

Home and Community Care (HACC) Program

Barwon-South Western Regional Plan, 2003-06

Incorporating the 2003-04 Regional Plan required under
the *HACC Amending Agreement 1998*

December 2003



Glossary of terms

Annual Plan	Victorian Home and Community Care Program Annual Plan 2003-04
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
DHS	Department of Human Services
HACC	Home and Community Care Program
MDS	Minimum Data Set
Primary Data	Consistent data sets used by all regions
RREF	Regional Resource Equity Formula
VICACD	Victorian Indigenous Committee on Aged Care and Disability
WREN	Within Region Estimate of Need

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Section 1 – HACC Regional Plan 2003-06

1.1. Context of the Regional Plan

The Home and Community Care (HACC) Program is funded jointly by the Commonwealth and the State governments. The administrative framework of the HACC Program is documented in the *Amending Agreement, 1998*.

Since the inception of HACC in 1985, services have grown each year. The Agreement stipulates that the Commonwealth and the State Ministers jointly agree an Annual Plan specifying outputs to be provided in each region, including the mix, level and quality of services. After both Ministers approve the Annual Plan, the State Minister is mandated to allocate growth funds to agencies in accordance with the Annual Plan. The Annual Plan is comprised of information drawn from each of the nine Regional Plans. Victoria is accountable to the Commonwealth for its performance against the Annual Plan. Appendix A is the timeline for developing the Annual Plan for 2003-04.

1.2. Purpose of the Regional Plan

The Regional Plan has a three-year planning horizon, 2003-04 – 2005-06. The aim is to set goals for service expansion and plan to achieve them progressively over a three-year period. The objective is to expand HACC services where the demand is greatest.

DHS has analysed service provision and demographic data, research and evaluation reports of various stakeholders and information received during the consultation period, drawn conclusions and proposed a number of measures to:

- Implement the Ministerial Priorities
- Redress funds inequity across local government areas
- Expand HACC services, paying attention to service mix
- Allocate growth funding to agencies.

These are the subjects of the present Regional Plan.

The Regional Plan will be adjusted as necessary each year during the triennium, taking account of exact Commonwealth and Victorian government budget allocations, the most up-to-date data and unanticipated events.

1.3. Consultation with the sector

During July 2003, each DHS region presented a *Draft Regional Plan* to the sector. The Draft Regional Plan documented all proposals and accompanying rationales. DHS sought critical appraisal from the sector on each of the proposals through the consultation sessions or in writing. The aim was to test the conclusions drawn by DHS, and change them where information had been overlooked or where a more sensible conclusion could be drawn. The Ministerial Priorities formed the framework for service expansion.

All HACC service providers, planners, and consultative groups for clients and carers were encouraged to contribute to the development of the final Regional Plan.

Please see Appendix B for a summary of the outcomes of consultation in the Region.

1.4. What is the HACC Program?

The HACC Program funds services that are targeted to frail older people, people with disabilities, and carers, providing basic support and maintenance to people living at home whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care. Services include Home Care, Respite, Allied Health, Nursing and social support services.

1.5. Characteristics of HACC service users in Victoria

The following data is derived from the HACC Minimum Data Set, 2002-03.

Numbers: Around 220,000 Victorians used HACC services during 2002-03. Of these, 67% were people aged 70-plus.

Ethnicity: Seventy-nine percent of HACC clients were born in Australia or other English-speaking countries. The other 21 percent came from over 140 different countries. Of these, the top 10 were Italy, Greece, Poland, Germany, Netherlands, China, Malta, Egypt, India and Sri Lanka.

Location: About 37% of clients live in the non-metropolitan regions of Victoria. Northern and Western metropolitan regions have the highest proportions of overseas-born people—more than a third of all clients. In the Eastern and Southern regions, the proportions are around 20%, and the five rural regions are all below 10%.

Living arrangements: 42% of clients live alone, 50% with their families, and 8% with other people. The proportion of clients living alone rises steadily with age (up to age 95). Among people aged 70-plus, more than half live alone, which is largely an effect of widowhood.

Housing: 79% live in owner-occupied dwellings, 8% in private rental and 7% in public rental. Only 2% live in a Supported Residential Service.

Carers: About half of HACC clients report that they have a family caregiver; where there is a carer, it is most likely to be a spouse (43%) or a daughter (24%).

Types of service: The most common HACC activities were Home Care, Nursing and Allied Health services. Home Care and Planned Activity Groups (PAG) accounted for 63% of total HACC hours. Attendance at a PAG was typically 4 hours per fortnight. Typical use of Home Care was 1–2 hours per fortnight.

Quantities: Over 90% of clients received a modest 0–14 hours per month, mostly from a single type of HACC service. By contrast, among the 6% of clients receiving 15–39 hours per month, nearly half were receiving 2–3 kinds of HACC service. Grampians and Loddon–Mallee regions appeared to have a somewhat greater proportion of high-use clients than the average. Statewide, less than 2% of clients received more than 40 hours per month.

Mix of services: Two-thirds of people received only one HACC service type. Of those receiving a mix, the most common combination was Home Care plus Property Maintenance.

Auspice type: Local councils provided some 84% of the 2.25 million hours of Home Care delivered in Victoria, and 80% of delivered meals. By contrast, ethno-specific and Aboriginal agencies are mainly involved in running Planned Activity Groups. The Royal District Nursing Service dominated in the provision of home nursing across metropolitan Melbourne. Community health centres were the site for delivery of most HACC Allied Health, particularly occupational therapy, physiotherapy and podiatry.

1.6. Better planning & funds allocation

DHS has actively responded to complaints from the sector that the HACC funding round processes were unnecessarily cumbersome and complex. After extensive consultation and detailed data analyses, the State Minister announced an administrative reform package, the *Better Planning and Funds Allocation for the Home and Community Care Program in Victoria*. The reforms aim to:

- Simplify the funding round processes
- Facilitate more equitable distribution of HACC funds across local government areas
- Increase consistency and transparency in funding decisions across the State
- Give greater certainty to providers.

The reforms were launched in April to be implemented from 1 July 2003:

1. Focused Ministerial Priorities for HACC growth funds

The priorities for the next three years focus growth funding where the demands are greatest. They are evidence based and were developed in consultation with the sector. The major benefit is that more predictable growth funds will be allocated in larger parcels, enabling more effective outcomes to be achieved. (See Section 2.)

2. Consistent three year planning

Instead of only planning growth funding for one year, there is a three-year planning horizon. This provides agencies greater certainty of funding, facilitating better workforce and service planning. In addition, consistent planning methods have been introduced across all regions, including a formula to guide intra-regional funds equalisation (the Within Region Estimate of Need or WREN). Regional Plans have been developed in consultation with the sector and document the rationale for all planning and funds allocation decisions, thus providing greater transparency.

3. More diverse means of funds allocation

Instead of allocating all growth funds through a submission process, funds are distributed directly to agencies, or via invited or advertised submission as appropriate. This means that where an agency is the only provider of services to be expanded, DHS negotiates directly with that agency about its capacity to grow the service. The result for agencies is significant savings in time and effort that can be devoted to meeting the needs of clients and carers.

4. Automatic allocation of minor capital

All service providers automatically receive an annual allocation for minor capital, without application or separate acquittal. This gives all agencies a fair portion of the minor capital funding and greater certainty of funding. Importantly, the inefficient submission and separate acquittal process have been abolished for minor capital.

5. More focussed research and development program

The HACC research agenda in 2003-04 is targeted at service evaluation, service development initiatives and practice-relevant research.

A detailed explanation and rationale of the planning and funds allocation framework can be found at <http://www.health.vic.gov.au/agedcare/hacc>

1.7. HACC budget

1.7.1. Service expansion - recurrent funding

The Victorian HACC budget for 2003-04 is \$358 million (full year effect), inclusive of indexation and growth. The HACC budget is comprised of Commonwealth and State funds allocated according to an agreed ratio and an additional Victorian contribution. Funds available to expand services for 2004-05 and 2005-06 are subject to State and Commonwealth government budget decisions in those years so these are presented as indicative.

1.7.1.1. Joint Commonwealth/State commitment

Commonwealth/State growth in HACC service expansion is estimated to be \$35.3 million over the next three years, that is, \$11.2m in 2003-04, \$11.7m in 2004-05, and \$12.4m in 2005-06. This is subject to confirmation in 2004-05 and 2005-06.

