most mainstream agencies and external contractors do not have Indigenous workers.
- Significant developmental work is often required with the external agencies around cultural awareness and culturally appropriate models of care, to enable their services to be acceptable to Indigenous clients (especially when services are to be delivered in the client's home).
- Linking clients with other service providers and/or external contractors requires a level of trust which takes time to build and maintain. Where an external referral or service does not meet the needs of the Indigenous client it is usually the ACCO that the client blames/turns to.

[13] Local Government, non-government and external contractors.

- Reporting and quality requirements must still be met by the ACCO.

The impact of low levels of HACC funding is compounded by the fact that most ACCOs receive small amounts of funding from multiple programs within the Department of Human Services (see section 3.3 of this report).

### 3.2.3 Lack of Income from Fees and Other Sources

The HACC Program has traditionally operated with the support of funding from other sources, in particular rate revenues and fees. In fact, the Victorian HACC Program Manual and National HACC Program Fees Policy assume that fees will be collected from clients to "enhance or expand services"[14]. Unlike councils and non-government organisations, ACCOs usually do not have other sources of income such as fees and rates.

Anecdotal evidence provided to the project consultants suggests that HACC programs within ACCOs are often cross subsidised by the Community Development and Employment Project (CDEP), which supports Indigenous people to gain employment and skills through training and work experience.

### 3.2.4 Impact of Low Levels of Funding

The impact of low levels of HACC funding has been documented in previous reports, VICACD minutes, and discussed at statewide and regional forums. Some examples include:

- Inconsistent completion and reporting of MDS information.
- Poor performance in the HACC National Service Standards Audit process by many ACCOs.
- Viability issues. Some ACCO HACC programs have at times temporarily suspended services, or in some cases services have been transferred to mainstream agencies.
- Services are sometimes interrupted when staff are on leave or attending training.
- High staff turnover due to low wages, poor working conditions, insufficient hours of work available, and stress.
- Service contraction (less average hours available to clients) to accommodate rising costs such as fuel and consumables.
- Insufficient time for staff to build partnerships with other agencies.

In response to these issues, some ACCOs are choosing to use their recurrent HACC funding to undertake a service coordination role rather than service delivery. For example the Western Suburbs Indigenous Gathering Place has employed an Information and Referral Worker whose role is to link Indigenous clients into HACC services provided by mainstream agencies, and the Bendigo and District Aboriginal Cooperative which will employ a HACC Access and Referral Worker when the HACC service resumes at the Cooperative in early 2006.

[14] Victorian Home and Community Care (HACC) Program Manual (February 2003) p 214.

### 3.2.5 Summary

In summary, the findings of the project suggest that DHS and the ACCOs should investigate how the output based purchasing model can be more effectively applied to the funding of Koorie specific HACC services. For example, consideration should be given to:

- Narrowing the range of activities ACCOs are funded to deliver, to enable services to focus on key activities (particularly the culturally sensitive in-home services) needed by the community rather than the broad range of HACC service activities available.
- Refocusing some HACC programs away from direct service provision and towards employing staff to perform an access, referral, service coordination and advocacy role.
- A development and funding strategy to build partnerships between ACCOs and mainstream agencies.

## 3.3 Impact of Low Levels of Funding from Multiple DHS programs

**The impact of low levels of HACC funding is compounded by the fact that most ACCOs receive small amounts of funding from multiple programs within the Department of Human Services.**

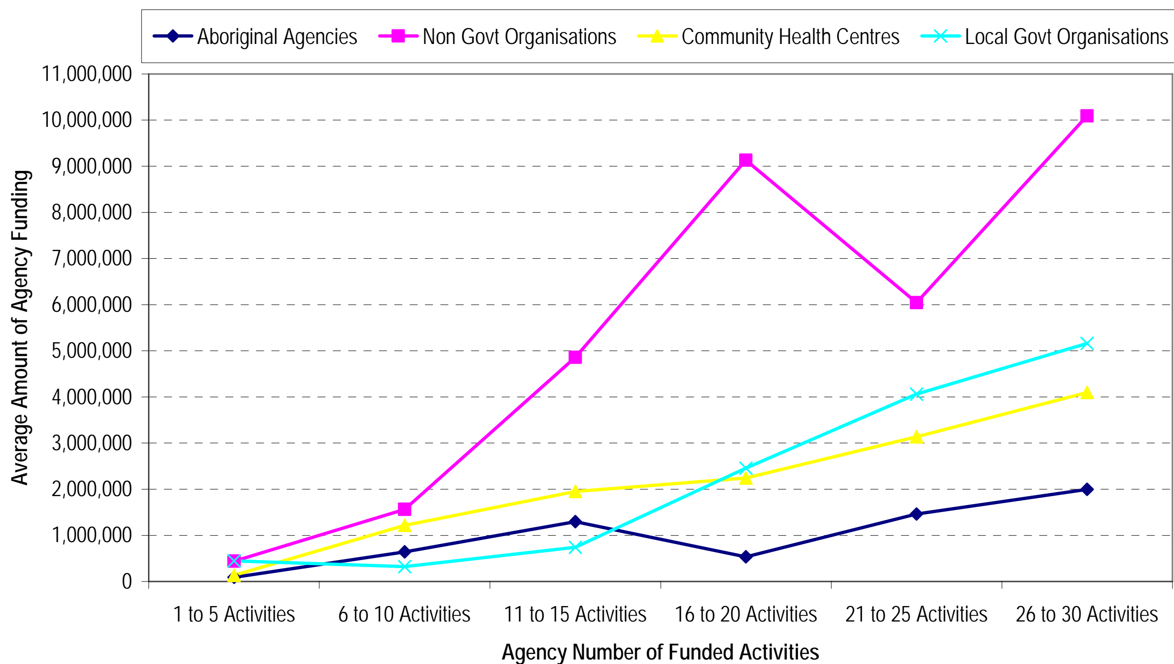
The impact of low levels of HACC funding is compounded by the fact that most ACCOs receive small amounts of funding from multiple programs within the Department of Human Services. The level of funding from other DHS programs is often also insufficient to employ full time staff and adequately fund management and infrastructure functions.

### 3.3.1 Profile of DHS funding to ACCOs

An analysis of DHS funding to ACCOs shows that most ACCOs receive small amounts of funding from multiple programs. For example an ACCO may receive funding from Disability Services, Drug Treatment Services, Child Protection and Family Services, Juvenile Justice and Youth Services, and Mental Health. Unpublished DHS data shows:

- ACCOs often receive less than $100,000.00 per annum from DHS program areas. In fact many programs provide funding of less than $50,000.00 per annum.
- That when comparing average amounts of agency funding with the total number of funded activities by agency type (local government, non government, community health and ACCO), ACCOs receive the lowest average amount of agency funding.
- Average funding per activity is $72,268.00 for ACCOs, compared to $268,550.00 in non-government organisations, $160,359.00 in community health services and $146,680.00 in local government organisations.
- That it is not untypical for an ACCO to receive funding from more than eight (8) DHS program areas to deliver more than 20 activities.
- While most of the other DHS Program areas fund for one or two activities, the HACC Program often splits a relatively small quantum of funds into six to eight service activity types.

The chart overleaf provides an overview of the average amount of funding provided to agencies by DHS, based on the number of funded activities and agency type.




While some organisations like the Rumbalara Aboriginal Cooperative have pooled funding to resource service manager positions (e.g. the Aged and Disability Manager position is funded from HACC, Disability, CACPs), this approach is the exception not the norm. The typical organisational structure of an ACCO is characterised by a CEO, responsible for managing a range of staff working relatively independently across a range of funded programs.

### 3.3.2 Mix of DHS Program Funding to ACCOs

Analysis of unpublished DHS data (2005/2006) shows that there is no consistency in type and mix of program funding provided by DHS to ACCOs, in particular how the ACCOs are funded, which programs provide funding, and in what services the ACCOs are funded to deliver. The table overleaf provides a summary of the funding received by 5 ACCOs in 2005/2006 and shows:

- The inconsistency in the programs funded and the amount of program funding provided.
- That the total amount of program funding received by ACCOs is not linked to the size of the Indigenous community.
- The relatively low levels of funding provided by programs, for example the PDRSS funding provided by the Mental Health Branch is not sufficient to employ a full-time worker.
- The only two programs which provide funding to all five ACCOs are HACC and Mental Health (PDRSS).

| Example of DHS Program Funding provided to Five ACCOs in 2005/2006 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Agency** | **Indigenous Population** | **Total DHS Program $** | **# HACC Activities funded** | **Other DHS Program funding** | | | | | | |
| | | | | Acute | Child Protection | Early Years | Drug Treatment Services | Family Services | J.J | PDRSS |
| A | 832 | $379,000 | 10 | x | X | $59k | $135k | x | X | $24k |
| B | 322 | $375,000 | 10 | $24k | X | $30k | $39k | x | $82k | $25k |
| C | 1,394 | $450,000 | 9 | x | X | $29k | $115k | $87k | $46k | $25k |
| D | 939 | $240,000 | 2 | x | $57k | x | $35k | x | $21k | $11k |
| E | 556 | $563,000 | 9 | $165k | $168k | x | x | x | x | $66k |

Funding for new projects and services such as the Aboriginal Health Promotion and Chronic Care Partnerships (AHPACC) projects also add complexity.

Managing coordinated and integrated services in this situation would be difficult for any organisation, not just ACCOs.

### 3.3.3 Summary

Significant redevelopment of the current funding arrangements is required to achieve the intent of the Victorian government's policy commitments to Indigenous health and ACCOs, in particular its stated goal to "Build capacity in Aboriginal organisations to develop quality services and partnerships to meet community needs" and stated strategy that "the Department will support the viability and sustainability of ACCOs funded by the Department and their ability to provide good quality services[15]".

Adequate funding for governance, management, assessment / care management, administration, infrastructure, and partnerships is therefore a cross-program responsibility. DHS program areas need to work together to address program and funding fragmentation issues, with a view to better coordination to strengthen the viability of ACCOs.

[15] Victorian Aboriginal Services Plan (2004). Department of Human Services.

## 3.4 Financial Analysis

**Estimating the cost of delivering HACC services to Indigenous people was difficult and indeterminate. However, the costing data collected and analysed, as well as anecdotal feedback from the ACCOs and mainstream agencies which participated in the project indicated that the cost of delivering HACC services to Indigenous people is higher than the provision of services to non-Indigenous people.**

A financial analysis was undertaken as part of the project. The purpose of the financial analysis was to inform the project about funding and costs by analysing current funding arrangements and service costs for a selected range of HACC activities - General Home Care (HC), Personal Care (PC), Property Maintenance (PM), and Planned Activity Groups (PAG).

Estimating the cost of delivering HACC services to Indigenous people was difficult and indeterminate. However, the costing data collected and analysed, as well as anecdotal evidence from ACCOs and mainstream agencies indicated that the cost of delivering HACC services to Indigenous people is higher (with the possible exception of PAG) than the provision of services to non-Indigenous people.

### 3.4.1 Approach to Financial Analysis

The approach adopted was to compare the actual funding and service costs of the selected activities for both mainstream and ACCOs. The costing model (refer Attachment 2) adopted was the model used in the report on Finding The Unit Cost (1995) and also in the Home and Community Care Unit Cost Survey (1997).

Two mainstream agencies (one metropolitan and one regional) and two ACCOs (regional) were identified to participate in the financial analysis. Two ACCOs withdrew from the project due to organisational and workload issues and the third replacement organisation was unable to provide the level of data required. Consequently the resultant analysis compares a single ACCO with two mainstream agencies.

### 3.4.2 Interpreting the Financial Data

The data provided by the participating agencies has not been audited but in each case the resultant costing model has been reviewed and generally agreed with relevant management in each agency as being reasonably reflective of their actual performance. The challenge for all agencies was to provide the data in the format required. Only one agency had a dedicated resource for aged and disability analysis and there was significant variance in the reporting methodologies of each agency.

All agencies had direct cost data but it is reasonable to assume that indirect costs (including overhead allocations) are conservatively stated. For the ACCOs (including the agency not included) the use of CDEP workers provides a complication with both cost and funding (sponsorship) impacts. This impact may not be accurately assessed in the analysis. There

was no opportunity for inter-agency discussion and all agencies had time and resource constraints which limited the project's ability to pursue further analysis in respect of comparative anomalies. For all of these reasons the analysis findings should be seen as indicative only.

To assess total cost and funding for each selected service, assessment and care management costs and funding was allocated across the services on a basis advised by the agency. Only one agency makes this allocation as part of normal management reporting and thus there may be a level of comparative variance in respect of the net cost of this service element.

Detailed financial information collected and analysed for the project can be found in Attachment 2.

### 3.4.3 Financial Analysis

The following comments can be made from the cost and funding analyses for each HACC activity:

- The service hours reported by mainstream agencies significantly exceed the funded hours (in excess of 50%). The ACCOs report only funded hours.
- With the exception of PAG services, ACCO Direct Worker Costs per service hour and Total Unit Costs significantly exceed comparable mainstream costs. Possible reasons for this are:
  - Lack of economies of scale.
  - The complexity of the model of care.
- The unit cost of PAG services provided by ACCOs compares favourably with the mainstream agencies. Possible reasons for this are:
  - Significant economy of scale.
  - Understated costs, in particular the CDEP worker contribution.
- There is a dependence on CDEP worker support in ACCO service provision which may not be accurately costed or disclosed as other (sponsorship) income.
- ACCOs do not receive client contributions (fees) for services provided.
- For the ACCOs 'Other Fees and External Income' represent a mix of other State and Commonwealth funding, including CDEP.
- Unlike the mainstream agencies ACCOs cannot sponsor services by providing operating subsidies in the form of non-cash overhead support (Human Resources, IT etc) or cash revenue support from other agency services (eg. rates).
- The preliminary data provided by the second ACCO but excluded from this report generally confirms the above findings.

Although the project sample base for the costing exercises was limited there are some observations which may be relevant:

- There was significant variance in the methodology cost-output reporting (including accounting for indirect overheads). The quality of the information was also variable except for one agency with a dedicated resource.
- The ACCOs had considerable difficulty responding to the information requests which probably reflects their general lack of infrastructure and management resources.

- The findings of the cost and funding analysis generally reflect the anecdotal feedback provided by representatives from ACCOs and mainstream agencies who participated in the project.

### 3.4.4 HACC Unit Prices do not Reflect the Actual Cost of Delivering Services to Indigenous people

The consultations and costing research conducted for this project suggest that HACC services delivered to Indigenous clients by ACCOs cost more to deliver than services to non Indigenous clients. While a range of factors[16] contribute to the difference between the HACC Unit Prices and the actual cost of delivering services to Indigenous people, much of the discrepancy can be attributed to the model of care needed to attract and retain Indigenous clients within HACC.

The model of care underpinning the delivery of services to HACC clients by ACCOs is unique and contributes to the higher cost. For example, HACC services operated by ACCOs:

- Actively affirm, rather than simply accommodate cultural difference[17].
- Are underpinned by a knowledge of Indigenous culture, beliefs, values and history, as well as an understanding of the needs of the local community, which informs:
    - Service focus and design.
    - Service delivery models.
    - Service outcomes.
- Identify all clients as Indigenous or non-Indigenous and this drives the service response.
- Accommodate socio-economic factors such as housing arrangements, living conditions, and life style.
- Have a governance structure (community controlled) which enables clients, carers and the local community to have input into service planning, service delivery and priority areas.
- Possess an in-depth knowledge of the community including respect for culture and kinship, and a knowledge of men's business and women's business.
- Employ Indigenous staff at all levels: management, service delivery, assessment and governance.
- Operate holistic approaches to assessment and care which encompasses physical, social, spiritual and environmental factors, as well as a focus on all aspects of family.
- Operate models of service delivery which are flexible in relation to service location, delivery of services, time of service, staffing of service, and fees.

The financial analysis and information provided by the ACCOs consulted for this project suggest that the costs of delivering services within this model of care are higher because:

- There is a need for a high level of flexibility around rostering, staffing, service hours and service location.
- The nature of service delivery is different, for example an hour of Home Care may encompass house cleaning, shopping, social support, advocacy, escorting clients to appointments, food preparation, bill paying etc and this may vary from week to week.

[16] Catchment size, transport costs, economies of scale, direct costs etc.
[17] Cultural Safety Policy Construct.

- Client, family and community involvement in service development and delivery is a resource intensive process.
- Ongoing assessment and care management to engage and retain Indigenous clients in HACC services.
- A proportion of HACC funding is used to support organisational governance and infrastructure such as Front of House, vehicles etc.
- Human resource management is complex and sensitive, particularly with client and worker matching (acceptability, family relationships, men's and women's business), high levels of staff turnover, difficulties recruiting and retaining qualified Indigenous workers, training costs etc.
- In most agencies there is only minimal internal infrastructure to support the HACC Program, for example IT, Fleet Management, Financial and Accounting support, Quality and Continuous Improvement, Reception. This often results in HACC workers doing both service delivery and a range of infrastructure tasks such as reporting, policy development, audit reporting, client records, budgets, administration, staff management etc.
- There is usually no fee income to "enhance and expand" services or defray costs associated with service delivery such as materials for activities, meals, rubbish removal, maintenance etc.
- Many ACCOs have large catchment areas, which are characterised by higher than average travel costs.

Anecdotal evidence also suggests that culturally appropriate models of service delivery which meet the needs of Indigenous clients cost more to operate within mainstream agencies. Mainstream agencies consulted for the project identified the following factors which contribute to the higher costs:

- The need for flexibility around rostering, service hours and times.
- Staffing arrangements including matching clients with acceptable staff (Indigenous and non Indigenous) and respecting cultural needs of Indigenous staff eg. Time off to attend funerals and family matters.
- Housing arrangements and living conditions.
- Cultural awareness training for staff and managers.
- The resources and time required to build trust and effective working relationships between the Indigenous community, the HACC Program and the agency.
- Time for community education and awareness raising about HACC, client rights and responsibilities and what services can and cannot be provided.
- The costs of establishing and resourcing an Elders Advisory Group or Advisory Committee to oversee the HACC program and support continuous improvement.
- Lower fee income. Some mainstream agencies indicated that they waive fees for Indigenous clients as a strategy to encourage the Indigenous community to use their services.
- A significant service coordination and care coordination role to support Indigenous clients (individuals and families) to access the range of services and remain in the services.

### 3.4.5 Koorie Specific HACC Programs in Mainstream Agencies

As previously stated, mainstream agencies delivering Koorie specific HACC services also indicated that the cost of delivering HACC services to Indigenous clients was generally higher than non-Indigenous clients. This feedback was anecdotal only, as none of the mainstream agencies consulted during the project had systems in place to financially track the 'additional' costs. The consultants believe that DHS and mainstream agencies need a better understanding of the actual cost of delivering Koorie specific HACC services to guide future planning and funding of Koorie specific HACC programs. An action research project to track and quantify the actual cost of delivering Koorie specific HACC services within a mainstream agency could be undertaken with the Gannawarra Shire Council, Latrobe City Council and the Swan Hill Rural City Council.

### 3.4.6 Summary

In summary, estimating the cost of delivering HACC services to Indigenous people was difficult and indeterminate. However, the costing data collected and analysed, as well as anecdotal feedback from ACCOs and mainstream agencies that participated in the project indicated that the cost of delivering HACC services to Indigenous people is higher (with the exception of PAG) than the provision of services to non-Indigenous people.

The financial data collected suggests that the ACCO costs exceed comparable mainstream costs, with the exception of the Planned Activity Groups. In the case of Home Care, the Total Unit Cost of an hour of service was estimated to be $72.14 which is $47.19 more than the HACC Unit Price for Home Care in 2004/2005. The higher costs can be attributed to Direct Worker Costs and other variables specific to each activity. The CDEP appears to provide a significant in-kind resource in the provision of all the HACC activities studied for the financial analysis.

The ACCOs approached to participate in the financial analysis had considerable difficulty responding to the information requests, which probably reflects their general lack of infrastructure and management resources.

## 3.5 Models

**The current service system is characterised by a range of models, many of which do not appear to be effective or represent value for money.**

The mapping exercise undertaken for the project found that there are 38 different models for delivering Koorie specific HACC services. The service configuration of each model largely reflects historical factors, in particular:

- Funding initiatives and changes such as the move from block grants to output based purchasing.
- The availability and allocation of new recurrent HACC growth funds at a regional or local level.
- The availability of qualified staff and Indigenous workers.

### 3.5.1 Current Koorie Specific HACC Service System

The project mapped the current Koorie specific HACC service system. The following observations can be made:

- The majority of ACCO HACC services replicate the broader HACC service system (ie. provide a broad suite of HACC activities) rather than build upon and complement the local service system[18]. The new and redeveloping services (both ACCO and mainstream) are tending to adopt service coordination and referral focus, rather than a HACC service delivery role.
- ACCOs play a crucial role in the delivery of HACC services to the Indigenous population in Victoria. Service models, cultural safety and links to culture and community cannot be achieved by mainstream agencies. In addition, the HACC funded ACCOs through the regional Koorie HACC Networks and VICACD have played a central role in advocating for funding and improvements to the HACC service system for elders, people with a disability, and carers.
- In-home services and PAG appear to be the most culturally sensitive activities, because:
  - Indigenous people report being most reluctant to have in-home services provided by mainstream agencies and non Indigenous workers.
  - These services require the most flexibility around the nature of the service provided, service time, life style issues, living arrangements and conditions, and cultural sensitivity.
  - A central role of the PAG is enhancing social and cultural connectedness, and as an entry point into the service system.
- There appears to have been little or no research to determine which models are most effective (and represent value for money) in meeting the needs of frail older people, people with a disability and carers. The findings of the *Aboriginal and Torres Strait Island Communities HACC Needs Analysis Project: Victorian Report (2005*)[19] suggest that the effectiveness of Koorie HACC funding in mainstream agencies is 'patchy': For example:

[18] The redevelopment of the HACC services provided by the AAL, ACES and VAHS early in 2000 is perhaps the exception to this.
[19] Prepared for the Department of Human Services by Effective Change Pty Ltd (2005).

  - As few as 57 Indigenous clients may have received services from 10 mainstream agencies which received in excess of $570,000.00 to deliver Koorie specific HACC programs (during 2004/2005).
  - Goulbourn Valley Health reported that 118 Indigenous clients were seen by its HACC Access and Referral Worker, but the HACC MDS indicates few, if any of these Indigenous clients ended up receiving HACC services.
  - A mainstream agency receiving in excess of $60,000.00 Koorie specific HACC funding reported only 6 Indigenous clients received services in 2004/2005.
  - Four mainstream agencies saw 80% of all Indigenous clients receiving services from mainstream agencies with Koorie specific HACC services.
- Unlike the allocation of funding to mainstream agencies through the RREF, WREN and regional HACC planning processes, there does not appear to be any clear evidence base (or rationale) for the funding of ACCOs and mainstream agencies to deliver Koorie specific HACC services. For example:
  - In the Barwon South West (BSW) region more than half of the Indigenous population live in the local government area of Greater Geelong, yet only one quarter of the region's Koorie specific HACC funding is allocated to this area.
  - Some ACCOs are funded to provide a broad range of HACC activities, but do not receive any Assessment and Care Management funding.
  - There are some medium sized Indigenous communities where there are no Koorie specific HACC funds allocated, such as communities living in the local government areas of Maroondah, Macedon Ranges, Baw Baw and Whitehorse.
- There is great disparity in expectations between agencies receiving Koorie specific HACC funding. For example in 2004/2005:
  - An ACCO received $143,025.00 to provide: Assessment and Care Management, Allied Health, Home Care, Personal Care, Property Maintenance, Respite- Home and Community, SSR and FSR.
  - A mainstream agency received $108,001.00 for Allied Health, Nursing and FSR.
  - An ACCO received $160,515.00 for Assessment and Care Management, Delivered Meals, Home Care, Personal Care, PAG and Property Maintenance.
  - A mainstream ageny received $102,914.00 for Service Coordination and Care Management Worker role.

Clearly, the Service Coordination models are simpler to manage, require less infrastructure for reporting and quality, have lower overheads, and less complex staffing arrangements.

### 3.5.2 Koorie Specific HACC Models

The service models adopted by the ACCOs fall into two main categories:
- Service Delivery.
- Service Coordination.

#### 3.5.2.1 Service Delivery

Twenty (20) of the ACCOs HACC services can be characterised as operating 'service delivery' models. That is, delivering a range of HACC activities including Home Care, Personal Care, Property Maintenance, Planned Activity Groups and possibly Volunteer Coordination, Allied Health and Respite services. The service delivery models can be further categorised as:

- Integrated Aged Care and Disability services, where HACC, Disability and commonwealth funding is grouped together to provide a broad range of aged and disability services, currently in place in agencies such as Rumbalara Aboriginal Cooperative and GEGAC.
- HACC focused services, where HACC is the main service provided by an agency, currently operating in agencies such as the Aborigines Advancement League and Budja Budja Aboriginal Cooperative.
- Multiple services, where HACC is just one of a broad range of human services provided by the agency, currently operating at the Ballarat and District Aboriginal Cooperative, Kirrae Health Service, Victorian Aboriginal Health Service and Njernda Aboriginal Corporation.

#### 3.5.2.2 Service Coordination

A small number of ACCOs have recently adopted what can be described as a Service Coordination Model. In these agencies a worker is employed to facilitate access to HACC and other services, which are provided by mainstream agencies such as councils, non-government organisations and community health centres. While the roles and responsibilities of workers vary across agencies, there is usually a dual focus within the role:

- Community development, awareness raising, advocacy, referral and support.
- Partnership development, including improving cultural awareness and the responsiveness of mainstream services.

A service coordination model has been operating out of the Western Suburbs Indigenous Gathering Place since 2004 and a new service will commence at Bendigo and District Aboriginal Cooperative in early 2006.

The HALO Project (a partnership between the Victorian Aboriginal Health Service (VAHS), Aborigines Advancement League (AAL), Aboriginal Community Elders Service (ACES), the City of Darebin, City of Hume and City of Whittlesea) also adopts a service coordination approach. A HACC Aboriginal Liaison Officer has recently been appointed to:

- Increase access to local government HACC services by Indigenous HACC target populations (elders, people with a disability and their carers) in the three participating municipalities.
- Improve the appropriateness and responsiveness of mainstream services to Indigenous clients' needs.
- Develop collaborative and supportive working relationships with ACCOs to provide complementary services for Indigenous HACC target populations[20].

[20] HACC Aboriginal Liaison Officer Project: Phase One Report (September 2005).

#### 3.5.2.3 Mainstream Models

The models adopted by mainstream agencies funded to deliver Koorie specific HACC programs can be grouped under four main categories:

- Indigenous specific HACC programs within mainstream agencies. These models are characterised by Indigenous specific services operating semi-autonomously within a mainstream agency. Examples of this model include the Indigenous Health Team at Healesville located within Yarra Valley Community Health Services and the Kookaburra Club operating from Darebin Community Health Service.
- A partnership between a mainstream agency and an ACCO, where the agencies work together to deliver a suite of services. The mainstream agency often providing outreach services at the ACCO. An example of this model is the partnership between Southern Health and the Dandenong and District Aboriginal Cooperative.
- Service delivery, with a specific target for Indigenous clients. Currently there are a number of mainstream agencies undertaking this role including the Gannawarra Shire and Swan Hill Rural City Council.
- Assessment / Service Coordination role, with a focus on linking Indigenous clients into the local HACC services. Currently five mainstream agencies have funding for this role, including Bayside Health, Latrobe City Council, Peninsula Community Health, Mornington Peninsula Shire, and Peninsula Community Health.

Further information about each of these models can be found in the *Summary of Current HACC Funding, Clients, Catchment and Models Report (May 2005)* in Attachment 1 of this report.

### 3.5.3 Alternative Models of Koorie HACC

This section of the report provides a brief overview of 5 new models which have recently been established, or are in the process of development. Many of these models address the issues and problems identified in this report, in particular:

- The difficulties associated with delivering Koorie specific HACC services within the HACC Unit Price, with low volumes and a broad range of activities.
- Minimising the need for a large investment in management and infrastructure resources.
- Access to sufficient levels of assessment and care management.
- The importance of partnerships for referral, resource sharing and enhancing client outcomes.
- Addressing the cultural awareness of mainstream agencies and assisting them to develop culturally sensitive models of care.

#### 3.5.3.1 Darebin/Hume/Whittlesea HALO

In 2004, the DHS funded a partnership (between ACES, AAL, VAHS and the Darebin, Hume and Whittlesea councils) to undertake a project to develop a model that would increase access for people from Indigenous communities to mainstream HACC services and to enhance relationships between the three ACCOs and mainstream agencies. The key outcome of the project was the establishment of a HACC Aboriginal Liaison Officer position, which was filled in late 2005. The HACC Aboriginal Liaison Officer's role[21] involves:

[21] HACC Aboriginal Liaison Officer Project: Phase One Report (September 2005).

- Being a primary contact point for facilitating referral and linkages into HACC services.
- Advocating for culturally appropriate local government HACC services.
- Providing advice and support to local government staff regarding cultural issues.
- Raising local government awareness of Indigenous communities.
- Promoting local government HACC services to local communities.
- Providing referral and intake support, including linking people into local government HACC services and establishing collaborative referral relationships.
- Promoting priority areas and HACC needs within local government on behalf of local Indigenous communities.
- Establishing local support networks that support promotion and information sharing.
- Community development and capacity building within local communities.

While a formal evaluation has not been undertaken, feedback from the project partners indicates that the project development phase was beneficial and the new HACC Aboriginal Liaison Officer role will have a positive impact. A key outcome of the project development phase was the establishment of partnerships and effective working relationships between the project partners, increased awareness of the HACC needs (including a framework to address these) and improved cultural awareness and sensitivity in the three local government HACC services.

#### 3.5.3.2 Gannawarra Shire Council

The Gannawarra Shire Council took over responsibility for a small Koorie specific HACC service in 2004. The funding received was to provide Home Care to Indigenous clients and a small amount of service system resourcing to establish a Planned Activity Group and resource an Elders' Committee.

Key outcomes:

- The Shire has introduced changes to improve the flexibility and cultural sensitivity of its HACC service.
- HACC and front of house staff have participated in culturally appropriate communication training (understanding culture, and behaviour and respect).
- An Elders' Advisory Group has been established to facilitate communication and information sharing between the HACC service and the Indigenous community.
- Improved trust between the community and council services eg. Community members have recently been hiring the council bus to provide transport to funerals.

#### 3.5.3.3 Latrobe City Council

In 2004, the DHS and Latrobe City Council jointly funded a Koorie HACC Community Development Position. The role of this position is primarily:

- Advocacy for individual Indigenous clients.
- Building community knowledge and awareness about HACC.
- Capacity building and role modelling within the community.
- Working with and assisting Council Assessment staff undertaking assessments and care management of Indigenous clients.
- Communication and follow up on individual client's concerns, issues and needs.

While this is a relatively new model and still in a developmental phase, the following learnings were identified:

- Developing relationships between mainstream agencies and Indigenous communities takes time, commitment and resources.
- The establishment of an Indigenous Advisory Group is essential.
- Indigenous staff are critical for any community development role.
- An organisational commitment to reconciliation.

#### 3.5.3.4 Western Suburbs Indigenous Gathering Place

The Western Suburbs Indigenous Gathering Place received funding to employ an Intake and Referral Worker. The initial priority of this role was to build relationships with mainstream agencies and assist them to develop culturally appropriate and sensitive services across disability, primary health and community care. The Intake and Referral worker worked closely with Managers, Assessment Officers and HACC staff. Once trust had been developed, the role expanded to supporting community members to access HACC services.