Allocations on the basis of the Relative Resource Equity Formula (RREF), for each region are listed below:

Region	Growth 2003-04	Indicative Growth 2004-05	Indicative Growth 2005-06
Barwon-South Western	\$835,047	\$854,649	\$910,751
Grampians	\$509,922	\$524,690	\$567,157
Loddon Mallee	\$734,879	\$753,604	\$810,891
Hume	\$583,815	\$598,390	\$645,978
Gippsland	\$658,137	\$685,652	\$721,866
Western	\$1,295,727	\$1,353,730	\$1,466,073
Northern	\$1,720,255	\$1,756,788	\$1,828,373
Eastern	\$1,937,771	\$2,014,279	\$2,184,003
Southern	\$2,476,750	\$2,569,283	\$2,752,060
Statewide	\$435,751	\$600,000	\$550,000
TOTAL	\$11,188,055	\$11,711,065	\$12,437,152

Note: Growth allocations include those for the HACC Response Service

1.7.1.2. Victoria's additional commitment

Redressing funds inequity between regions

The Victorian Minister for Aged Care has allocated an additional \$1 million of unmatched Victorian funds to boost 'HACC Basic' services (see Priority 1 in Section 2.1) distributed as set out below:

- \$335,700 for Northern Metropolitan Region
- \$371,100 for Southern Metropolitan Region
- \$293,200 for Western Metropolitan Region.

This recognises the significant degree to which these regions have been underfunded compared with other Regions.

Improving services for people from culturally and linguistically diverse backgrounds

The Victorian Minister for Aged Care has committed an extra \$2.018 million to improving the responsiveness of local government HACC services to people from CALD communities.

The Culturally Equitable Gateways Strategy is for three years and has a number of components:

- Capacity building in local government assessment and care management - \$1,128,000
- Capacity building in large and established ethno-specific services - \$500,000
- Services for small and emerging communities - \$100,000
- Bilingual and multicultural staff recruitment by Migrant Resource Centres - \$150,000
- Leadership and sectoral development by the Municipal Association of Victoria and the Ethnic Communities Council of Victoria - \$140,000.

1.7.2. Research & development

The intention is to allocate non recurrent funds equivalent to 5% of growth funding to research and development in the HACC Program. Each region may allocate \$30,000 of this fund each year for 'local' initiatives. The remainder will be used to address statewide systemic questions. The statewide allocation for 2003-04 is \$1,693,844.

1.7.3. Minor capital

The intention is to allocate non recurrent funds equivalent to 1% of total HACC expenditure for minor capital. The allocation for 2003-04 is \$3,630,193. Each year agencies receive their share of the annual allocation according to the formula documented in *Better Planning and Funds Allocation for the Home and Community Care Program in Victoria*, Appendix 4.

Section 2 – Ministerial Priorities 2003-06

2.1. Introduction

As part of the *Better Planning and Funds Allocation for the Home and Community Care Program in Victoria*, the State Minister endorsed a strategic framework for 2003-06 to guide the allocation of HACC growth funds.

The framework differs from Ministerial priorities in earlier years in that it:

- Has a three year rather than one year outlook
- Has drawn wherever possible on demographic and service system evidence
- Explains the relationship between priorities for growth funds, and the strategic directions overall for HACC
- Has had the benefit of stakeholder input through the Departmental Advisory Committee on HACC.

For regional planning purposes, the key elements of the framework are as follows:

- **Priority 1** – Increase the supply and improve the responsiveness of ‘HACC Basic’ services and consolidate the ‘HACC Basic’ service system around the key local government and health sector providers.

HACC Basic activities are Home Care, Personal Care, Nursing, Allied Health, Delivered Meals, Property Maintenance, and Assessment and Care Management.

- **Priority 2** - Increase the quantity and quality of ‘HACC Basic’ services for people from CALD backgrounds and develop new collaborative direct service delivery arrangements between mainstream, multi-cultural and ethno-specific organisations.
- **Priority 3** - Increase the quantity and quality of HACC services for Aboriginal and Torres Strait Islander (ATSI) communities.

2.2. Evidence and rationale

Commonwealth and State governments increase HACC funding each year because the HACC target population is growing and there is a long-term commitment to expand the Program. However, provider and consumer groups contend that the growth funding is not keeping pace with the growth in demand. In this context, the Victorian Minister announced a strategic framework to guide the distribution of HACC growth funds for the coming triennium, 2003-06. The objective is to concentrate the growth funds where the demand is greatest.

There are two main reasons for the Ministerial Priorities:

1. Demographic projections show that the greatest growth in persons in need over the next three years is among frail older people, and ageing people with disabilities. During the same period the Victorian population younger than 55 years will grow slightly, and shrink in rural regions.
2. The need to strengthen the basic HACC system in order to balance service provision against growing demand, by: expanding core HACC services; strengthening HACC’s preventative, maintenance and support role; and

improving people's capacity to self manage in a better stocked and more robust system, rather than be required to seek 'care packages'.

This does not imply any change to HACC eligibility or priority of access guidelines. Nor does it imply any intrinsic lesser value to those HACC activities not specified in Priority 1, that is, Respite, Volunteer Co-ordination, Planned Activity Groups and Linkages are all highly valued activities.

A detailed rationale for the Ministerial Priorities can be found in the *Better Planning and Funds Allocation for the Home and Community Care Program in Victoria*, Appendix 1, at <http://www.health.vic.gov.au/agedcare/hacc>
The following sections provide a summary of the demographic and service provision data underpinning the Ministerial Priorities.

2.2.1. What do the data tell us?

2.2.1.1. Priority 1

Projected changes in population and target groups indicate that growth in demand for HACC services will come predominantly from older age-groups. Not only does the rate of disability increase with age, but the rate of uptake of HACC services is also much higher among older persons, relative to the prevalence of disability. There are several reasons for the greater uptake of services among the aged:

- Increased frailty and vulnerability
- Reduced coping resources, including mobility, low income
- Living arrangements, eg. living alone, dependence on informal carers, which may affect the foregoing
- Chronic ill-health and deterioration of health status.

The figures in this section demonstrate the most significant increase in the HACC population will be in the 50-69 and 70+ age groups. Accordingly, the greatest pressure on the HACC service system is likely to be on those services that are accessed more heavily by these age groups, that is, HACC Basic in-home support and health care activities (Home Care, Personal Care, Nursing, Allied Health, Delivered Meals, Property Maintenance, and Assessment and Care Management).

Figure 2.1 shows the projected change in age groups between 2001-06. There are:

- Some reductions in the younger age groups
- Major increases in the 45-69 age groups
- Significant increases in the 75+ age groups.

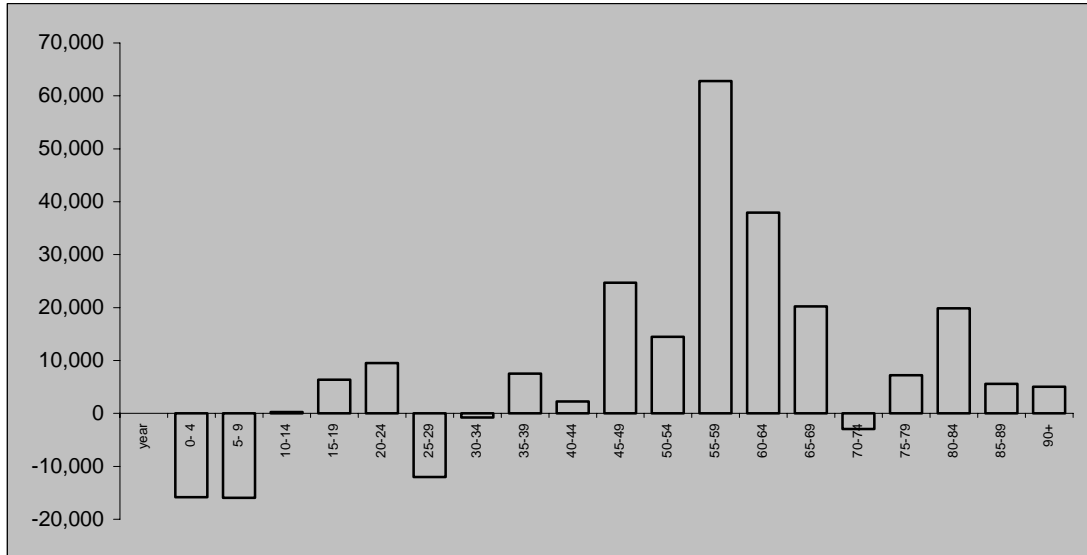


Figure 2.1: Changes in population groups 2001-06 Victoria
 Source: Department of Infrastructure *Victoria In Future*

Figure 2.2 compares the population changes between rural and metropolitan regions. The projected changes show a more pronounced pattern in rural areas, with fewer rural residents expected under age 50 and a stronger increase in numbers aged 50+. Only four rural local government areas are projected to increase their overall number of persons under 50 years of age; all others will experience decreases of up to 15%.