While the Intake and Referral role has not been formally evaluated, the following outcomes were identified by the Gathering Place:

- An increase in the number of Indigenous people accessing HACC services in the western region (this is supported by the HACC 2004/2005 MDS).
- Engagement of Indigenous families who were previously not accessing services.
- Reduced isolation amongst elders and families.
- A better understanding of the Indigenous community and its needs by local government and non government organisations.
- A higher profile of the Indigenous community and culture in the region.
- The Gathering Place is operating as an entry point into the HACC service system and other services.
- Effective working relationships between the Gathering Place, local councils, non government organisation and the DHS.

#### 3.5.3.5 Bendigo and District Aboriginal Cooperative

During 2005, the BDAC and the DHS worked together to develop a new model for HACC to be managed by the Cooperative. As a result, an Access and Referral Position was created. The position has a dual focus:

- Working with the community to link them into services, and
- Working with mainstream agencies to ensure services are accessible and culturally sensitive.

The aim of the position will be to:

- Undertake assessments and link Indigenous people into services within the community.
- Maintain a strong outreach focus, working closely with the community to raise awareness, advocate and facilitate access to HACC services.
- Work with other agencies to build and maintain culturally sensitive models of care.
- Participate in joint assessments and case management.
- Undertake systemic and individual advocacy.

#### 3.5.3.6 Emerging Models

The models described above are relatively new or still in the establishment phase, and their effectiveness has not yet been assessed. However, all those consulted believed that the models will be successful and make a positive impact on their respective communities. The following learnings were identified during the consultations undertaken for the project:

- Service Coordination type models are suitable for small and medium sized communities, which do not attract significant HACC funding and do not warrant large Koorie specific HACC services.
- Resources are needed to build partnerships and assist mainstream agencies to develop culturally sensitive models of care.
- Mainstream agencies must be committed, as ACCOs place a lot of trust in mainstream agencies. When community members are referred to mainstream agencies by ACCO staff, it is the reputation of the ACCO that is at stake.

#### 3.5.3.7 RDNS Homeless Persons Program

While the RDNS Homeless Persons Program is not a new service or in receipt of Koorie specific HACC funding, the findings of *Aboriginal and Torres Strait Island Communities HACC Needs Analysis Project: Victorian Report (2005*) show that in 2004/2005, the RDNS Homeless Persons Program was the largest provider of HACC services to Indigenous people in Victoria.

The RDNS Homeless Persons Program provides nursing care and support to people who are homeless or at risk of homelessness, through an assertive outreach model. The nurses from this program who were consulted for the project identified the following factors which contributed to the success of this program engaging Indigenous clients:

- The program's assertive outreach model, with nurses being seen in the community and in public areas.
- The program's commitment to social justice and equity of access.
- Program flexibility which enables the nurses to spend time with the clients, building trust and encouraging them to use the service.
- Collaboration and partnerships with other homeless programs and clinics.
- The skills and knowledge of the nurses.
- Recognition that the client group is marginalised and an understanding of Indigenous culture.
- No fees are charged to clients.

### 3.5.4 Summary

In summary, the Koorie HACC service system is diverse and complex. The majority of ACCO HACC programs have a service delivery focus. New models emerging are tending to take on a service coordination role.

## 3.6 Utilisation of HACC Services by Indigenous People

**The majority of mainstream agencies provide HACC services to few or no Indigenous clients and significant work is required to make these services culturally sensitive and attractive to Indigenous communities and families.**

There is significant debate about the size of the Victorian Indigenous population and the actual utilisation of HACC services by Indigenous people. While ABS population data suggests that 0.54 percent of the population are Aboriginal and /or Torres Strait Islander people and DHS publications suggest that Indigenous people are not under-represented in the HACC Program, these views are contested by the majority of ACCOs and consultative bodies such as VICACD and the regional Koorie HACC Networks.

### 3.6.1 Size of the Victorian Indigenous Population and HACC Target Group

There is significant debate about the size of Victoria's Indigenous population. The Australian Bureau of Statistics (ABS) Experimental Estimates of Indigenous Populations (June 2001) suggests that the Aboriginal and Torres Strait Islander population in Victoria is 27,928 people or 0.6% of the total population. Many ACCOs and Indigenous community representatives believe that the ABS data significantly under-estimates the actual number of Aboriginal and Torres Strait Islander people living in Victoria. The Department of Human Services has also acknowledged the ABS estimates may underestimate the actual size of the Indigenous population [see Victorian Koorie State Health Plan 2001 and Albury Wodonga Koorie Cross Border Regional Health Plan and Needs Analysis 2002].

As opinions about the size of the population under-estimate also vary considerably, an agreed benchmark was set for analysis of information in the Victorian Aboriginal Communities HACC Needs Analysis projects. The project worked on an assumption that the Indigenous population was between 50% and 100% higher than the ABS data. The size of the Indigenous HACC Target Group and the utilisation of HACC services by Indigenous people was then compared to the ABS population estimates as well as the higher benchmarks.

### 3.6.2 Utilisation of HACC Services by Indigenous People

The *Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Project: Victorian Report* states that while caution should be taken in drawing strong conclusions from the HACC MDS[22] on Aboriginal and Torres Strait Islander use of HACC services during the 2003/2004 reporting period, key themes have emerged from the project:

[22] Source: *Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Project: Victorian Report*

- Over 14% of the records in the 'Cleaned Up' HACC MDS included non-Aboriginal and Torres Strait Islander clients and this may have skewed the data (age, gender, average annual hours of service etc) and hidden the underutilisation of HACC by Aboriginal and Torres Strait Islander people.

- The number and percentage of Aboriginal and Torres Strait Islander people in receipt of HACC services is less than initially thought. That is, the total number of Aboriginal and Torres Strait Islander recipients is approximately 325 less than the data suggests, reducing the unduplicated count of Aboriginal and Torres Strait Islander HACC recipients from 2,264 to 1,939 or by 14.0%.
- HACC MDS data (age, average annual hours of service, percentage of Aboriginal and Torres Strait Islander people receiving an activity) relating to Aboriginal and Torres Strait Islander people must be interpreted with caution because at least 14.0% of all records are for non Indigenous people and this may skew or mask the real utilisation of services by Aboriginal and Torres Strait Islander people.
- The 'Adjusted' HACC MDS indicates that mainstream agencies do not play as significant a role in the provision of HACC services to Aboriginal and Torres Strait Islander people as initially suggested by the data.
- There are key areas where the utilisation of HACC by Aboriginal and Torres Strait Islander people needs to be improved, in particular:
  - the average annual hours for Personal Care, Respite and Social Support utilised,
  - the percentage of Aboriginal and Torres Strait Islander people accessing Home Care, Meals and Respite,
  - the overall up-take and utilisation of services in the Hume and metropolitan regions,
  - the low percentage of Aboriginal and Torres Strait Islander people accessing Home Care in the metropolitan regions and in the Grampians and Hume regions, and
  - The small number of Aboriginal and Torres Strait Islander people accessing Linkages Packages statewide.

### 3.6.3 ACCOs and utilisation of services by Indigenous people

The *Aboriginal and Torres Strait Islander Communities HACC Needs Analysis Project: Victorian Report* provides an analysis of the 'Adjusted' HACC MDS which shows that for the 2003/2004 reporting period (based on a duplicated count):

- 36% (815 individuals) of Aboriginal and/or Torres Strait Islander people accessed HACC services from an Indigenous HACC service.
- 13% (292 individuals) of Aboriginal and Torres Strait Islander people accessed HACC services from a mainstream agency with 'Koorie Specific' HACC funding.
- 40% (913 individuals) of Aboriginal and Torres Strait Islander people accessed HACC services from a mainstream agency.
- 10.5% (237 individuals) of Aboriginal and Torres Strait Islander people accessed HACC services from the Royal District Nursing Service (RDNS).

The data indicates that the RDNS (with 237 HACC clients) was the largest single provider of services to Aboriginal and Torres Strait Islander people during the 2003/2004 reporting period, followed by Victorian Aboriginal Health Service, Goulburn Valley Health, Gippsland East and Gippsland Aboriginal Cooperative, Rumbalara Aboriginal Cooperative, Aborigines

- Clients where no 'Indigenous Status' was recorded have been allocated as non-Aboriginal and Torres Strait Islander people which is likely to underestimate the actual number of Aboriginal and Torres Strait Islander clients and exclude their records from the MDS reports considered for the project.
- MDS data was not submitted by five Indigenous HACC services and three mainstream agencies with Koorie Specific HACC funding, which suggests that the total number of Aboriginal and Torres Strait Islander HACC recipients may be an underestimate.

Advancement League, Gunditjmara Aboriginal Cooperative and Aboriginal Community Elders Service.

### 3.6.4 Mainstream and utilisation of services by Indigenous people

The HACC MDS suggests that approximately 60% of Indigenous HACC recipients accessed HACC services through agencies with Koorie specific HACC funding or the RDNS. Again, this data should be interpreted with caution. The clients of Goulburn Valley Health (118 Indigenous HACC clients) predominantly received information and referral support. Likewise the Indigenous clients accessing HACC through RDNS, were largely clients of the RDNS Homeless Persons Program.

The findings of *Aboriginal and Torres Strait Island Communities HACC Needs Analysis Project: Victorian Report (2005*) show that Indigenous people who access HACC services through mainstream agencies generally receive a narrower range of services and less average hours of service than non-Indigenous clients. The report concluded that significant improvements are required in mainstream agencies for them to be seen as acceptable by local Indigenous communities and provide 'real choice' for Indigenous HACC users.

### 3.6.3 Summary

It is timely that ACCOs and mainstream agencies funded to deliver Koorie specific HACC services reflect on the effectiveness of their current service models and determine the most appropriate approach and model to meet future needs and demands. Where an agency maintains a service delivery focus, reasonable and achievable targets should be set, adequate funding for assessment and care management provided, and sufficient resources for management / infrastructure and partnership development secured.

The majority of HACC funded agencies provide HACC services to few or no Indigenous clients, and significant work is required to make these services culturally sensitive and attractive to Indigenous communities and families.

# 4. Conclusions and Recommendations

## 4.1 Conclusions

Viable and sustainable Aboriginal Community Controlled Organisations (ACCOs) in partnership with culturally sensitive and appropriate mainstream agencies are essential to:

- increase and improve the up-take of Home and Community Care (HACC) services by Indigenous people,
- ensure Indigenous people access equitable and appropriate HACC services, and
- improve the health, well being and quality of life for elders, people with a disability and carers.

The pre-requisite for any effective HACC service is adequate resources for governance, management, administration, infrastructure, assessment / care management and partnerships.

The low levels of funding received by the majority of ACCOs make it difficult to adequately resource and maintain these management and infrastructure functions. For example, fifteen (15) of the 23 ACCOs funded to provide Koorie specific HACC services received less than $150,000.00 in 2004/2005. The majority of the ACCOs were not funded for sufficient hours of Home Care to employ a full-time worker.

The impact of relatively low levels of HACC funding is compounded by the fact that most ACCOs receive small amounts of funding from multiple programs within the Department of Human Services. For example an ACCO may receive funding from Disability Services, Drug Treatment Services, Child Protection and Family Services, Juvenile Justice and Youth Services, and Mental Health. The level of funding from these programs is often insufficient to employ full time staff and adequately fund management and infrastructure functions. Unpublished DHS data shows:

- ACCOs often receive less than $100,000.00 per annum from DHS program areas. In fact many programs provide funding of less than $50,000.00 per annum.
- That when comparing average amounts of agency funding with the total number of funded activities by agency type (local government, non government, community health and ACCO), ACCOs receive the lowest average amount of agency funding.
- Average funding per activity is $72,268.00 for ACCOs, compared to $268,550.00 in non-government organisations, $160,359.00 in community health services and $146,680.00 in local government organisations.
- That it is not untypical for an ACCO to receive funding from more than eight (8) DHS program areas to deliver more than 20 activities.
- While most of the other DHS Program areas fund for one two activities, the HACC Program often splits a relatively small quantum of funds into six to eight service activity types.

Estimating the cost of delivering HACC services to Indigenous people was difficult and indeterminate due to difficulties obtaining accurate costing data from Aboriginal Community Controlled Organisations within the Project parameters. However the costing data which was collected and analysed, as well as anecdotal evidence from the mainstream agencies that

participated in the Project indicated that the cost of delivering HACC services to Indigenous people appeared to be higher than the provision of services to non-Indigenous people.

The Koorie HACC service system has evolved in an ad hoc way and could be improved. The Koorie HACC service system is characterised by a range of models, many of which do not appear to be effective or to represent value for money. Typically ACCO HACC services operate in relative isolation and tend to replicate the broader HACC services (i.e. provide a broad suite of HACC services) rather than build upon and complement the local service system. There is also a clear disparity between agencies receiving Koorie specific HACC funding to deliver HACC activities and those agencies funded for a service coordination role. Clearly service coordination models are simpler to manage, require less infrastructure for reporting and quality, have lower overheads and less complex staffing arrangements.

The majority of mainstream agencies provide HACC services to few or no Indigenous clients and significant work is required to make these services culturally sensitive and attractive to Indigenous communities and families.

**Project Conclusions**

Significant redevelopment of the current funding arrangements is required to achieve the intent of the Victorian government's policy commitments to Indigenous health and ACCOs, in particular its stated goal to "Build capacity in Aboriginal organisations to develop quality services and partnerships to meet community needs" and stated strategy that "the Department will support the viability and sustainability of ACCOs funded by the Department and their ability to provide good quality services[23]".

The provision of adequate resources for governance, management, assessment / care management, administration, infrastructure, and partnerships to support service delivery is essential. The majority of ACCOs receive comparatively low levels of funding from a range of program areas, and this makes it difficult to adequately resource and maintain these functions.

Adequate funding for governance, management, assessment / care management, administration, infrastructure, and partnerships is therefore a cross-program responsibility. DHS program areas need to work together to address program and funding fragmentation issues, with a view to better coordination to strengthen the viability of ACCOs.

The DHS HACC Team should:

i. Initiate a cross-program review of DHS funding to ACCOs, with the aim of improving coordination between program areas and ensuring sufficient resources are available to adequately resource management and infrastructure functions.

[23] Victorian Aboriginal Services Plan (2004). Department of Human Services.

A refocusing of current HACC funding and a redevelopment of the Koorie specific HACC service system is required to:

- Achieve 'value for money' from the $6 million of Koorie specific recurrent HACC funding.
- Ensure Indigenous people have access to, and benefit from, a choice of quality HACC services.
- Strengthen the ACCOs' ability to provide sustainable and viable HACC services, and to build and maintain effective partnerships.
- Support the viability and sustainability of Koorie specific HACC services provided by mainstream agencies.
- Increase the effectiveness and accountability of mainstream agencies in delivering services to Indigenous people.
- Build a strong platform for meeting the current needs of Indigenous people as well as managing future demand.