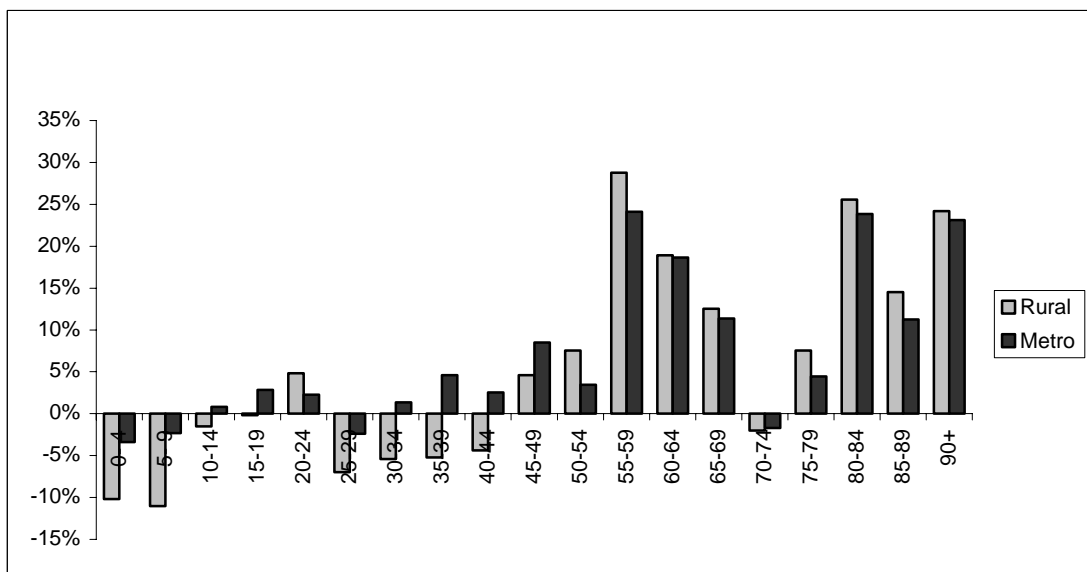


Figure 2.2: Comparison of population group changes: Rural and metropolitan regions
 Source: Department of Infrastructure *Victoria In Future*

Figure 2.3 shows the changes between 2001-06 in the number of people in different aged groups with a disability. The figures are derived by applying the age-related disability rates from the 1998 Disability Ageing and Carers Survey which enables an estimate to be made of the likelihood of disability at different ages. The graph shows that the major growth in numbers of people with disabilities will occur in the 55-69 and 80-84 age groups. There will be negligible growth in numbers of people with disabilities below 55 years, and reductions in three age groups.

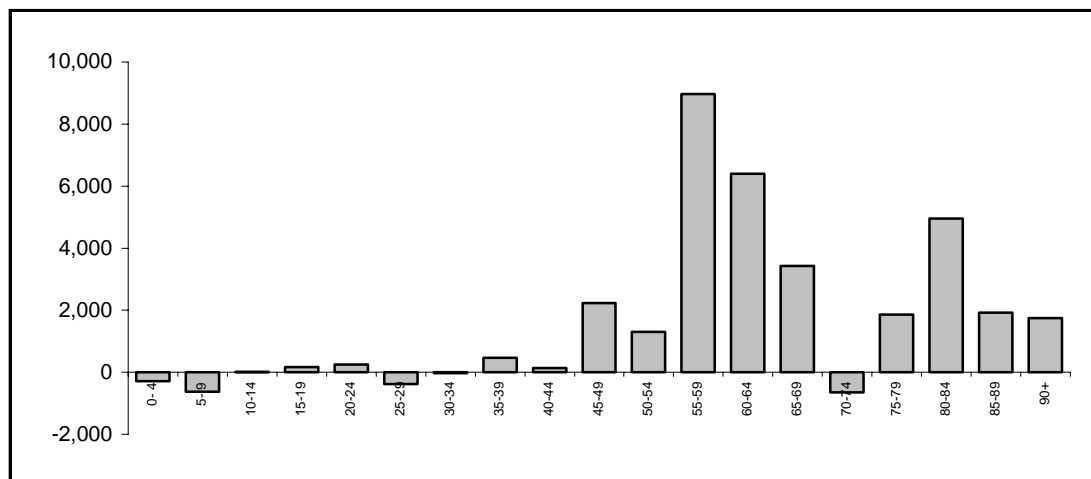


Figure 2.3: Changes in the estimated number of persons with a disability, 2001-06
Source: Department of Infrastructure *Victoria In Future* and 1998 ABS *Disability, Ageing and Carers Survey*

Clients aged 70 and over received 64% of all HACC service hours, with 18% to those aged 50-69 years and another 18% to those below age 50. The average client aged 70+ received more Home Care, Personal Care, Delivered Meals, Nursing and time in Planned Activity Groups than younger clients. Aged clients were more prevalent in those activities (Home Care, Personal Care, Delivered Meals, Property Maintenance) which constitute independent living support. With rising age the proportion of clients receiving more than one activity also increased. Over the last three years there has been significant expansion of funding to Planned Activity Groups, and this will be subject to evaluation. Growth for the years 2003-04 to 2005-06 will be concentrated on those activities in greater demand from the aged.

2.2.1.2. Priority 2

Culturally appropriate access to services for people with CALD background is a Ministerial Priority for 2003-06. Analysis of the HACC Minimum Data Set in conjunction with data from the 2001 population census, shows the current under-representation of clients with CALD background in most HACC activities: without taking account of age or differentials in disability rates, the rate of HACC clients per 1000 target population is almost twice (1.9 times) as high for English speakers as for persons who speak a language other than English at home. This differential steadily reduces with increasing age.

Importantly for the HACC 2003-06 triennial plan, the ratio of English speakers to speakers of languages other than English tends to be highest (that is, most unfavourable to speakers of languages other than English) for health care and independent living services, which have been accorded priority. Planned Activity Groups are the only activity type with a higher rate of participation by speakers of languages other than English than English speakers. Respite care is in a somewhat different category from other service types because of its atypical (for

HACC) client age profile, with younger people with disabilities predominating. For older persons, receipt of Respite is more evenly spread across all language groups.

Figure 2.4 shows the ratios of English speakers compared to speakers of languages other than English in the October – December 2002 quarter. The graph shows the relative under-servicing of clients speaking a language other than English at home by activity. A ratio of less than one would indicate a higher rate for clients speaking a language other than English than for English-speaking clients. In the most extreme instance, in every 1,000 persons in the HACC target group speaking a language other than English the number of Delivered Meal recipients was only one-fifth of the number of English-speaking meals recipients per thousand.

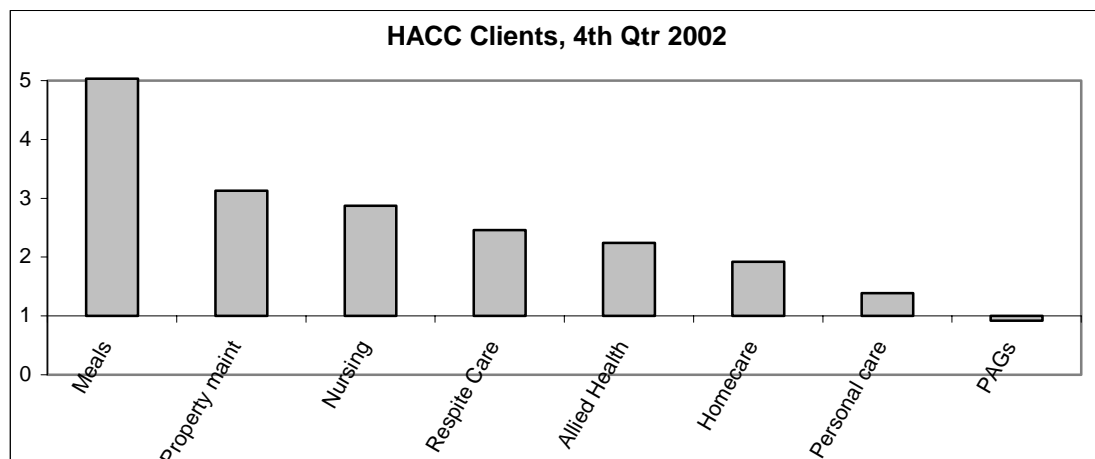


Figure 2.4: Ratio of rates of service provided to English/LOTE clients

Source: HACC MDS December Quarter 2002 and 2001 Population Census

Note: These relativities do not take account of possible differences in disability and need in the two population groups, and of course between different ethnic groups among non-English speakers.

For a more detailed data analysis of the CALD populations in Victoria and their HACC service usage, please see Appendix C, *Supporting Evidence for HACC Priority 2*.

2.2.1.3. Priority 3

ATSI communities suffer a much higher burden of ill health and premature death than other groups. HACC services are among the most critical in Indigenous communities where basic maintenance and support services are vital to frail older people, people with disabilities and their carers. The strategic objective is to ensure that an adequate quantum and range of HACC services is available to Victoria's Indigenous communities in culturally relevant and appropriate ways, including where services are provided by mainstream providers.

2.3. Putting the Priorities into action

2.3.1. Statewide strategies

During the 2003-06 triennium, Victoria is undertaking a range of strategies to improve the quality and level of HACC service delivery to frail older people, younger people with disabilities and carers, including:

Developing culturally responsive services

- Implementing a communication strategy about HACC services for people from CALD backgrounds.
- Undertaking a range of projects to enhance the cultural responsiveness of HACC Basic services.
- Building the capacity and responsiveness of HACC services for people from an ATSI background.

Investing in the HACC workforce

- Strategically influencing workforce development in Victoria to improve HACC funded agencies' access to a more diverse and adequate supply of trained, suitable staff who will provide consumers of HACC services with good quality services and continuity of care.

Improving the quality of services

- Supporting HACC funded agencies to implement the HACC National Standards Instrument, including the preparation of action plans focused on improving consumer outcomes.
- Promoting and sharing good practice across the HACC sector.

Effective program planning and evaluation

- Improving the systems supporting the collection and analysis of data to enable quality program planning, research and evaluation.

Targeting in the HACC program

- Undertaking work to develop and implement the Victorian HACC assessment framework to improve the quality and consistency of decision making about client need and access to services.

Funding and accountability

- Continuing to critically examine the costs of service delivery.
- Developing sustainable funding models and costings for services.

Investing in research and development

- Developing a clearing house for service development and research projects.
- Developing a forward research agenda including the impact of Victoria's cultural diversity on community, and opportunities of new technology for home care.

2.3.2. Regional strategies

Within the context of the Ministerial Priorities and the statewide initiatives, each region is responsible for developing local strategies to implement the Ministerial Priorities. These strategies are proposed in the following sections of the Regional Plan.

Section 3 – Regional context

3.1. Introduction

To address the Strategic Ministerial Priorities, data has been gathered and analysed to provide an evidenced based approach to planning and funds allocation in anticipation of growth funds over the triennium, 2003-06. The focus of the examination has been on developing a picture of HACC in the Region in terms of the population demographics, and service supply and demand. This picture has been used to anticipate where the demand in HACC services will be greatest between 2003-06, and thus to assist in best targeting resources. Section 3 describes the data that has contributed to the recommendations.

The data included a number of data sets (primary data) used by all DHS Regional Offices to develop each Regional Plan, as well as additional data available locally. The primary data included:

- The Region's agency composition
- Planning and other data
- Population
- Service provision (including HACC Minimum Data Set data)
- Funding.

In addition the Region has examined additional data including:

- Service provision data from the broader health and aged care sectors (hospital, residential care. For details see Appendix G)
- Regional reports.

3.2. The Region's HACC sector

3.2.1. The Region's local government areas

The Region comprises the local government areas depicted in Figure 3.1.



Figure 3.1: Local government areas in Region

3.2.2. The HACC sector

Within the nine local government areas, DHS funds 50 HACC providers. HACC providers are a diverse group and include:

- 9 local governments
- 1 community health centre
- 14 hospitals
- 2 residential aged care centres
- 2 bush nursing centres
- 15 non-government agencies
- 5 ATSI-specific agencies
- 2 CALD agencies.

Appendix D is a list of HACC providers in the Region.

Of these 50 agencies, two provide services statewide.

95% of agencies have completed training and are beginning an assessment against the National Service Standards Instrument.

3.3. How the Region communicates with the sector

In order to manage and support the HACC sector effectively, DHS engages a number of strategies to develop and sustain partnerships and to enhance sharing of local knowledge. These strategies enable DHS and HACC agencies to understand the needs of the HACC sector and to work together to develop services and implement changes that will better meet the needs of HACC clients.

In Barwon-South Western, DHS works through two ongoing Aged Care/HACC Committees that meet quarterly to discuss HACC and aged care planning, development and general issues. The Committees comprise representatives from local governments, non-government organisations and CALD services. The Committees are:

- Barwon Sub Region Aged Care and HACC Advisory Committee
- South West Sub Region Aged Care and HACC Advisory Committee.

In addition there is a specific HACC Koori Network that works across both BSW and Grampians Regions:

- Koori Aged and Disability Network Advisory Committee (meets quarterly – to discuss issues of concern around HACC service provision for ATSI agencies).

3.4. The planning context

In developing proposals for HACC service expansion, the Regional Plan takes account of the fact that HACC operates and is influenced by the broader human services sector as well as initiatives within the HACC sector. Therefore in developing the Regional Plan, the impact of both the broader human services sector and other HACC planning projects have been taken into account.

The planning process for HACC has been broadly influenced by the following initiatives/factors:

- **Integrated planning, service development and delivery**

The Region is committed to planning based on the reality of service availability and utilisation in local communities. Communities are not concerned whether services are provided by one DHS program as distinct from another. All that matters is that human services are there. Effective planning for current and future needs must be based on a clear understanding of the services funded through all DHS programs, how they interact in practice, and the strengths and weakness of the system as a whole in each community. 'Planning in context' is a major priority of the Region, and applies to planning within individual programs as well as for the system as a whole.

Based on this approach, the Regional Office is continuing to map the general availability of community-based services across the Region. These include HACC, community health, services provided through hospital outpatient clinics, services provided by Healthstreams/Multi Purpose Services, community-based mental health and drug and alcohol services, and various acute health funded services provided in the community to reduce the need for hospital admission (e.g. hospital in the home, Post Acute Care, Hospital Admission Risk Program - HARP). Developing a more sophisticated understanding of the availability and utilisation of these services is enabling the Region to identify how demand for and use of one service type is influenced by the availability of other services. These links between service types in different programs must be better understood and articulated so that planning can be more effective at all levels - within individual programs and cross-program planning in geographic areas.

Work on this project to date has highlighted the relative strengths in the broader service system in some parts of the Region, related to the mix of services available across all DHS programs and to innovative service responses developed by some agencies to meet unusual client needs. The relative strengths of the general service system in each geographic area of the Region are part of the context within which planning for HACC (and all other programs) will take place in the Region.

- **Small rural health service reforms**

Regional work with some smaller rural health agencies over the next three years will focus on the planning and delivery of all community-based services, including HACC and the conversion of weighted in-patient equivalent separations (WIES) to community-based health services.

- **Ambulatory Care Sensitive Conditions**

Unexpectedly high rates of hospitalisation for some medical conditions are the focus of a major project in the Region. Data on Ambulatory Care Sensitive Conditions (ACSC) is being analysed to identify issues that affect the hospitalisation of people for conditions that would ordinarily be treated in the community. Data analysis will provide useful information about the need for and supply of community-based services (including HACC), which could reduce hospitalisations for ACSCs. Broader patterns of hospital treatment for all conditions are also being examined through further analysis of Victorian Admitted Episodes Data Set (VAED) data in the Region.

- **Neighbourhood renewal**

Neighbourhood renewal projects in the Region have identified Colac-Otway Shire and Corio as areas of particular disadvantage across a range of indicators. For example, although Colac is a major town (about 10,000 people) there is no bulk-billing health service available and over two thirds of its residents have Health Care Cards. A high proportion of its residents also receive a Disability Pension (69% compared to 50% statewide). Its distance from both Geelong and Warrnambool affects access to the broad range of services available in these larger cities. As a result of its relative isolation and the numbers of its residents with poor financial, social and health outcomes, it has been identified as an area for further concentrated work.

The high needs of both Colac-Otway and Corio (Greater Geelong) will affect planning for all DHS services in these local government areas, including HACC.

- **Service delivery and utilisation patterns**

While the local government areas of Queenscliffe and Greater Geelong are distinct, provision of services for their residents involves complex service delivery and utilisation patterns. This has produced some areas where services have catchments across local government area boundaries. Further analysis of service provision data across all DHS programs is needed to clarify patterns of service delivery and utilisation, particularly within the eastern parts of Greater Geelong and Queenscliffe. This will inform future planning in all DHS programs, including HACC.

- **Transport**

Transport has been identified as a major issue for all communities in the Region. Successful service models have been developed through the HACC Program in the South West (South Grampians, Moyne, Warrnambool, Corangamite and Glenelg) and Barwon (Colac-Otway). Their consolidation is a regional priority. The service is particularly significant for older people.

The planning process for HACC has been specifically influenced by the following HACC initiatives/factors:

- **Increase in older populations**

Between 1996 and 2001 population trends show growth in total population in the more urbanized/coastal areas of the Region – Surf Coast, Warrnambool, Greater Geelong and Colac-Otway. However, there are different patterns of change predicted for older people across the Region to 2006 (Department of Infrastructure projections). While all local government areas show an increase in the 70+ population (peaking in Surf Coast (5.4%) and Corangamite (5.6%)), within the 70+ population, the trends vary considerably depending on the age group. There is a dramatic overall increase predicted in the 85+ group in all local government areas except Queenscliffe (up to 17.1% in Surf Coast). This increase in the old population will have implications for the HACC service system, as the rate of dependency on external services to remain living at home increases with age.

- **MDS compliance**

A significant deficiency in the HACC MDS for the Region has been the lack of data from a major provider of allied health and nursing services in the Barwon-sub region. The lack of data about service utilisation and client details is a major issue. This affects the reliability of data drawn from the MDS about these service types (and other HACC activities delivered by the agency, including Assessment and Care Management) across the Region, and also about the relative performance of HACC agencies servicing these local government areas. It is expected that this issue will be resolved by December 2003.