Given that it is unlikely that significant growth funding from HACC will be available to substantially increase the resources needed for adequate management and infrastructure functions, the HACC Team at DHS will need to:

ii. Examine how the HACC output based funding model can be more effectively applied to adequately fund the essential functions of management, infrastructure, assessment / care management and partnerships. This could be done through:
    - A review of the effectiveness of the Koorie specific HACC funding in each region to establish whether it represents value for money and is delivering improved outcomes for Indigenous communities.
    - Prioritising future growth funding to support the resourcing of HACC management and infrastructure functions (HMIF) in those ACCOs with a service delivery focus. The consultants suggest that DHS conduct a small number of action research trials to test the effectiveness, outcomes and actual cost of establishing HMIF, which effectively and efficiently support ACCO HACC services.

iii. Work with all agencies funded to provide Koorie specific HACC services to:
    - Determine the most appropriate service model to meet current and future needs of the community. This may involve some agencies considering shifting to a service coordination model or a combination of service coordination and service delivery, especially where there are relatively small Indigenous communities.
    - Clearly define the role and responsibilities of all agencies in meeting the needs of Indigenous clients across the HACC service system and within the aged and disability service system more broadly. This may involve agencies restructuring or narrowing the range of activities delivered, and developing clear referral pathways.
    - Establish formal partnerships across the HACC and aged care service systems to ensure Indigenous people access the range of services required.

iv. Develop a planning and funding approach for Koorie specific HACC which complements the 3 year HACC planning and funding cycle and ensures funding is equitably distributed, and that all Indigenous communities benefit from Koorie specific HACC funding (see conceptual framework in Attachment 4).

v. Undertake further investigation of the real costs associated with the delivery of HACC services to Indigenous clients in both ACCOs and mainstream agencies. The Models Project was only able to collect and present indicative costing information, however more accurate costing information would assist with future planning and funding decisions. To obtain reliable costing information, DHS should consider undertaking an action research project which assists ACCOs and mainstream agencies to establish financial systems which can be used to track and monitor the real cost of delivering services to Indigenous clients.

vi. Develop a strategy to increase the capacity of mainstream agencies to meet the needs of Indigenous HACC clients through culturally sensitive service provision and culturally appropriate models of care, this may involve:
   - Implementing a cultural auditing process (such as was undertaken by HACC funded agencies with the Cultural Planning Tool) which enables agencies to reflect on the cultural sensitivity of their policies, procedures, practices and systems.
   - The provision of training in cultural awareness and culturally sensitive communication for both management and HACC workers.
   - Assistance to establish formal partnerships between mainstream HACC funded agencies, ACCOs and Indigenous communities.

## 4.2 Recommendations

**Recommendation 1.**

The DHS program areas which provide funding to ACCOs jointly work together to:
- Examine the impact of low level, fragmented cross-program funding on the viability and sustainability of ACCOs.
- Develop a more coordinated funding approach to ensure sufficient resources are available to support governance, management, administration, infrastructure, assessment / care management and partnership functions.
- Develop business rules to guide future DHS funding of ACCOs.
- Provide adequate levels of funding to resource:
  - The management, governance and infrastructure functions needed to operate effective services including reporting, quality, human resources management, planning, service development, financial management, community development and partnerships.
  - Assessment and Care Management, to ensure that all Indigenous clients are properly assessed and linked into the full range of services needed.
  - The establishment of partnerships between ACCOs and mainstream HACC agencies.

**Recommendation 2.**

The DHS HACC Team evaluate the effectiveness of the new Service Coordination /Assessment and Care Management models (in both ACCO and mainstream agencies) as an alternative approach to HACC service delivery. This may involve tracking and evaluating a

selection of models and disseminating findings to the DHS Regional staff, VICACD, ACCOs and mainstream agencies. Possible models for evaluation include:

- The new Bendigo and District Aboriginal Cooperative Access and Referral Worker.
- The Information and Referral Worker position at the Western Suburbs Indigenous Gathering Place.
- The HALO model operating in the cities of Whittlesea, Hume and Darebin.
- A mainstream Service Coordination and Referral worker model in operation in the Southern Metropolitan Region (there are currently 4 such models operating in this region).

**Recommendation 3.**

The DHS HACC Team recognise the importance of Assessment and Care Management in the delivery of HACC services to Indigenous people, and ensure that all ACCOs with a service delivery focus, have sufficient funding to effectively and efficiently perform their assessment and care management role. This could be achieved by prioritising Assessment and Care Management in new recurrent funding or through the rationalisation of existing activity funding.

**Recommendation 4.**

The DHS HACC Team work with a selection of ACCOs and key mainstream agencies to track and quantify the additional costs associated with the delivery of culturally sensitive HACC services and models of care for Indigenous people. An action research project involving the Shire of Gannawarra, Latrobe Rural City Council and/or the Swan Hill Rural City Council and a small number of ACCOs should be considered.

**Recommendation 5.**

The DHS HACC Team works with each of the Aboriginal Community Controlled Organisations to:

- Conceptualise the most effective role for their HACC program over the next 5 – 10 years (service delivery, service coordination, or a combination of both).
- Revise HACC targets and funding set out in the Funding and Service Agreement to reflect the future role of the organisation's HACC service.
- Define the role of Koorie specific HACC services within the broader service system.
- Identify resources required to support adequate governance, management, administration, infrastructure, assessment / care management and partnership functions.
- Build partnerships with mainstream agencies to ensure that Indigenous people have access to the full suite of HACC (and Aged and Disability) services in their local area.

**Recommendation 6.**
The DHS develop a strategy to assist mainstream agencies to:

- Review their HACC policies, practices, procedures and systems to ensure they are culturally sensitive.
- Develop models of care which are culturally acceptable and effective.
- Build relationships and partnerships with ACCOs and /or local Indigenous communities.

The DHS should consider adapting the Cultural Planning Tool for use by mainstream agencies, to facilitate their reflections on current practices, procedures and systems and guide them to implement any changes required to develop culturally sensitive services.

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# Attachments

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|---|---|
| **Attachment 1.** | Summary of Current HACC Funding, Clients, Catchments and Models Report (May 2005) |
| **Attachment 2.** | Project Costing Model and Findings of financial analysis |
| **Attachment 3.** | Maps Depicting Koorie Specific HACC Funding and Geographical Location of the Indigenous Communities in Victoria |
| **Attachment 4.** | A Conceptual Framework for Moving Forward |

# Summary of Current HACC Activities, Catchments and Models

May 2005

Prepared by Juliet Frizzell, Effective Change

This reports sets out:

A. Summary of current Indigenous specific HACC services in Victoria.
B. Recommendations for models to be considered for further detailed analysis.

## A. Summary of current Indigenous specific HACC services in Victoria

The table below provides a summary of the current Indigenous specific HACC services in Victoria. Funding is either targeted at:

- direct service delivery,
- specific positions e.g. Assessment, Access and Equity, Service Coordination, Capacity Building, or
- Specific activities e.g. VICACD and the Indigenous Services Directory Project.

Both Koorie and mainstream agencies in receipt of funding for services to Indigenous communities have been included in the table. The agencies have been categorised as follows:

1. **Koorie Integrated Aged Care and Disability Service**: Koorie agency with multiple aged and disability services eg. HACC, CACPS, NRPC funding, and/or disability funding which operate in an integrated manner.

2. **Koorie HACC Focus:** HACC is the main service provided by the Koorie agency.

3. **Koorie HACC as one of a range of services provided:** HACC is one of a range of services provided, other services are not directly related e.g. Bringing Them Home (BTH), Family Services, and Alcohol and Drug.

4. **Indigenous HACC Program within mainstream:** A specific Indigenous HACC service with some level of community control auspiced by a mainstream agency.

5. **Partnership:** Partnership / resource sharing between a Koorie agency and a mainstream agency.

6. **Mainstream service delivery:** Mainstream agency has funding to deliver an Indigenous specific HACC service/s.

7. **Mainstream HACC position:** Mainstream has funding to employ a worker/s with a focus on Indigenous HACC, usually Assessment, Service Coordination, and Social Support.

8. **Other:** specific activities e.g. VICACD and the Indigenous Services Directory Project.

## Model 1: Koorie Integrated Aged Care and Disability Service

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **ACES**<br><br>TG[24]: 2674 - 5352 | ▪ AH<br>▪ FSR<br>▪ PAG Core<br>▪ PAG High<br>▪ SSR<br>▪ Transition<br>▪ Vol CO<br>▪ Minor Capital | ▪ **AH**: NMR, EMR, WMR<br>▪ **PAG Core**: NMR, WMR, SMR<br>▪ **PAG High**: NMR, WMR, SMR<br>▪ **Vol Cord**: NMR, WMR, SMR | PAGs 5 days per week, plus other aged and disability services such as CACPs and Nursing Home. | Aged Care (CACP). | ▪ Cost of transporting clients to PAGs (delivered from East Brunswick) who live outside the local area. Not met by current unit price.<br>▪ Catchment size (3 regions). |
| **GEGAC**<br><br>TG: 364 - 728 | ▪ AxCM<br>▪ Meals<br>▪ FSR<br>▪ HC<br>▪ PAGC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC<br>▪ Minor Capital | ▪ East Gippsland Shire<br>▪ Wellington Shire<br><br>* GEGAC catchment was the entire Gippsland Region up until 2004. Restructure of region's HACC Program (to reflect this unrealistic catchment) will enable GEGAC to focus resources in the Shires of East Gippsland and Wellington. | Aged and Disability Services Team incorporating HACC, CACPS, and Respite.<br><br>SSR funds the Aboriginal Development Officer role which is managed by the Koorie Regional HACC Network. | Range of other DHS Programs including: Crisis Support, Residential Care, JJ, Family Services, Community Alcohol and Drug Resource Centre.<br><br>OATSIH Health, Substance Use, BTH. | ▪ Cost of travel across the entire region / large geographical area.<br>▪ Level of funding for assessment.<br>▪ Staff recruitment and turnover.<br>▪ Governance issues. |

[24] Estimated size of the Koorie HACC Target Group within the catchment area. Please note, not all the clients in the Target Group will want or need services.

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Mildura Aboriginal Coop**<br><br>TG: 229 - 458 | ▪ AH<br>▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ NB Nursing<br>▪ PAGC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | Mildura Rural City | HACC Team. | Other DHS: Home Based Outreach, Respite, Home First, Preschool, Residential Care, Home Based Care, Placement Prevention, Alcohol and Drug Resource Centres.<br><br>OATSIH: Health, Substance Use, Eye Health, BTH, Mental Health. | |
| **Rumbalara**<br><br>TG: 372 - 744 | ▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PAGC<br>▪ PM<br>▪ SSR<br>▪ VolC | Shepparton<br>Moira<br>Strathbogie | Aged and Disability Services Team incorporating HACC, CACPS, and Respite. | Other DHS: Home Based Outreach, Respite, ISHY, Home Based Care, Client Placement Support, Placement Prevention, JJ, Family Services, Family Violence, Alcohol and Drug Resource Centre, A&D Worker.<br><br>OATSIH: Health. Hearing, Mental Health, PHACP, Substance Use, BTH.<br><br>CACPs.<br><br>Aged Care Respite. | ▪ Costs associated with transport to PAG for clients from a large geographical area. |

## Model 2: Koorie HACC Focus

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **AAL**<br><br>TG: 2674 - 5352 | ▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | North and West Region<br><br>Eastern Region<br><br>Southern Region | Home Care and Property Maintenance Teams. | Other DHS: Family Services, Neighbourhood House, Housing Information and Referral.<br><br>OATSIH: Health.<br><br>Aged Care Residential Subsidy. | ▪ Staffing EFT.<br>▪ Staff recruitment.<br>▪ Funding for staff salary increases when they have gained qualifications.<br>▪ Transport including increased fuel costs.<br>▪ Rising costs of Property Maintenance.<br>▪ CDEP. |
| **DWEC**<br><br>TG: 60 - 120 | ▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | Portland and District | Focus on elders and social support with Home care and Property Maintenance. | Other DHS: Home based outreach.<br><br>OATSIH: PHCAP. | ▪ Transport costs due to large geographical area. |
| **Budja Budja**<br><br>TG: 16 - 32 | ▪ FSR<br>▪ PM<br>▪ SSR | Northern Grampians | Funding to support elders with a focus on Property Maintenance. | nil | ▪ Small amount of funding, doesn't allow for the employment of staff.<br>▪ Reporting requirements. |
| **Western Suburbs Gathering Place**<br><br>TG: 478 - 959 | ▪ AxCM<br>▪ SSR | Western Region | Assessment and Service Coordination Worker position.<br>▪ Link community into services.<br>▪ Capacity building within mainstream to ensure culturally appropriate services. | nil | ▪ No funding to provide services to those clients who refuse to consider mainstream HACC services. |

## Model 3: HACC one of a range of services

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Ballarat & District Aboriginal Coop**<br>TG: 272 - 544 | ▪ AH<br>▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ PAGC<br>▪ PM<br>▪ Respite HC<br>▪ Respite ON<br>▪ SSR | City of Ballarat<br>and closer parts of Hepburn Shire.<br>Moorabool Shire<br>Golden Plains Shire<br>Pyrenees Shire<br>Maryborough Shire | | Other DHS: Home Based Outreach, Preschool, Alcohol and Drug. | |
| **BDAC** | ▪ FSR<br>▪ PAGC | Greater Bendigo<br>Loddon Shire<br>Central Goldfields Shire<br>Mt Alexander Shire | Planned Activity Group.<br>Worker to liaise and link clients into Council services. | Other DHS: Home based Outreach, Client Placement and Support, JJ<br>OATSIH Health | ▪ Council does Home Care and Property Maintenance. |
| **Dandenong and District Aboriginal Coop**<br>TG: 126 - 252 | ▪ AxCM<br>▪ Meals<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PAGC<br>▪ PM | City of Greater Dandenong | HACC Team providing Home Care and Property Maintenance.<br>PAG two days per week in partnership with Southern Health. | Other DHS: Home Based Outreach, Family Services.<br>OATSIH: Health, mental Health, BTH. | ▪ Hard to manage a HACC service with limited funding. |

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Goolum Goolum**<br><br>TG: 33 - 66 | ▪ AH<br>▪ FSR<br>▪ HC<br>▪ PM<br>▪ SSR | Horsham and immediate surrounding areas. | | Other DHS: Home Based Outreach, Preschool.<br><br>OATSIH: Health, Substance Use, BTH. | |
| **Gunditjmara**<br><br>TG: 66 - 132 | ▪ Meals<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PAGC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | City of Greater Warrnambool | Small HACC Team. | Other DHS: Home based Outreach.<br><br>OATSIH: Health, PHCAP, BTH. | ▪ Funding does not support HACC MDS reporting requirements.<br>▪ Transport costs, especially for elders who need to travel to Melbourne for medical appointments.<br>▪ Funding insufficient for purchasing allied health services. |
| **Kirrae**<br><br>TG: 39 - 78 | ▪ Meals<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PAGC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | Framlingham Aboriginal Community in the Shire of Moyne. | Full-time Coordinator and community members are employed to provide Home Care, Personal Care and Property Maintenance. | Other DHS: Home based Outreach, Preschool, JJ, Alcohol and Drug.<br><br>OATSIH: Health, Substance Use, Eye Health, BTH. | ▪ Funding insufficient for transport costs.<br>▪ Respite funding insufficient to provide in-home or centred based respite. |
| **Lake Tyers** | ▪ Meals<br>▪ HC | Lake Tyers Catchment | | OATSIH: Health. | |

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Mungabareena**<br>TG: 154 - 308 | ▪ FSR<br>▪ PAGC | Wodonga<br>Indigo<br>Towong,<br>Alpine<br>Wangaratta<br>Benalla<br>Mansfield | Aboriginal Liaison Officer and PAG with a focus on Wodonga | Other DHS: Home Based Outreach, Respite, Building Inclusive Communities, Preschool.<br>OATSIH: Health, PHCAP. | |
| **Murray Valley Aboriginal Coop**<br>TG: 450 - 900 | ▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ Nursing<br>▪ PC<br>▪ PAGC<br>▪ PM<br>▪ SSR<br>▪ VolC | Swan Hill Shire<br>Mildura Rural City | HACC Team | Other DHS: Home based Outreach, Preschool, Home Based Care, JJ, Family Services<br>OATSIH: Health, Substance Use, Hearing Services, BTH | ▪ Catchment size |
| **Njernda**<br>TG: 172 - 344 | ▪ AxCM<br>▪ Meals<br>▪ FSR<br>▪ HC<br>▪ PAGC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | Campaspe Shire | Small HACC Team | Other DHS: Home based outreach, Preschool, Crisis Support Accommodation, JJ, Alcohol and Drug Worker.<br>OATSIH: Health, BTH. | |