A further issue which affects all regional data in the MDS is the recording of services provided through brokerage arrangements. There are differences between agencies as to who reports to the MDS - the agency purchasing the service or the one delivering the service. The Region will continue to work with agencies to ensure consistency in reporting in these circumstances. Public use of this data should improve collection and quality.

- **Shortage of low care aged residential beds**

The availability of aged care residential beds impacts directly on the HACC service profile in the Region. A shortage of low care beds, particularly in the local government areas of Greater Geelong and Surf Coast, places higher demands on the HACC system to provide services to maintain very frail older people at home. This shortage exists in 2003, and is projected to worsen by 2006. (See *HACC plan beds summary* in Appendix G.)

The Region has examined data (see Appendix G) about current users of HACC services, and there is a link between provision of a high level of HACC services to a person (e.g. more than 260 hours per year - five hours per week - of Home Care, Personal Care, Property Maintenance, Allied Health and Nursing) and deficits in the number of low care beds available. It is reasonable to expect that the number of 'high use' clients will increase over the planning period given the low care bed shortages to 2006 and significant increase in the proportion of the HACC population aged 85 and over during the same period.

3.5. Data

3.5.1. Population

The data in Section 3.5.1 builds a picture of the HACC population across the Region. This picture is important in helping to identify where the likely pressures will be on the service system over 2003-06.

3.5.1.1. Regional HACC population 2003-06

Table 3.1 and Figure 3.2 show the relative distribution across local government areas of the HACC target population in the Region.

In developing data to determine the relative HACC population, DHS uses the Relative Resource Equity Formula (RREF) to identify the relative need for HACC services across the nine regions in Victoria. The RREF is then used to allocate the growth funds between the regions.

DHS uses the Within Region Estimate of Need (WREN) to indicate relative need for HACC services at a local government area level within each region. For a detailed explanation of the WREN, please see Appendix E.

Table 3.1 shows the HACC needs weighted population (WREN) for each local government area and the estimated proportion of that population over 70 years of age.

Table 3.1: WREN population and percentage of WREN that is 70+ 2003-06

LGA	2003-2004		2004-2005		2005-2006	
	WREN pop'n	% 70+	WREN pop'n	% 70+	WREN pop'n	% 70+
Colac-Otway	3,304	67.9%	3,344	68.0%	3,365	67.9%
Corangamite	2,957	63.6%	2,992	64.0%	3,041	64.7%
Glenelg	3,106	60.3%	3,122	60.2%	3,140	60.2%
Greater Geelong	31,149	63.1%	31,552	63.0%	32,002	63.1%
Moyne	2,263	56.6%	2,279	56.5%	2,301	56.5%
Queenscliffe	728	72.0%	738	72.3%	744	72.5%
Southern Grampians	2,830	64.4%	2,861	64.6%	2,891	64.8%
Surf Coast	2,786	59.7%	2,848	59.7%	2,907	59.6%
Warrnambool	4,141	62.0%	4,208	62.0%	4,270	61.9%
Total	53,265	62.9%	53,945	62.9%	54,662	62.9%

* Scaled to make the Victorian total equal the RREF base (unweighted) population

Figure 3.2 shows the estimated relative amount of change in the HACC target population by local government area on the 30 June each year. This is important in being able to identify where pressure on HACC services might be likely to ease or intensify over time.

It is clear from Figure 3.2 that the HACC target population is increasing over the three years, but that the amount of the increase is variable across local government areas. Where the first bar is higher than the second bar, the HACC target population is not increasing as fast in 2005-06 as in 2004-05. Where the second bar is higher than the first bar, the HACC population growth is accelerating.

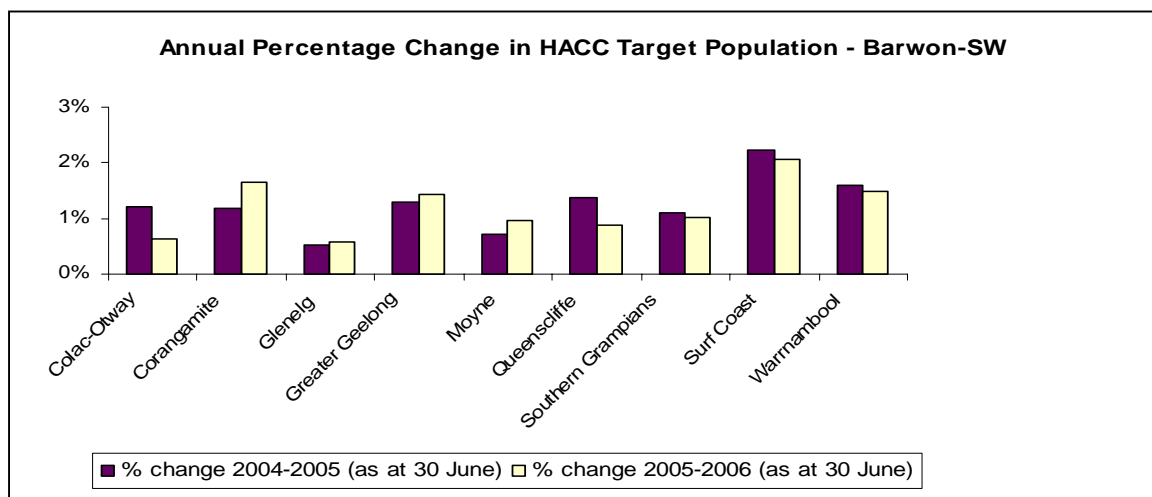


Figure 3.2: Annual percentage change in the growth in HACC target population by local government area

Source: Table 3.1, population as at 30th June in each financial year

3.5.1.2. Special needs populations

Having looked at the relative distribution across local government areas of the HACC target population, it is important to look at other population data that may indicate variable need for HACC services between local government areas. This is important in determining whether responses to enhance access to services for special needs groups should be targeted to particular local government areas.

Data about people from culturally and linguistically diverse backgrounds (CALD) is provided in Section 3.5.1.3. Data about ATSI is provided in Section 3.5.1.4.

3.5.1.3. Regional CALD population and languages spoken at home

Please refer to Appendix C, *Supporting Evidence for HACC Priority 2 - Appendix 3*, for a detailed breakdown of languages spoken at home by local government area. Language spoken at home has been used as a proxy for cultural identification, as this is the best available indicator of the nature of service delivery required.

See Section 5.4 for a specific 'regional' description and analysis of CALD issues and priorities.

3.5.1.4. Profile of the Aboriginal and Torres Strait Islander (ATSI) population

Table 3.2 shows the distribution of the ATSI population in the Region.

Table 3.2: Experimental estimates of total Indigenous population

LGA	0-49	50-69	70+	Total
Colac-Otway	93	13	0	106
Corangamite	54	11	8	73
Glenelg	248	22	4	274
Greater Geelong	1,255	106	33	1,394
Moyne	96	20	6	122
Queenscliffe	0	3	0	3
Southern Grampians	75	20	6	101
Surf Coast	67	2	1	70
Warrnambool	295	21	6	322
Total	2,183	218	64	2,465

Source: Australian Bureau of Statistics 2001 Census ATSI-experimental estimates of Indigenous population.

Notes:

Experimental estimates of the resident Indigenous population are based on 2001 Census usual residence counts and make allowance for instances in which Indigenous status is unknown, and for net under-enumeration. Estimates are considered experimental in that the standard approach to population estimation is not possible because satisfactory data on births, deaths and migration is not generally available, and because of the intercensal volatility in Census counts of the Indigenous population.

Final experimental estimates for the Indigenous population are expected to be available in August 2003.

Indigenous Persons are Census respondents who identified themselves as being of ATSI origin.

3.5.2. Service provision

The focus of analysis of the service provision data is on identifying the relative levels of resourcing of each HACC activity in the Region. This will assist the development of proposals for activity expansion in response to Priority 1.

Figures 3.3 – 3.9 below show the per capita service provision of 'Priority 1' activities by local government area. The per capita data is derived from the HACC Minimum Data Set divided by the HACC target population (WREN) for each local government area. The line across the bars represents the rural average. Figures 3.3 – 3.9 provide a picture of the relative levels of service across each local government area, and relative to the rural average.