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Ngwala**<br>TG: 2674 - 5352 | ▪ FSR | Metropolitan Region | ? | Other DHS: ISHY, Alcohol and Drug Resource Centre, Alcohol and Drug Worker.<br>OATSIH: Health, BTH. | |
| **VAHS**<br>TG: 2674 - 5352 | ▪ AH<br>▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ Nursing NB<br>▪ SSR | Metropolitan regions | Model currently being redeveloped. | Other DHS: Adult Continuing Care, Child and Adolescent, Home Based Outreach, PDRSS, BBV/STI, MCH, A&D Worker.<br>OATSIH: Health, BTH, Mental Health, Substance Use. | |
| **Wathaurong**<br>TG: 359 - 718 | ▪ AH<br>▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PM<br>▪ Respite HC<br>▪ SSR<br>▪ VolC | Barwon end of BSW | Part-time HACC Coordinator and full time Property Maintenance Worker. Home Care and Personal Care is contracted out to individual providers. | Other DHS: Home Based Outreach, Preschool, JJ, Alcohol and Drug Resource Centre, A&D Worker.<br>OATSIH: Health, BTH, PHCAP. | ▪ Reporting onerous<br>▪ Insufficient resources and funding for training and support for coordinator position<br>▪ MDS and Reporting does not adequately capture what we do. |
| **Winda Mara**<br>TG: 30 - 60 | ▪ FSR<br>▪ SSR | Heywood and District | New and establishing HACC service. | Other DHS: Home Based Outreach, Preschool, Alcohol and Drug Resource Centre.<br>OATSIH: Health, BTH, National Suicide Prevention. | |

## Model 4: Indigenous Program within Mainstream

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Darebin Community Health**<br>TG: 253 - 506 | ▪ PAGC<br>▪ SSR | City of Darebin | A range of PAGs (Kookaburra Club, Men's Group, Emu Strutters) with a focus on community development and linkage into other Community Health services.<br>Aboriginal Development Worker to engage community and link them into services. | | ▪ Indigenous Programs are not funded adequately and are currently subsidised by the Community Health Service.<br>▪ There is not enough funding to meet demand or develop new programs. |
| **Eastern Health Indigenous Health Team**<br>TG: 335 - 670 | ▪ AxCM<br>▪ FSR<br>▪ HC<br>▪ PC<br>▪ PAGC<br>▪ PM | Shire of Yarra Ranges<br>City of Maroondah<br>City of Knox | Indigenous Health Team includes a HACC Team.<br>Assessments are done by the Nurse and the HACC Team delivers Home Care, Personal Care, and Property Maintenance.<br>PAG is also provided. | OATSIH: Health, Mental Health, BTH, National Child Nutrition Program. | ▪ Recruitment and retention of competent and/or trained staff.<br>▪ Insufficient funding for infrastructure such as bus to transport elders to PAG, vehicles for transporting elders. |

## Model 5: Partnership

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Loddon Mallee Housing**<br>TG: 302 - 604 | ▪ FSR | Greater Bendigo<br>Loddon Shire<br>Central Goldfields Shire<br>Mt Alexander Shire | Aboriginal Assertive Outreach Program. | | |
| **AMICUS Group**<br>TG 352 - 704 | ▪ FSR<br>▪ PAGH | Greater Bendigo<br>Loddon Shire<br>Central Goldfields Shire<br>Macedon Ranges Shire<br>Mt Alexander Shire | HACC PAG for Koorie clients with ABI. | | |
| **Southern Health – Greater Dandenong CHS**<br>TG: 228 - 456 | ▪ AH<br>▪ FSR<br>▪ Nursing B | South East:<br>Cardinia<br>Casey<br>Greater Dandenong | Work in partnership with the Dandenong Coop to provide PAG and allied health (podiatry and physio) and diabetes support. | | |

## Model 6: Mainstream Service Delivery

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Gannawarra Shire Council**<br>TG: 37 - 73 | ▪ FSR<br>▪ HC | Gannawarra Shire | Elders Committee to work with and advise the Council. Elders Group has been trained in HACC.<br>Cultural Awareness Training for Council. | | |
| **Inner East Community Health**<br>TG: 36 - 72 | ▪ SSR | City of Stonington | Rainbow Club – social support group. | | |
| **St Vincent's de Paul** | ▪ FSR | | | | |
| **Swan Hill District Hospital**<br>TG: 221 - 442 | ▪ AH<br>▪ Nursing B | Swan Hill Rural City | Allied health and district nursing. | | |
| **Swan Hill Rural City Council**<br>TG: 221 - 442 | ▪ AxCM<br>▪ FSR<br>▪ PAGC<br>▪ SSR | Swan Hill Rural City | Elders Committee advises the Council on the HACC service. | | |

# Model 7: Mainstream HACC Position

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Bayside Health – Caulfield and General Medical Centre**<br>TG: 67 - 134 | ▪ SSR<br>▪ MK | City of Glen Eira | Access and Equity Worker 2 days per week. | | |
| **Goulburn Valley Health**<br>TG: 388 - 776 | ▪ SSR | City of Greater Shepparton<br>Mitchell Shire<br>Murrindindi Shire<br>Moira Shire<br>Strathbogie Shire | Aboriginal Development Officer Position. | | |
| **Latrobe City Council**<br>TG: 187-374 | ▪ SSR | City of Latrobe | Indigenous Assessment and Service Coordination Worker. | | |
| **Mornington Peninsula Shire**<br>TG: 140 - 280 | ▪ FSR<br>▪ SSR | Mornington Peninsula Shire | Koorie Access Service Worker to link clients into Council Services and a social support role. | | |
| **Peninsula Community Health Service**<br>TG: 265 - 530 | ▪ FSR | Mornington Peninsula<br>Frankston | Part-time Assessment and Service Coordination role to link client into allied heath services. | | |
| **Peninsula Health at the Frankston Community Health site**<br>TG: 265 - 530 | ▪ FSR | Mornington Peninsula<br>Frankston | Worker in the community. | | |

## Model 8: Other

| Agency | HACC Activities | Catchment | Model | Other Funding / Services | Viability Issues |
|---|---|---|---|---|---|
| **Ramahyuck** | VICACD Funding. | | | | |
| **Northern Division of General Practice** | ▪ SSR | | Develop Koorie Service Directory. | | |

## B. Recommendations for models to be considered for further detailed analysis.

| Agency | Model Category | Region | Currently Operating | Service Delivery or Worker Role | Cultural safety |
|---|---|---|---|---|---|
| **Rumbalara** | Koorie Integrated Aged Care and Disability Service | Loddon Mallee | ✓ | Service delivery | ✓ |
| **Aborigines Advancement League** | Koorie HACC focus | Metropolitan | ✓ | Service delivery | ✓ |
| **Western Suburbs Gathering Place** | Koorie HACC focus | Western Region | ✓ | Worker | ✓ |
| **Dandenong and District Aboriginal Cooperative** | HACC one of a range of services | Southern Region | ✓ | Service delivery | ✓ |
| **Wathaurong** | HACC one of a range of services | Barwon South West | ✓ | Service delivery including contracted services | ✓ |
| **Darebin Community Health** | Indigenous program within mainstream | North West Region | ✓ | Worker and service delivery | ✓ |
| **Southern Health** | Partnership | Southern Region | ✓ | Service Delivery and funded partnership | ? |
| **Gannawarra Shire Council** | Mainstream service delivery | Loddon Mallee | ✓ | Elders Committee and service delivery | ✓ |
| **Latrobe City Council** | Mainstream HACC position | Gippsland | ✓ | Worker | ? |

*Project Costing Model and Findings of Financial Analysis*

*Service Cost Analysis*

HAAC Funding Model Project
Service Cost Analysis

| Cost Area | Cost Definition - as per 1997 HAAC unit cost analysis | Sub Category | General Home Care | Personal Care | Home Maintenance | PAG High | Assessment & Care Management |
|---|---|---|---|---|---|---|---|
| Direct Workers | Wages, & Salaries, Superannuation, Workers Compensation, Long Service Leave, Lump Sum Payments, Staff Training & Development, Volunteer Allowances, Other | Direct Care Staff Salaries & Oncosts | | | | | |
| | | Travel Time | | | | | |
| | | Training & Seminars | | | | | |
| | | Sub Total | 0 | 0 | 0 | 0 | 0 |
| Travel | Kilometre Allowances, Motor Vehicle Running Expenses, Volunteer Travel Allowances, Other | Travel Allowance | | | | | |
| | | Vehicle Operating Costs | | | | | |
| | | Subtotal | 0 | 0 | 0 | 0 | 0 |
| Consumables | Nursing & Paramedical Consumables, Food & Delivered Meals Consumables, Home Help Consumables, Uniforms & Protective Clothing | Uniforms and uniform allowance | | | | | |
| | | Food | | | | | |
| | | Recouped Costs | | | | | |
| | | SubTotal | 0 | 0 | 0 | 0 | 0 |
| Purchase of Services | Nursing Services, Home Help Services, Respite Services, Other | Contractors & Agency | | | | | |
| | | **Total Direct Costs** | 0 | 0 | 0 | 0 | 0 |
| Assessment & Coordination | Assessing consumer needs, Rostering of Staff, Coordinating other services, field staff supervision & coordination: Wages, Saries & Travel | Assessment Allocation | | | | | |
| | | Supervision & Admin | | | | | |
| | | Sub Total | 0 | 0 | 0 | 0 | 0 |
| Service Management | Management, Administrative Support, Bookkeeping | MSU & SPP | | | | | |
| Accommodation | Rent, Rates & Charges, Building R & M, Non capital furniture & fitting, Building insurance, Building Dep., Cleaning, Electricity, Gas & Water, Other | | | | | | |
| Other Service Costs | Insurance, Printing & Stationery, Non-capital equipment, Equipment R & M, Communications, Fees, Indirect travel, Depreciation Vehicles & Other,Other indirect costs | Other Expenditure | | | | | |
| | | Equipment, Phones, Uitlities etc | | | | | |
| | | SubTotal | 0 | 0 | 0 | 0 | 0 |
| Organisation Overheads | Payroll, Personnel, IT, Central administration, Corporate Management and other corporate overheads | Apportioned Overheads | | | | | |
| | | **Total Indirect Costs** | 0 | 0 | 0 | 0 | 0 |
| Total Costs of Service Operations | | | 0 | 0 | 0 | 0 | 0 |

## *Service Income Analysis*

**HACC Funding Model Project**
**Service Income Analysis**

| Income Area | Income Definition – as per 1997 HAAC unit cost analysis | Sub Category | General Home Care | Personal Care | Home Maintenance | PAG High | Assessment & Care Management |
|---|---|---|---|---|---|---|---|
| **HACC Grant** | All receipts for the current year from approved HACC grants for recurrent purposes | | | | | | |
| | | | 0 | 0 | 0 | 0 | 0 |
| **Client Contributions** | All receipts from clients of the service for the year whether described as fees or donations | | | | | | |
| **Other Fees & External Income** | **Fees for Service**: Community Aged Care Packages | | | | | | |
| | **Fees for Service:** Dept of Veterans Affairs | | | | | | |
| | **Fees for Service:** other brokerage agreements | | | | | | |
| | **Other Government Grants**: State or Federal (e.g. health, employment, education & training funding) | | | | | | |
| | **Other Income**: Interest, donations (non-client) | Rental of part of centre | | | | | |
| | Sub Total | | 0 | 0 | 0 | 0 | 0 |
| **Sponsor Operating Subsidies** | All cash contributions made by the provider organisation (e.g. membership fees, fund raising, budgeted operating subsidy | | | | | | |
| | All non-cash contributions made but not charged for (service costs and organisational overheads apportioned but not paid for) | | | | | | |
| | **Total Sponsor Subsidies** | net cost balancing amount | | | | | |
| **TOTAL INCOME** | | | 0 | 0 | 0 | 0 | 0 |
| **TOTAL COSTS** | | | 0 | 0 | 0 | 0 | 0 |

*Findings of Financial Analysis*

**3.3.3.1 Home Care**

The financial analysis shows that both Direct Costs and Indirect Costs per hour of Home Care provided by the ACCO exceed the comparable mainstream agencies' costs. It also shows that the mainstream agencies both:

- Receive client contributions of $3.83 and $5.92 per hour respectively.
- Significantly subsidise Home Care $14.55 per hour (40.5% of total funding) and $7.08 per hour (16.4% of total funding) respectively.

**Direct Costs**

Total Direct Costs (being Direct Worker, Travel, Consumables, Purchase of Services) per hour of Home Care delivered by the ACCO was $45.32, $18.65 per hour higher than the metropolitan mainstream agency and $13.44 per hour higher than the regional mainstream agency. The Travel cost per hour of Home Care is highest in the ACCO at $3.45 per hour of service.

**Indirect Costs**

Total Indirect Costs (being Assessment and Coordination, Service Management, Accommodation, Service Costs and Overheads) per hour of Home Care delivered by the ACCO was $26.82, $17.54 per hour higher than the metropolitan mainstream agency and $15.44 per hour higher than the regional mainstream agency. The higher Indirect Costs in the ACCO were largely associated with Assessment and Care Management.

**Total Unit Costs**

The Total Unit Cost per hour of Home Care delivered by the ACCO was $72.14, $36.19 per hour higher than the metropolitan mainstream agency and $28.90 per hour higher than the regional mainstream agency. It should be noted that the HACC Unit Price in 2004/2005 for Home Care was $24.95 per hour.

**Funding**

Both mainstream agencies fund Home Care through a combination of HACC recurrent funding, client contributions and subsidies. Subsidies represent a significant component of the overall funding in the metropolitan agency $14.55 (40.5% of total funding) per hour and $7.08 (16.4% of total funding) per hour in the regional mainstream agency. The ACCO funds the additional costs associated with an hour of Home Care through Other Fees and External Incomes which includes CDEP workers.

## Financial Analysis: General Home Care

HACC Funding Model Project
UNIT COST SUMMARY
**General Home Care**

| Unit Cost Summary | Sub Category | Metropolitan Mainstream | Regional Koorie | Regional Mainstream |
|---|---|---|---|---|
| HOURS | Hours Direct Service | 97,751 | 1,480 | 52,435 |
| | HAAC Funded Hours | 53673 | 1480 | 35,865 |
| | % Total Hours Funded | 55% | 100% | 68% |
| COSTS | | | | |
| Unit Costs per Direct Service Hour Provided | DIRECT COSTS | | | |
| | Direct Workers | $23.44 | $41.73 | $29.59 |
| | Travel | $1.85 | $3.45 | $2.25 |
| | Consumables | $0.34 | $0.14 | $0.05 |
| | Purchase of Services | $1.04 | $0.00 | $0.00 |
| | Total Direct Costs | $26.67 | $45.32 | $31.88 |
| | INDIRECT COSTS | | | |
| | Assessment & Coordination | $6.86 | $15.07 | $6.07 |
| | Service Management | $0.57 | $8.56 | $0.00 |
| | Accommodation | $0.00 | $0.96 | $0.00 |
| | Other Service Costs | $0.08 | $2.24 | $0.00 |
| | Organisation Overheads | $1.77 | $0.00 | $5.30 |
| | Total Indirect Costs | $9.28 | $26.82 | $11.38 |
| | Total Unit Costs | $35.95 | $72.14 | $43.26 |
| FUNDING | | | | |
| Funding per Direct Service Hour Provided | HACC Grant | $15.55 | $45.03 | $17.18 |
| | % costs covered | 43.3% | 62.4% | 39.7% |
| | Client Contributions | $3.83 | $0.00 | $5.92 |
| | Other Fees & External Income | $2.03 | $27.11 | $13.08 |
| | Total External Funding | $21.41 | $72.14 | $36.18 |
| | % costs covered | 59.5% | 100.0% | 83.6% |
| | Sponsor Operating Subsidies | $14.55 | $0.00 | $7.08 |
| | Total Funding | $35.95 | $72.14 | $43.26 |
| | susbsidy % | 40.5% | 0.0% | 16.4% |

### 3.3.3.2 Personal Care

The financial analysis shows that both Direct Costs and Indirect Costs per hour of Personal Care provided by the ACCO exceed the comparable mainstream agencies' costs. It also shows that both mainstream agencies receive client contributions of $2.33 and $5.77 per hour respectively for Personal Care services. The metropolitan mainstream agency subsidises Personal Care by $21.11 per hour (40.6% of total funding).

**Direct Costs**
Total Direct Costs (being Direct Worker, Travel, Consumables, Purchase of Services) per hour of Personal Care delivered by the ACCO was $77.94, $36.80 per hour higher than the metropolitan mainstream agency and $42.72 per hour higher than the regional mainstream agency. The higher Direct Costs per hour of Personal Care is largely the result of higher Direct Worker Costs within the ACCO. Interestingly the travel costs per hour were lower in the ACCO, $1.03 per hour compared to $4.80 and $4.87 in the mainstream agencies.

**Indirect Costs**
Total Indirect Costs (being Assessment and Care Management, Service Management, Accommodation, Service Costs and Overheads) per hour of Personal Care delivered by the ACCO were similar to the Indirect Costs of the mainstream agencies, $9.67 compared to $10.86 and $11.91.

**Total Unit Costs**
The Total Unit Cost per hour of Personal Care delivered by the ACCO was significantly higher than the mainstream agencies at $87.61 per hour of service. This is $35.60 per hour higher than the metropolitan mainstream agency and $40.48 per hour higher than the regional mainstream agency. It should be noted that the HACC Unit Price in 2004/2005 for Personal Care was $28.53 per hour.

**Funding**
The metropolitan mainstream agency subsidises Personal Care by 40.6% or $21.11 per hour. The ACCO funds the additional costs associated with an hour of Personal Care though Other Income, Fees and External Incomes which includes CDEP workers.

**Financial Analysis: Personal Care**

HACC Funding Model Project
UNIT COST SUMMARY
Personal Care

| Unit Cost Summary | Sub Category | Metropolitan Mainstream | Regional Koorie | Regional Mainstream |
|---|---|---|---|---|
| HOURS | Hours Direct Service | 32,118 | 769 | 4,833 |
| | HAAC Funded Hours | 24025 | 769 | 5,100 |
| | % Total Hours Funded | 75% | 100% | 106% |
| COSTS | | | | |
| Unit Costs per Direct Service Hour Provided | DIRECT COSTS | | | |
| | Direct Workers | $33.14 | $76.78 | $30.35 |
| | Travel | $4.80 | $1.03 | $4.87 |
| | Consumables | $0.30 | $0.13 | $0.00 |
| | Purchase of Services | $2.90 | $0.00 | $0.00 |
| | Total Direct Costs | $41.14 | $77.94 | $35.22 |
| | INDIRECT COSTS | | | |
| | Assessment & Coordination | $9.02 | $5.77 | $6.07 |
| | Service Management | $0.93 | $0.98 | $0.00 |
| | Accommodation | $0.00 | $0.26 | $0.00 |
| | Other Service Costs | $0.07 | $2.66 | $0.00 |
| | Organisation Overheads | $0.84 | $0.00 | $5.84 |
| | Total Indirect Costs | $10.86 | $9.67 | $11.91 |
| | Total Unit Costs | $52.01 | $87.61 | $47.13 |
| FUNDING | | | | |
| Funding per Direct Service Hour Provided | HACC Grant | $21.99 | $27.23 | $36.20 |
| | % costs covered | 42.3% | 31.1% | 76.8% |
| | Client Contributions | $2.33 | $0.00 | $5.77 |
| | Other Fees & External Income | $6.58 | $60.38 | $21.52 |
| | Total External Funding | $30.89 | $87.61 | $63.49 |
| | % costs covered | 59.4% | 100.0% | 134.7% |
| | Sponsor Operating Subsidies | $21.11 | $0.00 | -$16.36 |
| | Total Funding | $52.01 | $87.61 | $47.13 |
| | susbsidy % | 40.6% | 0.0% | -34.7% |

### 3.3.3.3 Property Maintenance

The financial analysis shows that both Direct Costs and Indirect Costs per hour of Property Maintenance provided by the ACCO are slightly higher than the mainstream agencies' costs. It also shows that both mainstream agencies receive client contributions of $5.58 and $9.74 per hour respectively for Property Maintenance. The metropolitan mainstream agency subsidises Property Maintenance by $22.05 per hour (37.4% of total funding) and the regional mainstream agency by $2.96 (5.6%) per hour.

**Direct Costs**
Total Direct Costs (being Direct Worker, Travel, Consumables, Purchase of Services) per hour of Property Maintenance delivered by the ACCO was $47.48, $4.93 per hour higher than the metropolitan mainstream agency and $7.36 per hour higher than the regional mainstream agency. The higher Direct Costs per hour of Property Maintenance is largely the result of higher Direct Worker Costs within the ACCO. The travel costs per hour for Property Maintenance were similar to those of the mainstream agencies.

**Indirect Costs**
Total Indirect Costs (being Assessment and Coordination, Service Management, Accommodation, Service Costs and Overheads) per hour of Property Maintenance were similar across the 3 organisations.

**Total Unit Costs**
The Total Unit Cost per hour of Property Maintenance delivered by the ACCO was higher than the mainstream agencies' at $62.89 per hour of service. This is $3.99 per hour higher than the metropolitan mainstream agency and $10.07 per hour higher than the regional mainstream agency. It should be noted that the HACC Unit Price in 2004/2005 for Property Maintenance was $36.30 per hour.

**Funding**
Both mainstream agencies fund Property Maintenance through a combination of HACC recurrent funding, client contributions and subsidies. Subsidies represent a significant component of the overall funding in the metropolitan agency $22.05 (37.4% of total funding) per hour and $2.96 (5.6% of total funding) per hour in the regional mainstream agency. The ACCO funds the additional costs associated with an hour of Property Maintenance largely though CDEP workers.

## Financial Analysis: Property Maintenance

HACC Funding Model Project
UNIT COST SUMMARY
**Home Maintenance**

| Unit Cost Summary | Sub Category | Metropolitan Mainstream | Regional Koorie | Regional Mainstream |
|---|---|---|---|---|
| HOURS | Hours Direct Service | 5,573 | 1,495 | 5,154 |
| | HAAC Funded Hours | 4,664 | 1,495 | 4,149 |
| | % Total Hours Funded | 84% | 100% | 81% |
| COSTS | | | | |
| Unit Costs per Direct Service Hour Provided | DIRECT COSTS | | | |
| | Direct Workers | $13.26 | $26.84 | $7.06 |
| | Travel | $2.15 | $1.37 | $0.93 |
| | Consumables | $4.96 | $0.20 | $0.00 |
| | Purchase of Services | $22.18 | $19.08 | $32.14 |
| | Total Direct Costs | $42.55 | $47.48 | $40.12 |
| | INDIRECT COSTS | | | |
| | Assessment & Coordination | $9.40 | $10.27 | $6.07 |
| | Service Management | $3.39 | $1.30 | $0.00 |
| | Accommodation | $0.00 | $0.34 | $0.00 |
| | Other Service Costs | $1.09 | $3.50 | $0.00 |
| | Organisation Overheads | $2.47 | $0.00 | $6.62 |
| | Total Indirect Costs | $16.34 | $15.41 | $12.69 |
| | Total Unit Costs | $58.90 | $62.89 | $52.82 |
| FUNDING | | | | |
| Funding per Direct Service Hour Provided | HACC Grant | $31.00 | $36.06 | $30.63 |
| | % costs covered | 52.6% | 57.3% | 58.0% |
| | Client Contributions | $5.58 | $0.00 | $9.74 |
| | Other Fees & External Income | $0.26 | $26.84 | $9.49 |
| | Total External Funding | $36.85 | $62.89 | $49.86 |
| | % costs covered | 62.6% | 100.0% | 94.4% |
| | Sponsor Operating Subsidies | $22.05 | $0.00 | $2.96 |
| | Total Funding | $58.90 | $62.89 | $52.82 |
| | susbsidy % | 37.4% | 0.0% | 5.6% |

### 3.3.3.4 Planned Activity Group

The financial analysis shows that both Direct Costs and Indirect Costs per hour of Planned Activity Groups provided by the ACCO are lower than the mainstream agencies' costs. This may be the result of the volume of service hours funded. The data also shows that both mainstream agencies receive client contributions of $0.90 and $3.79 per hour respectively, and subsidise the Planned Activity Groups by 7 cents per hour and $2.05 per hour respectively.

**Direct Costs**
Total Direct Costs (being Direct Worker, Travel, Consumables, Purchase of Services) per hour of Planned Activity Groups delivered by the ACCO was $6.07. This is less than the Direct Costs in both of the mainstream agencies. The ACCOs lower Direct Costs per hour of Planned Activity Groups can be largely attributed to the lower Direct Worker Costs. The travel costs per hour for Planned Activity Groups at the ACCO were also lower.

**Total Unit Costs**
The Total Unit Cost per hour of Planned Activity Group delivered by the ACCO was lower than both the mainstream agencies at $11.19 per hour of service. It should be noted that the HACC Unit Price in 2004/2005 for PAG Core was $10.14 per hour and PAG High $14.29 per hour.

**Funding**
The Planned Activity Group was the only HACC activity where the ACCO's costs were within the HACC Unit Price. Both the mainstream agencies fund Planned Activity Groups through a combination of HACC recurrent funding, client contributions and subsidies.

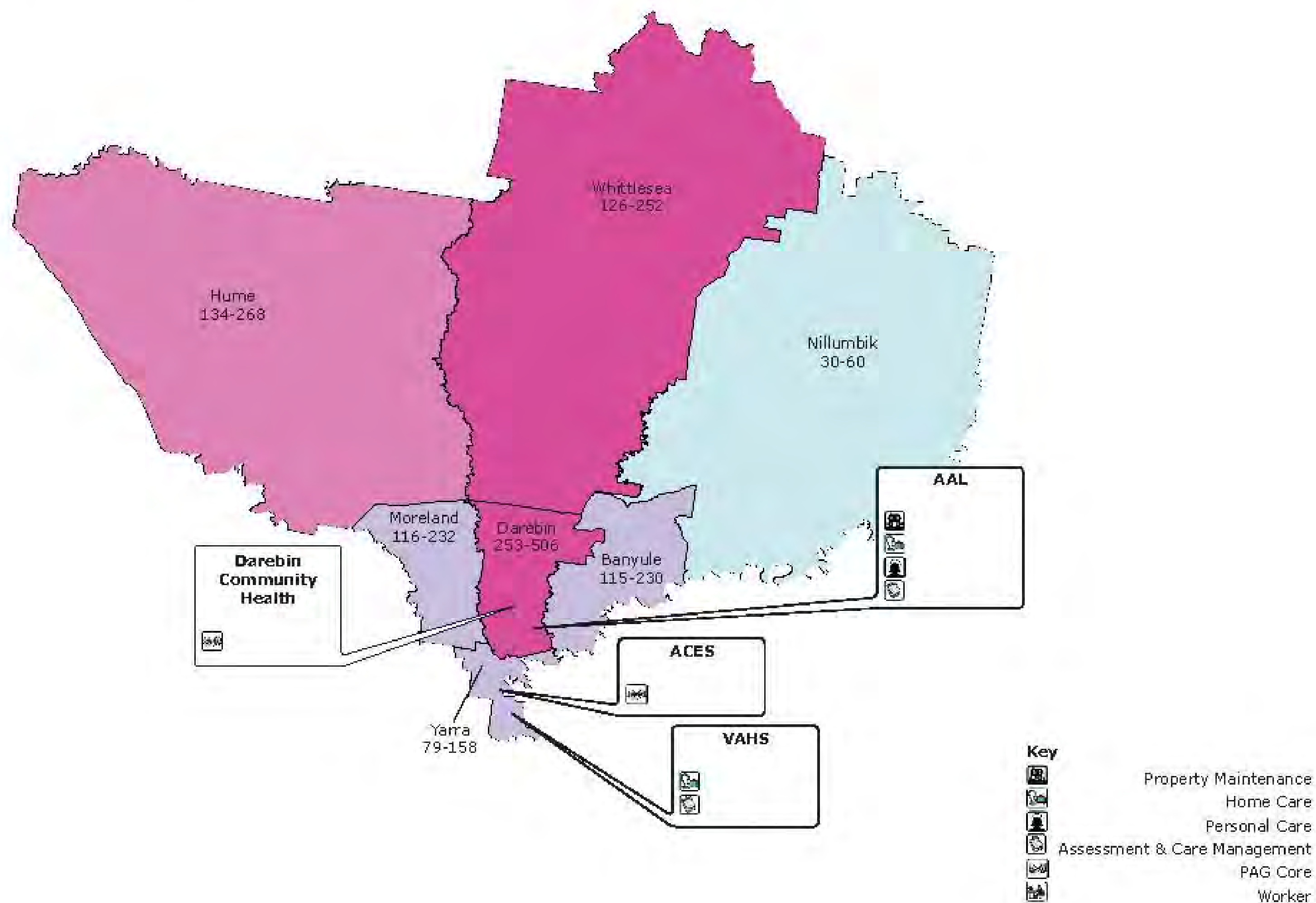
## Financial Analysis: Planned Activity Group