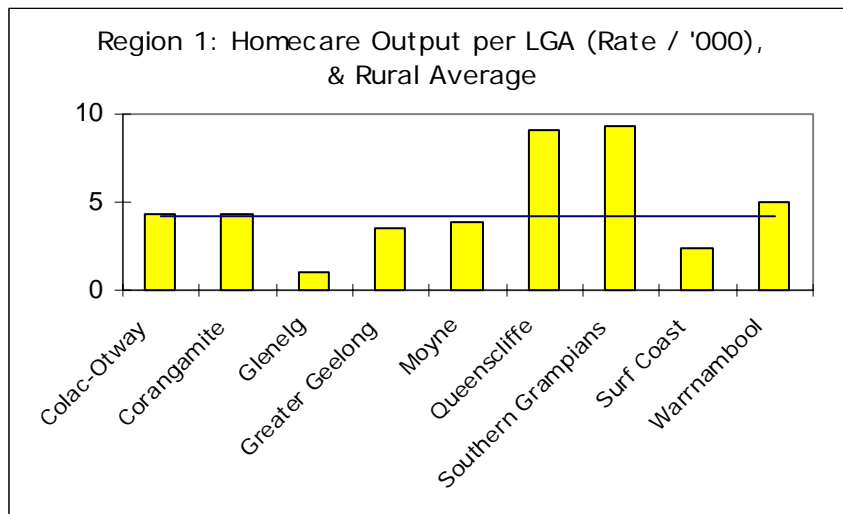


Figure 3.3: Hours of Home Care per 1,000 target population

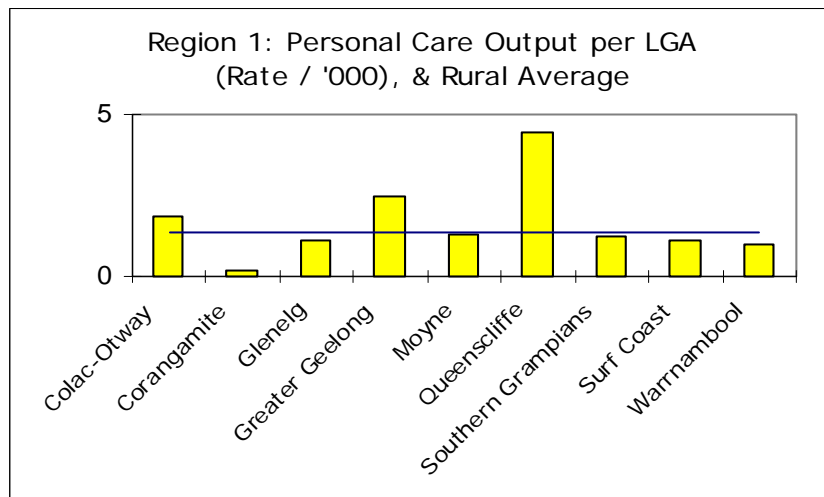


Figure 3.4: Hours of Personal Care per 1,000 target population

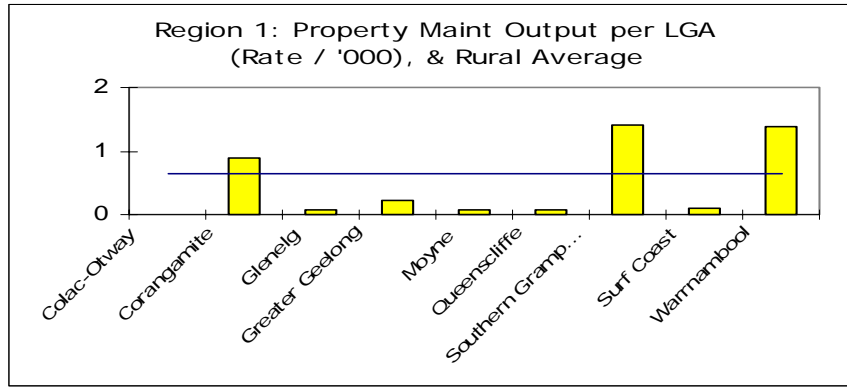


Figure 3.5: Hours of Property Maintenance per 1,000 target population

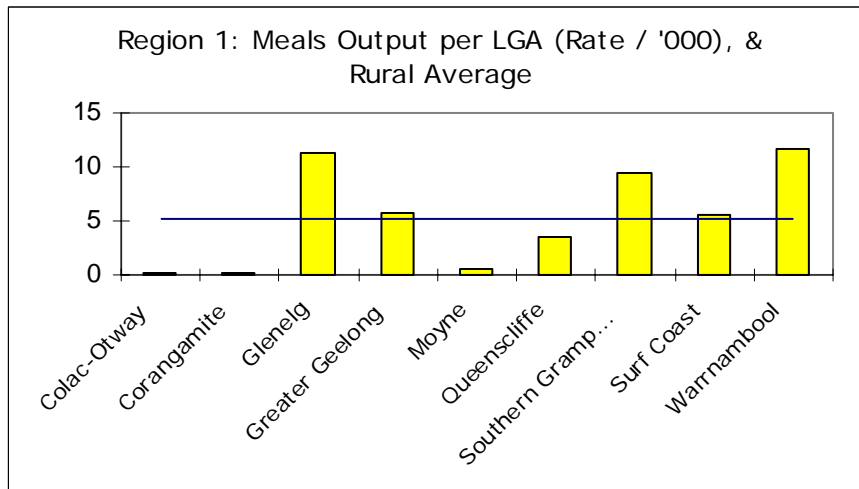


Figure 3.6: Meals per 1,000 target population

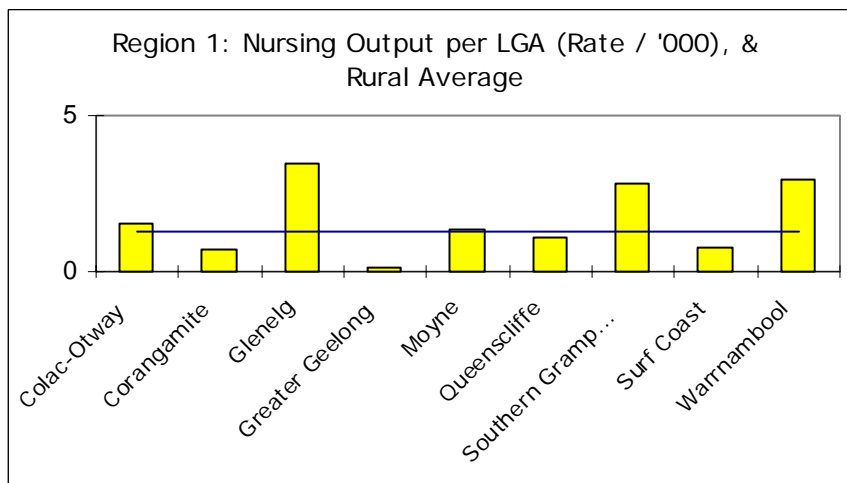


Figure 3.7: Hours of Nursing per 1,000 target population

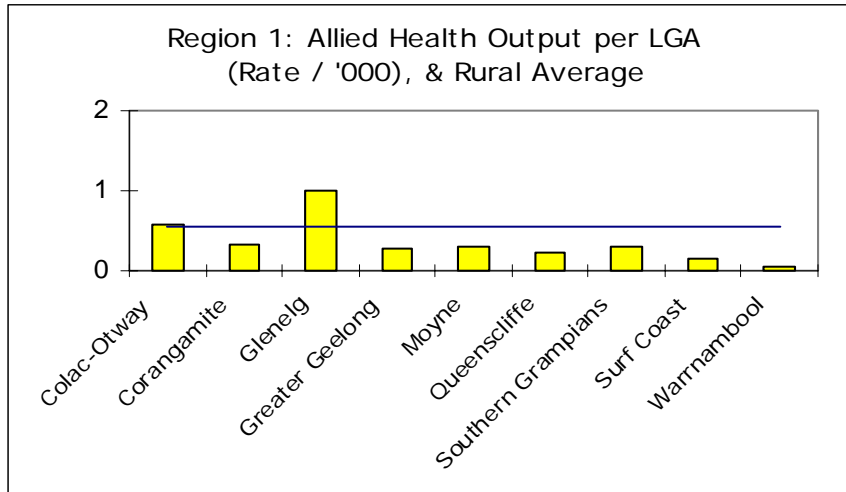


Figure 3.8: Hours of Allied Health per 1,000 target population

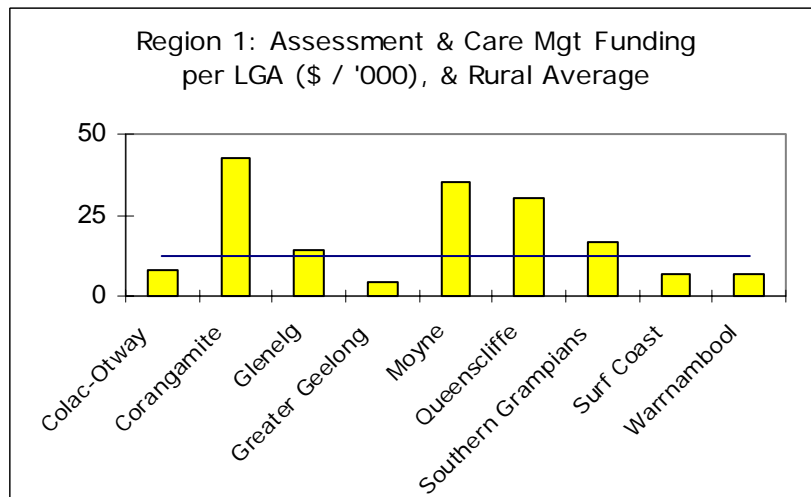


Figure 3.9: Dollars of Assessment and Care Management per 1,000 target population

3.5.3. Funding

To complete the picture of the Region, the proportion of the existing HACC recurrent funding has been compared to the proportion of the WREN population by local government area (see columns 4 and 5 in Table 3.3). The comparison provides a picture of relative HACC funds inequity between local government areas. This information is critical in determining how well the local government areas are resourced for HACC in relation to their relative share of the WREN population.