HACC Funding Model Project
UNIT COST SUMMARY
**Planned Activity Group**

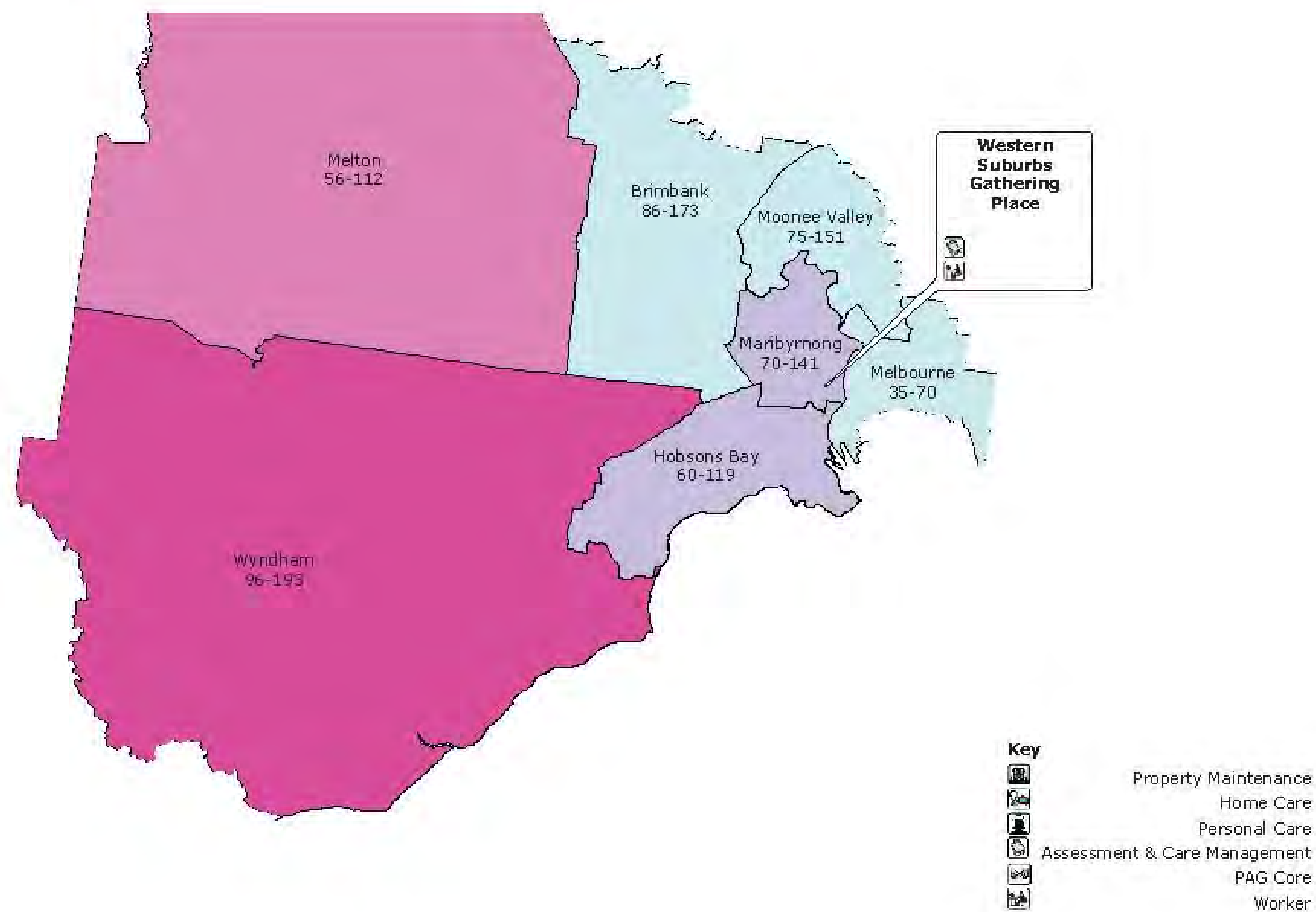
| Unit Cost Summary | Sub Category | Metropolitan Mainstream | Regional Koorie | Regional Mainstream |
|---|---|---|---|---|
| HOURS | Hours Direct Service | 19,600 | 33,832 | 6,836 |
| | HAAC Funded Hours | 16,474 | 33,832 | 4,000 |
| | % Total Hours Funded | 84% | 100% | 59% |
| COSTS | | | | |
| Unit Costs per Direct Service Hour Provided | DIRECT COSTS | | | |
| | Direct Workers | $12.90 | $4.58 | $30.00 |
| | Travel | $1.79 | $0.55 | $1.40 |
| | Consumables | $0.80 | $0.95 | $6.14 |
| | Purchase of Services | $0.42 | $0.00 | $0.00 |
| | Total Direct Costs | $15.90 | $6.07 | $37.55 |
| | INDIRECT COSTS | | | |
| | Assessment & Coordination | $0.00 | $1.87 | $6.07 |
| | Service Management | $0.97 | $2.45 | $0.00 |
| | Accommodation | $0.00 | $0.22 | $0.00 |
| | Other Service Costs | $0.85 | $0.57 | $0.00 |
| | Organisation Overheads | $1.09 | $0.00 | $6.21 |
| | Total Indirect Costs | $2.90 | $5.12 | $12.28 |
| | Total Unit Costs | $18.81 | $11.19 | $49.83 |
| FUNDING | | | | |
| Funding per Direct Service Hour Provided | HACC Grant | $14.83 | $9.82 | $40.56 |
| | % costs covered | 78.8% | 87.7% | 81.4% |
| | Client Contributions | $0.90 | $0.00 | $3.79 |
| | Other Fees & External Income | $3.00 | $1.37 | $3.43 |
| | Total External Funding | $18.73 | $11.19 | $47.79 |
| | % costs covered | 99.6% | 100.0% | 95.9% |
| | Sponsor Operating Subsidies | $0.07 | $0.00 | $2.05 |
| | Total Funding | $18.81 | $11.19 | $49.83 |
| | susbsidy % | 0.4% | 0.0% | 4.1% |