Table 3.3: Comparison of HACC recurrent funding with proportions indicated by WREN populations

Local government area (1)	Recurrent \$ 2002-03 (2)	Current \$ per capita (3)	% of recurrent budget 2002-03 (4)	WREN 2003-04 (5)
Colac-Otway	\$1,797,330	\$544	7.1%	6.2%
Corangamite	\$1,660,197	\$561	6.5%	5.6%
Glenelg	\$1,847,430	\$595	7.3%	5.8%
Greater Geelong	\$12,511,871	\$402	49.2%	58.5%
Moyne	\$1,480,879	\$654	5.8%	4.2%
Queenscliffe	\$715,306	\$983	2.8%	1.4%
Southern Grampians	\$2,003,056	\$708	7.9%	5.3%
Surf Coast	\$1,117,581	\$401	4.4%	5.2%
Warrnambool	\$2,314,616	\$559	9.1%	7.8%
Total	\$25,448,266	\$478	100.0%	100.0%

Figure 3.10 shows the relative gap between the distribution of recurrent funding and the distribution of the HACC target population (WREN) 2003-06. This information has guided proposals about the application of growth funds for equalisation across local government areas.

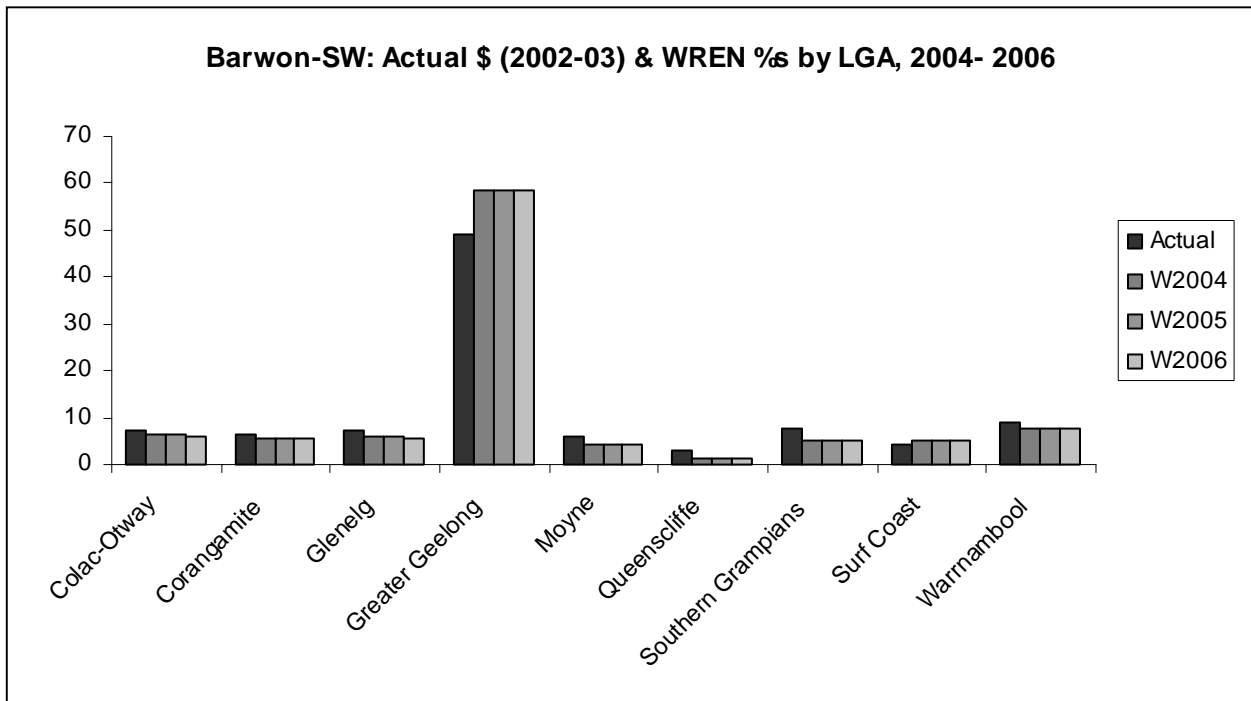


Figure 3.10: Proportion of actual recurrent budget (30 June 2003) and WREN population proportions 2003-06 by local government area

Section 4 - What do the data tell us?

Section 4 of the Regional Plan identifies the conclusions drawn from the data provided in Section 3.

4.1. Data analysis

The analysis of the data (population, service provision and funding shown in Sections 3.2 - 3.4.) is summarised below.

4.1.1. General

The primary data is not extensive enough to identify all the services provided in each local government area and other factors affecting need over the next three years. Additional data analysed by the Region examines other indicators of current and future need for HACC services, including:

- Detail about the proportion of funding received within each local government area for each of the service types covered by the Ministerial priorities (HACC Project Register)
 - Population trends in each of the HACC older age groups: 70-74 years, 75-84 years and 85+ years (ABS and DOI)
 - The number of HACC clients who use a high level of services over a year (more than five hours per week every week of Home Care, Personal Care, Property Maintenance, Allied Health and Nursing) (HACC MDS data)
 - Availability of operational low care aged residential beds within local government areas, and predicted shortages to 2006 (derived from Department of Health and Aged Care)
 - Distribution of funding for domiciliary nursing (for 2003-04 only), which has the same target group as HACC services (DHS, Aged Care)
 - The health of older people in the Region, especially hospital admissions for conditions that would ordinarily be managed in the community (ACSC)
 - The strength of the general community-based service system for older people and those with disabilities in each local government area.

Analysis of this data reveals:

- Greater Geelong has a lesser proportion of the recurrent base budget than its WREN share of the HACC target populations. Greater Geelong also has a lower than average share of all Priority 1 HACC services except Personal Care. Priority 1 services are also low in Surfcoast and Colac-Otway
- The practice in rural areas for personal care services to be performed by a nurse at the same time as nursing services are being delivered, produces artificially low personal care service delivery rates in these local government areas (Southern Grampians, Glenelg, Corangamite, Warrnambool)
- The lack of data about Allied Health and Nursing in the Barwon sub-region affects the validity of data on these activities, including calculation of the rural average
- Large increases in the proportion of 85+ population among people aged over 70, especially in Surfcoast (17%) and Colac-Otway (16%); Queenscliffe is the exception, showing no increase in this age group to 2006
- Significant shortages of low care aged residential beds by 2006, especially in Greater Geelong and Surfcoast will place added demand on HACC basic services

- The high proportion of HACC hours provided to 'high use' clients, especially in Greater Geelong, affects the capacity of agencies to meet the needs of other HACC clients
- Funding for domiciliary and community nursing affects the demand for HACC nursing services in the South West, especially Southern Grampians, and Glenelg
- High rates of hospitalisation among the 70 + population for ACSC raises issues about the capacity of HACC services to meet the needs of people before and after hospital treatment, and the extent to which HACC services should be better able to reduce the need for admissions among this age group in the first place
- Analysis of the cumulative effect of funding for community-based services shows that although the South West appears relatively well-resourced in HACC, the mix, volume and variety of services funded through all programs in Greater Geelong and Queenscliffe is able to complement HACC services to some extent.

4.1.2. Data analysis regarding CALD

The primary data showed that the larger CALD populations are living in the Barwon sub region, principally in the City of Greater Geelong, with much smaller populations living in the South West sub region.

The Region's analysis of MDS data compared to Census data reveals very low rates of participation in HACC services by older people in CALD communities across the Region. This low participation rate is of concern for all local government areas, irrespective of the numbers of people involved. Increases in the numbers of people from CALD communities who use HACC services can easily be measured in the MDS, and the Region will be working with agencies to monitor progress.

4.1.3. Data analysis regarding ATSI

There is little service provision data available for analysis about the delivery of services to ATSI communities in the Region. ATSI health services will be fully contributing to the HACC MDS by the end of 2003, and this will provide a much more detailed picture of the patterns of service delivery and help quantify areas of unmet need.

Over the last three years the Region has been targeting HACC funding to ATSI agencies to enable them to strengthen their capacity to develop culturally appropriate service models and deliver them effectively. Progress towards these objectives has been more significant in some parts of the Region than in others.

It is important to continue this process, enabling ATSI agencies to consolidate the gains they have made so far, and to broaden their client base where there are areas of unmet need within their communities. Some of these areas of unmet need arise because of the size of ATSI agencies' catchment areas, especially in Southern Grampians, and the Barwon sub-region.