## Maps Depicting Koorie Specific HACC Funding and Geographical Location of the Indigenous Communities in Victoria

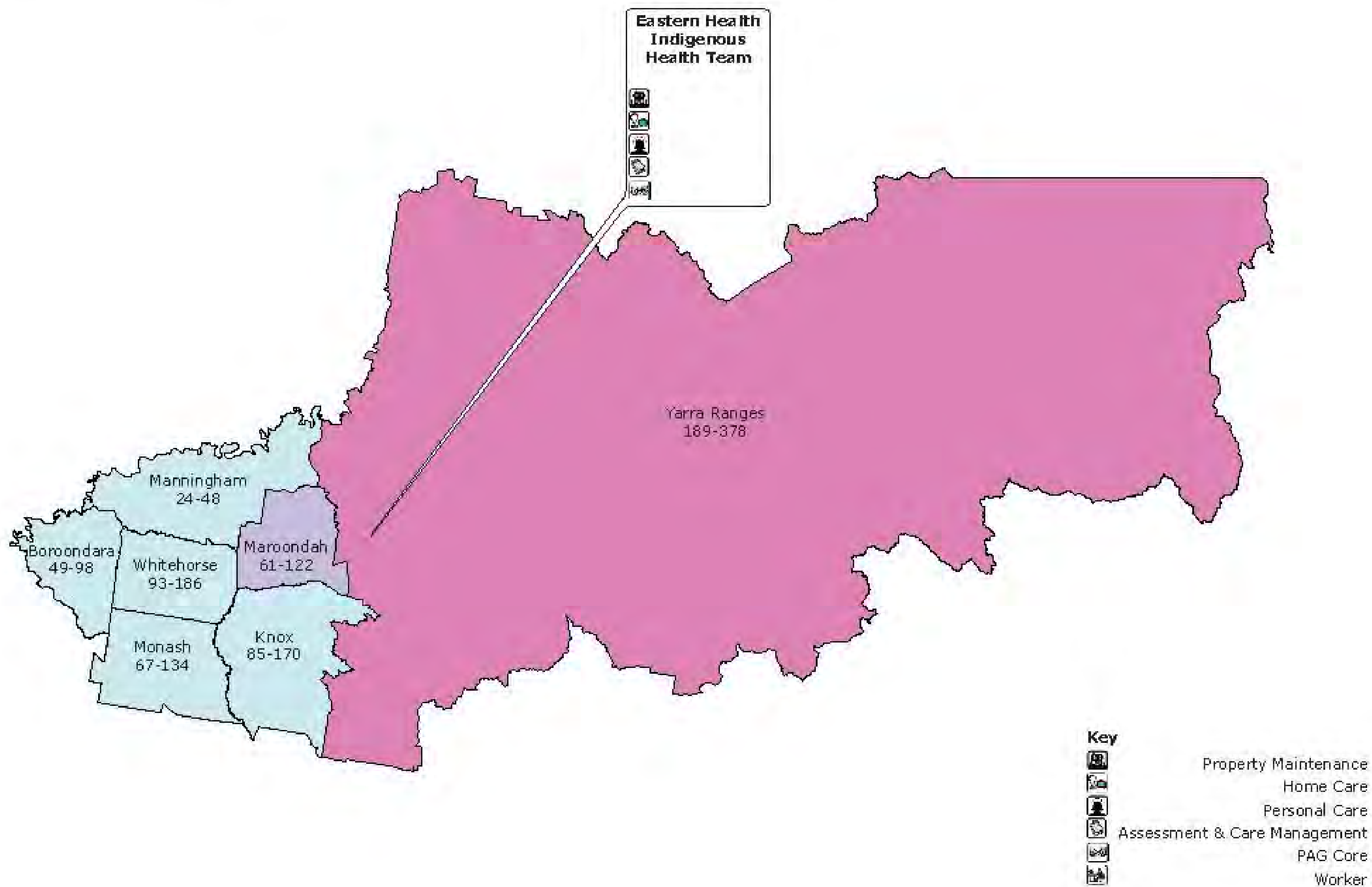
### Northern Metropolitan Region



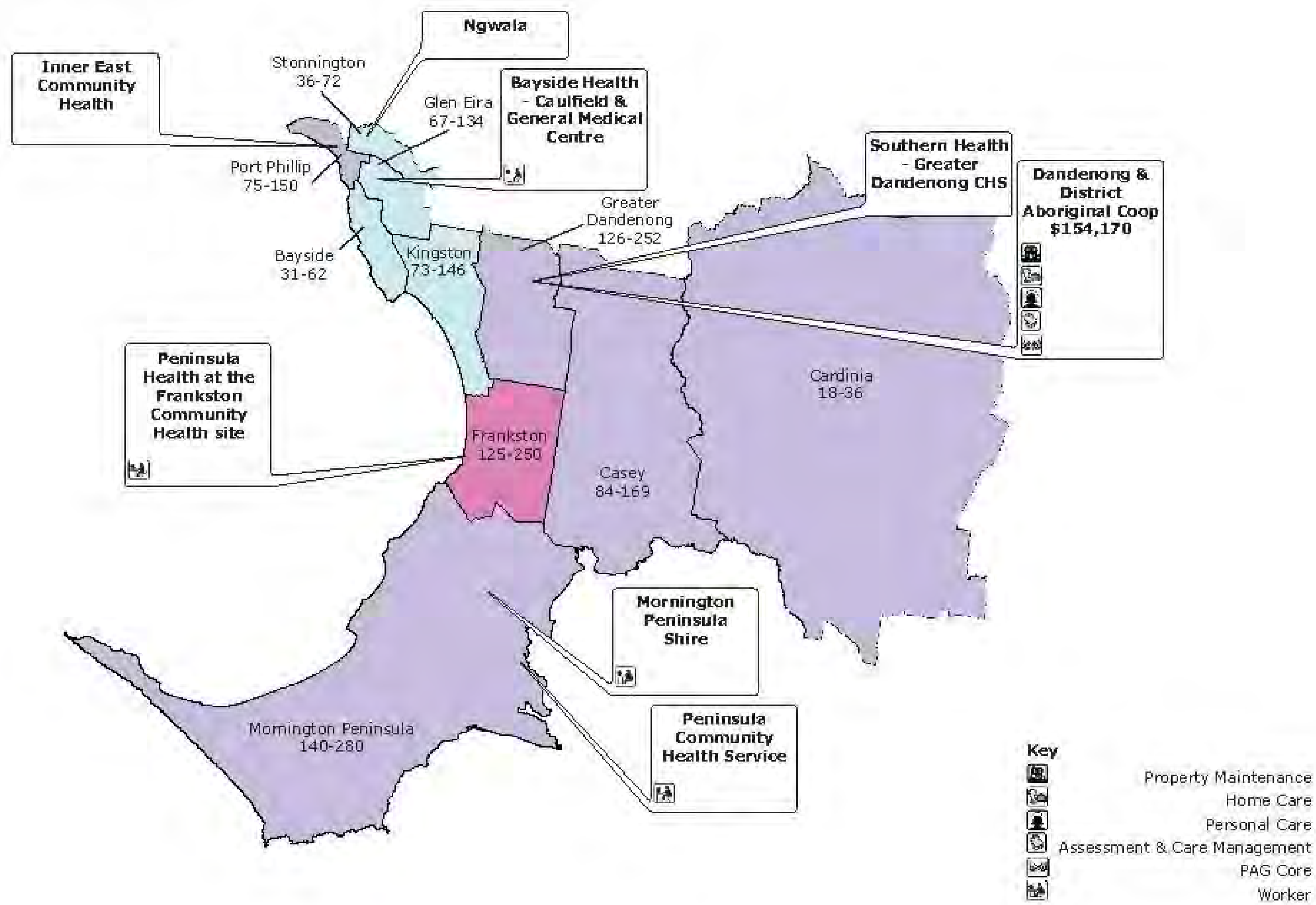
## Western Metropolitan Region



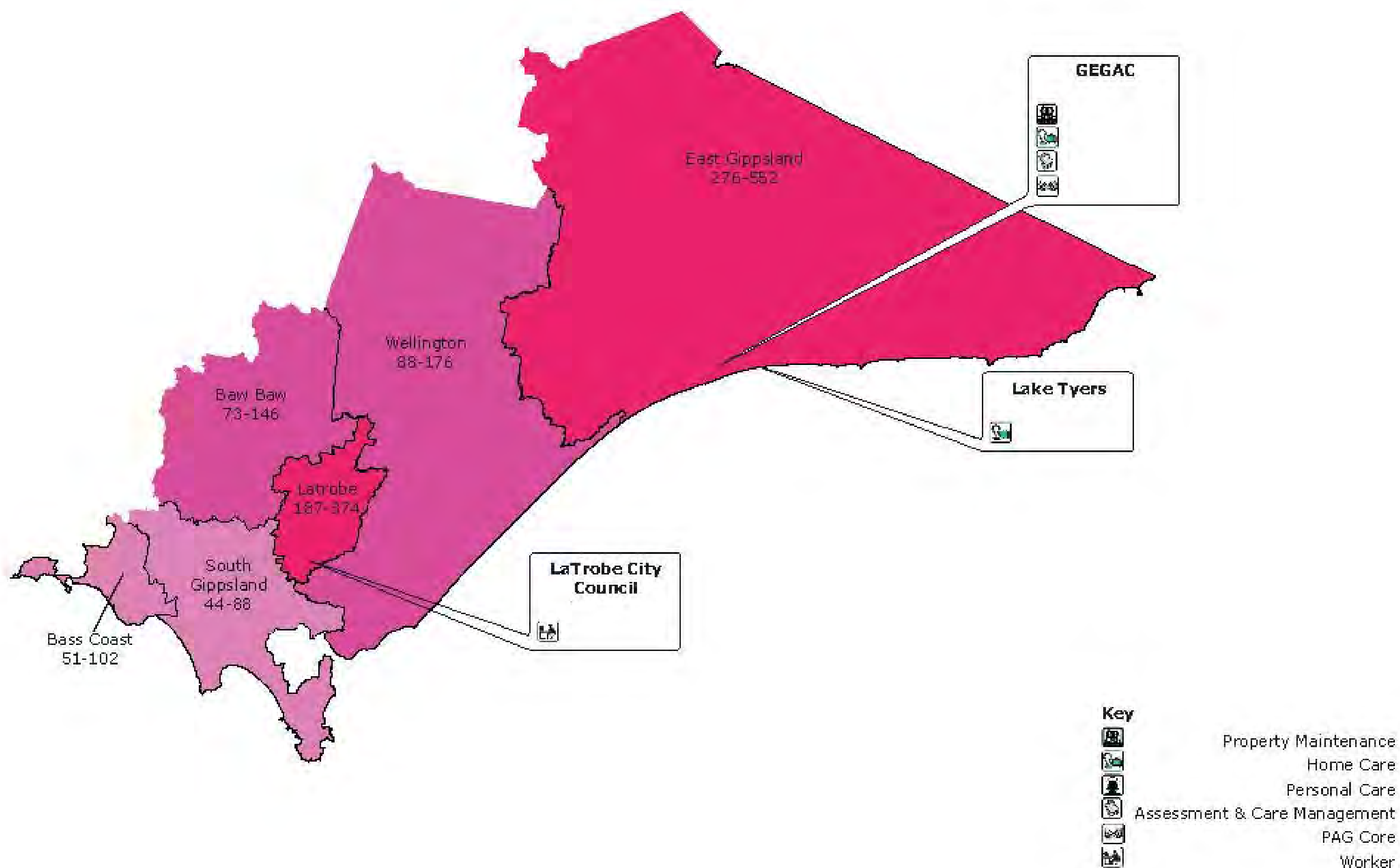
## Eastern Metropolitan Region



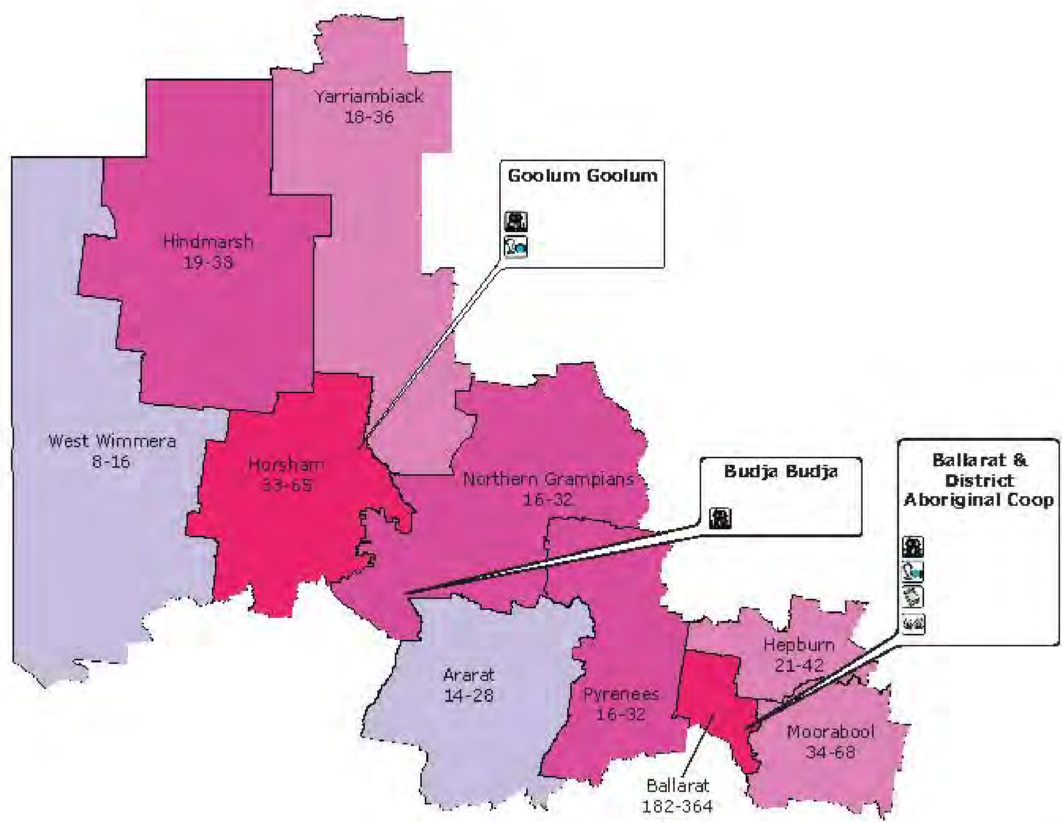
## Southern Metropolitan Region



## Gippsland Region



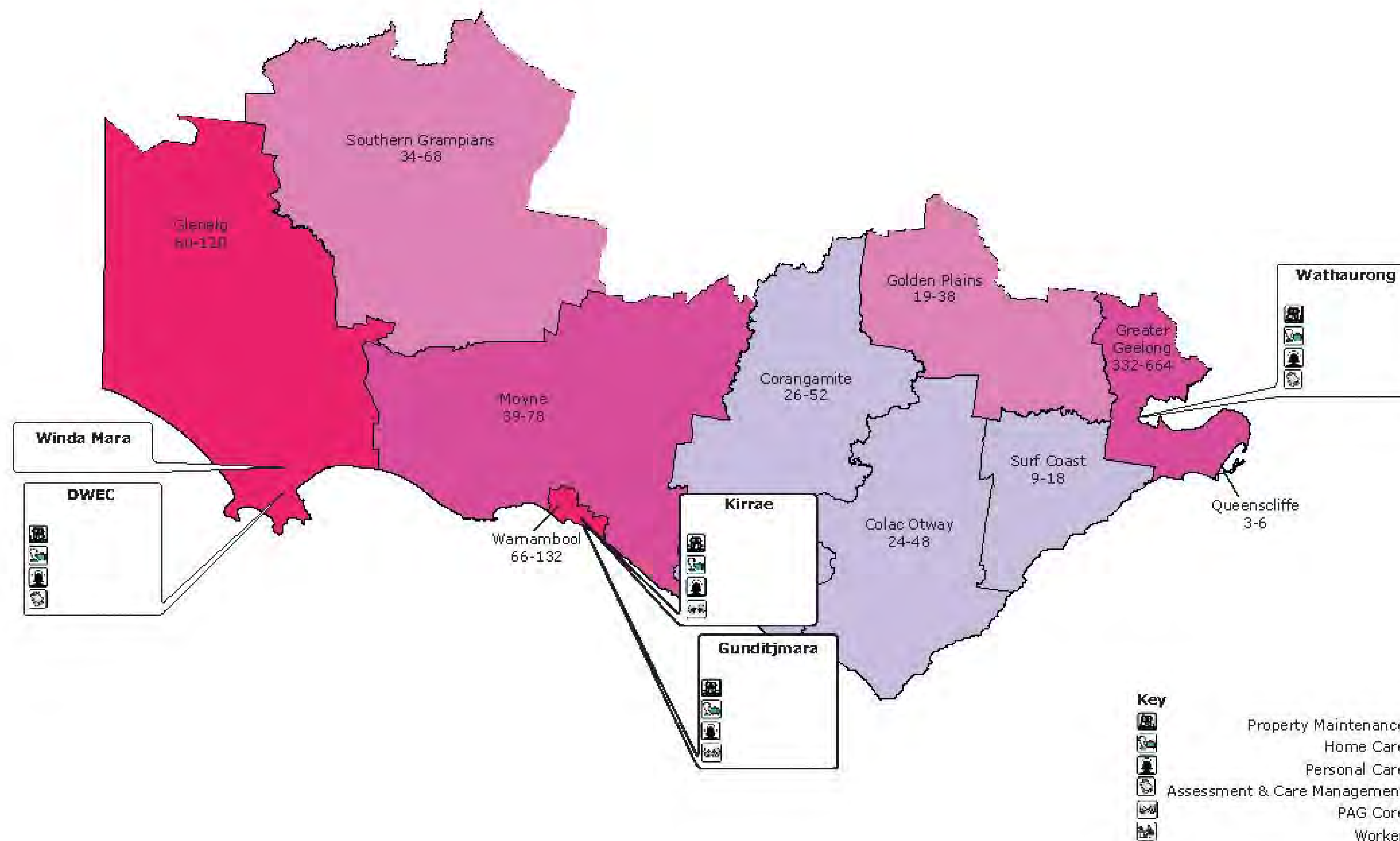
## Grampians Region



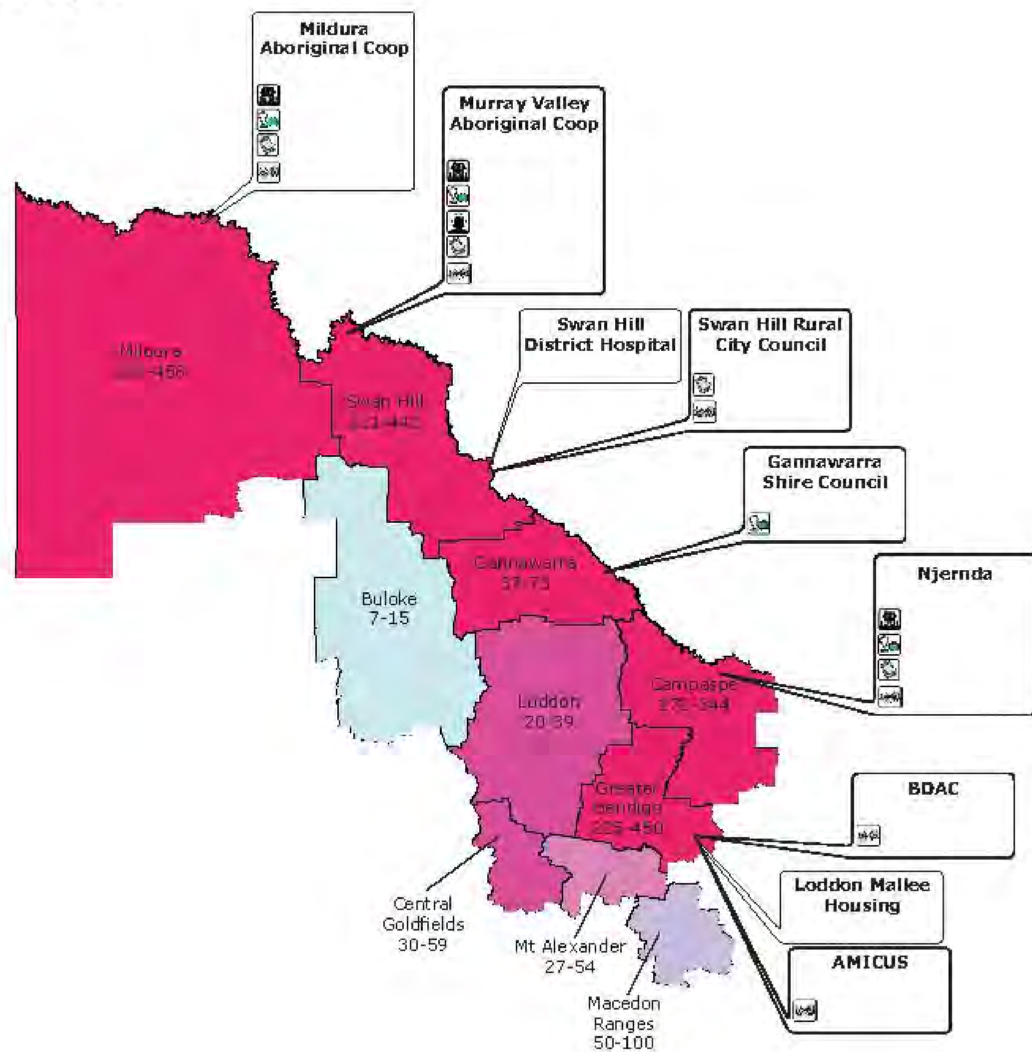

**Key**

- Property Maintenance
- Home Care
- Personal Care
- Assessment & Care Management
- PAG Core
- Worker

## Barwon South West Region



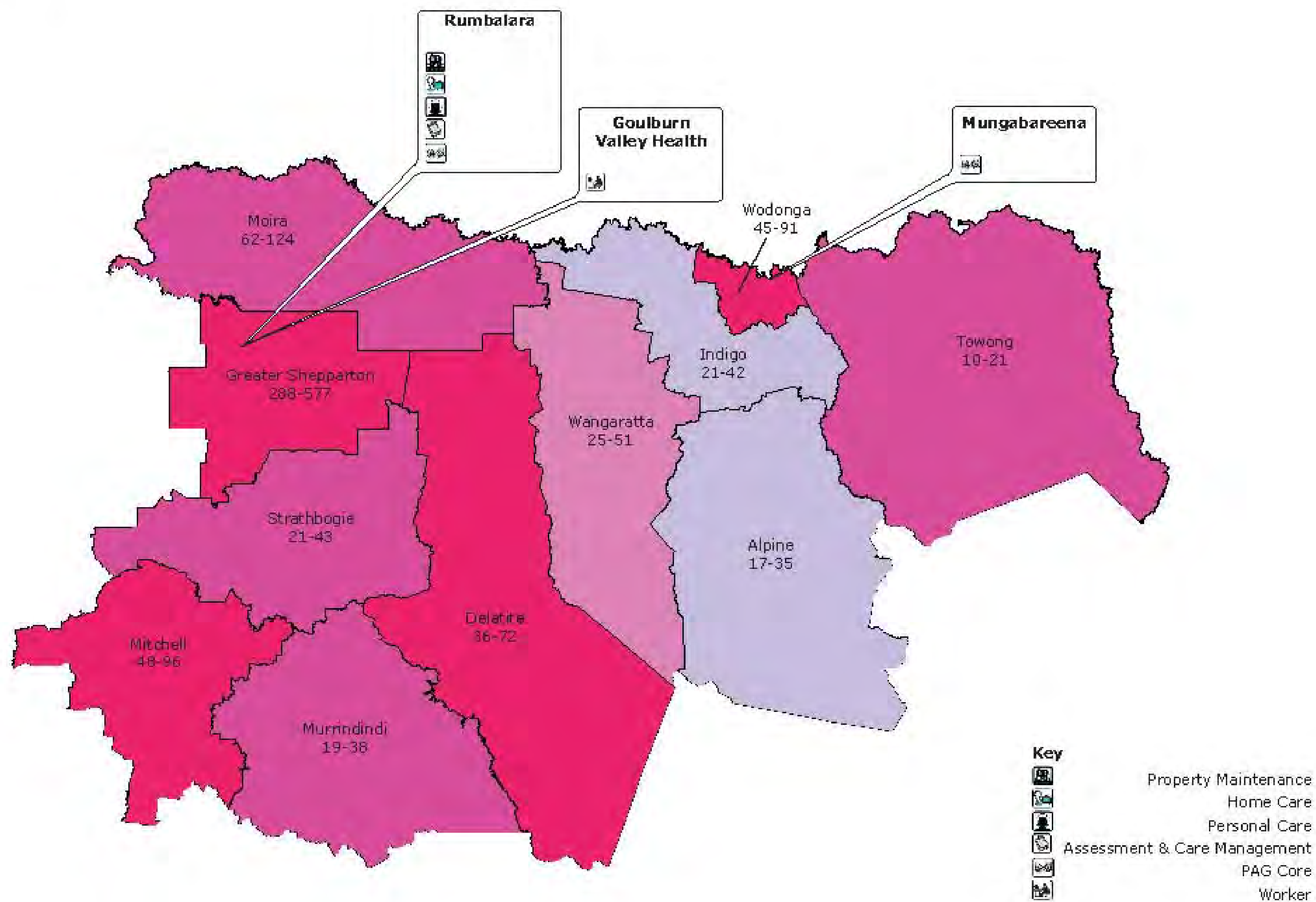
## Loddon Mallee Region




**Key**

- Property Maintenance
- Home Care
- Personal Care
- Assessment & Care Management
- PAG Core
- Worker

## Hume Region



**A Conceptual Framework for Moving Forward**

Funding and service models should be developed based on a range of criteria including:

- The actual size of the Indigenous HACC Target Group.
- Local resources and capacity, in particular the existence of an ACCO.
- Appropriate local catchment area.
- Koorie HACC as part of the service system, with clear referral and care pathways.
- In-home services culturally most sensitive.
- Best mix of Assessment and Care Management and service delivery.
- Partnerships.
- Community needs and priorities.

The Indigenous communities in Victoria have been categorised in the table below into a framework which can be used as a guide to funding and models options.

| | **Characteristics** | **Which local government areas?** | **Model options** |
|---|---|---|---|
| Type 1. | Substantial community and HACC target group of 200+ people, plus a local ACCO | ▪ Ballarat<br>▪ Campaspe<br>▪ East Gippsland<br>▪ Greater Bendigo<br>▪ Greater Geelong<br>▪ Mildura<br>▪ North and Western region<br>▪ Yarra Ranges<br>▪ Swan Hill and Latrobe[25] | ▪ Core HACC services with adequate SSR/FSR to fund HACC Management and Infrastructure functions (HMIF)<br>▪ Service Coordination role |
| Type 2. | Substantial community and HACC target group of 200+ people, no local ACCO | ▪ Frankston<br>▪ Mornington Peninsula<br><br>**Swan Hill and Latrobe[26] | ▪ Koorie specific HACC funding to reflect the higher cost of delivering to Indigenous people.<br>▪ Service Coordination role |
| Type 3. | Medium community and HACC target group of 100+, plus a local ACCO | ▪ Glenelg<br>▪ Warrnambool<br>▪ Wellington<br>▪ Maroondah | ▪ Shared or clustered SSR/FSR to fund HACC management and infrastructure functions<br>▪ Service Coordination role |
| Type 4. | Medium community and HACC target group of 100+ people, no local | ▪ Macedon Ranges<br>▪ Gannawarra<br>▪ Baw Baw | ▪ Koorie specific HACC funding to mainstream agencies |

[25] The ACCO is currently not responsible for running the Koorie specific HACC service.
[26] The Koorie specific HACC service is currently being auspiced by a mainstream agency.

| | Characteristics | Which local government areas? | Model options |
|---|---|---|---|
| | ACCO | ▪ Whitehorse<br>▪ Monash<br>▪ Knox<br>▪ Moira<br>▪ Kingston<br>▪ Glen Eira<br>▪ Port Phillip<br>▪ Casey | to assist with engaging Indigenous communities and meet the higher cost of delivering services to Indigenous clients. |
| Type 5. | Small Indigenous community only | Local government areas not specified above | Assistance to mainstream agencies to become culturally sensitive and deliver culturally appropriate services |