In 2002-03 an Aboriginal needs analysis project was completed for the Southern Grampians and Glenelg municipalities, which identified the need for increased resources for HACC services. A similar needs analysis is required for Warrnambool and districts.

4.2. Conclusion

DHS recommends the following broad directions for the HACC program 2003-06. Detailed explanations about the specific proposals will follow in Section 5.

Priority	Strategy	Time-frame	Strategy Description	Anticipated Outcome
1	Increased service access and utilisation in Greater Geelong, Surf Coast and Colac-Otway	2003-06	<ul style="list-style-type: none"> To expand all Priority 1 services, except Personal Care, especially in Greater Geelong 	<ul style="list-style-type: none"> Increased client numbers More services provided
1	Target areas of particular concern in the South West	2003-06	<ul style="list-style-type: none"> Targeted expansion of Allied Health, Nursing and Home Care services in local government areas in the South West 	<ul style="list-style-type: none"> Increased client numbers More services provided
1	Increase HACC Response Service across Region	2003-06	<ul style="list-style-type: none"> Increase is proportional to reallocation of Personal Alert Victoria (PAV) units (funded by Aged Care) 	<ul style="list-style-type: none"> Increased client numbers across Region More service provided
2	Develop greater capacity to meet needs of CALD communities	2003-04	<ul style="list-style-type: none"> Develop specific training package for use with mainstream agencies in all local government areas Increase funding for Assessment and Care Management services to facilitate entry of new CALD clients to HACC services 	<ul style="list-style-type: none"> Mainstream agencies with skills to develop and maintain relationships with CALD residents in the catchments. Higher participation rate of people from CALD communities in HACC services in each local government area
3	Improve access to and provision of culturally relevant services for ATSI communities	2003-06 2003-06 2005-06	<ul style="list-style-type: none"> Expansion of Priority 1 HACC services in Southern Grampians and Glenelg Consolidation of service developments in each of the region's ATSI agencies Conduct a HACC needs analysis for Warrnambool and districts. 	<ul style="list-style-type: none"> Increased client numbers in Southern Grampians & Barwon sub region (outside Geelong) ATSI agencies with enhanced capacity to provide services Comprehensive report on ATSI HACC needs in Warrnambool and surrounds

Section 5 – Regional proposals to implement Ministerial Priorities 2003-06

5.1. Introduction

Drawing on the data analyses and conclusions documented in Sections 3 and 4, this section details DHS' proposals to address the Ministerial Priorities 2003-06 and to implement the *Better Planning and Funds Allocation* processes.

Broadly speaking, the recommendations addressed the questions below:

- What do the data tell us?
- Do the data need supplementing? If so, what with and how?
- Is there funds inequity between local government areas? If so, does it need to be redressed? Why? How?
- What is the recommended growth allocation for each local government area?
- What are the special needs in the Region? How will Priorities 2 and 3 be met?
- What Priority 1 activities should be expanded in each local government area?
- What funding allocation method should be employed for each activity / bundle of activities?
- What service development issues should be addressed over the next three years? How?

5.2. Recurrent growth allocations

Tables 5.1 identify the recommended recurrent growth allocations to the Region and local government areas for Priorities 1 – 3, subject to consultation, yearly reviews and budget confirmation. The recommendations reflect the overall planning goals for the Region, and were discussed with the sector. It is important to note that the recommendations for 2003-04 are detailed, while those for the out-years are subject to change when the Regional Plan is adjusted for 2004-05 and 2005-06.

Proposals for Priorities 1-3 tally to these allocations, and are the subject of the remainder of Section 5.

Table 5.1.a: Recommended growth allocations by priority and local government area, 2003-04

2003-04	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Colac-Otway	\$ 54,500	\$ -	\$ -
Corangamite	\$ 14,000	\$ -	\$ -
Glenelg	\$ 35,500	\$ -	\$ 20,000
Greater Geelong	\$ 520,046	\$ -	\$ -
Moyne	\$ 27,500	\$ -	\$ -
Queenscliffe	\$ -	\$ -	\$ -
Southern Grampians	\$ 30,500	\$ -	\$ 10,000
Surf Coast	\$ 60,000	\$ -	\$ -
Warrnambool	\$ 35,000	\$ -	\$ 10,000
Region wide	\$ 18,000	\$ -	\$ -
Total	\$ 795,046	\$ -	\$ 40,000

Table 5.1.b: Recommended growth allocations by priority and local government area, 2004-05

2004-05	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Colac-Otway	\$ 70,004	\$ -	\$ -
Corangamite	\$ 39,982	\$ -	\$ -
Glenelg	\$ 19,506	\$ -	\$ 10,000
Greater Geelong	\$ 516,693	\$ 20,000	\$ 15,000
Moyne	\$ 4,496	\$ -	\$ -
Queenscliffe	\$ -	\$ -	\$ -
Southern Grampians	\$ 21,958	\$ -	\$ 10,000
Surf Coast	\$ 74,000	\$ -	\$ -
Warrnambool	\$ 20,008	\$ -	\$ 15,000
Region wide	\$ 18,000	\$ -	\$ -
Grand Total	\$ 784,648	\$ 20,000	\$ 50,000

Table 5.1.c: Recommended growth allocations by priority and local government area, 2005-06

2005-06	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Colac-Otway	\$ 50,000	\$ -	\$ -
Corangamite	\$ 57,486	\$ -	\$ -
Glenelg	\$ 16,000	\$ -	\$ 15,000
Greater Geelong	\$ 556,834	\$ 20,000	\$ 10,000
Moyne	\$ 24,492	\$ -	\$ -
Queenscliffe	\$ -	\$ -	\$ -
Southern Grampians	\$ 7,982	\$ -	\$ 10,000
Surf Coast	\$ 80,000	\$ -	\$ -
Warrnambool	\$ 24,957	\$ -	\$ 20,000
Region wide	\$ 18,000	\$ -	\$ -
Grand Total	\$ 835,751	\$ 20,000	\$ 55,000

5.3. Priority 1

Priority 1 is to increase the supply and improve the responsiveness of 'HACC Basic' services and consolidate the 'HACC Basic' service system around the key local government and health sector providers.

For Priority 1, the following questions are addressed, and proposals made:

- Should funds equalisation be applied?
- What should be recommended in order to best meet the needs of the HACC target population?

5.3.1. Funds equalisation or not?

BSW has recommended putting all Priority 1 funds into equalisation for the following reasons:

- Analysis of all the data available to the Region, including WREN data, shows that three local government areas in particular are relatively under-resourced in HACC. Greater Geelong and Surfcoast receive less than their WREN share of regional HACC funding, and other indicators show that HACC needs in these local government areas are likely to increase to 2006 (increase in older population, shortage of low care aged residential beds).
- The figures for Surfcoast are slightly misleading, as they do not take into account funding for Allied Health and Nursing provided to people living in Surfcoast from Geelong-based agencies. It is not possible to make a notional allocation of Allied Health and Nursing funding between the local government areas of Surfcoast and Greater Geelong until the agency involved resolves its outstanding data reporting issues and provides full data through MDS reports. Once that occurs, the actual proportion of HACC funding received by Surfcoast will be higher (and Greater Geelong's share will be lower).
- Colac-Otway has also been identified by the Region as an area of particular need, given its low scores on a variety of indicators of socio-economic and health status.
- While local government areas in the South West of the Region appear to be relatively well-resourced for HACC services, a number of indicators forecast increasing demand for HACC services in the South West and these require attention as well (e.g. increase in the proportion of people aged 85 and over, large numbers of 'high use' HACC clients, and high rates of hospitalisation for medical conditions which could be managed at home). Consequently, the Region recommends allocating limited growth funding to local government areas in the South West. The funding is targeted to cover increasing service needs that cannot be met solely through existing funding.
- It is recommended that Queenscliffe not receive any funding during the planning period as it receives twice its share of current funding in comparison to its WREN population proportion, and there are no other indicators that support increases to its funding to 2006.
- Overall, the Region recommends the approach of accelerated equity funding for Greater Geelong, Surfcoast, and, to a lesser extent, Colac-Otway, while recognizing that needs in the South West will continue to grow and the service system generally must be strengthened to accommodate them.

5.3.2. Recommended expansion of activities – Priority 1

Following the data analysis and conclusions described in Sections 3 and 4, the following proposals for service expansion are presented.

The service expansion recommended in each local government area is depicted in Appendix F. This is summarised in the tables below, that is, recommended expansion in activities during 2003-06. It should be noted that Priority 1 expansion targets the whole HACC population.

Table 5.2.a: Recommended expansion of Priority 1 activities, 2003-04

ACTIVITIES	Units	\$
Home Care	6,956	170,005
Personal Care	984	27,493
Property Maintenance	1,982	70,460
Allied Health	1,875	134,569
Nursing Blair	1,409	88,570
Nursing Non Blair	115	6,990
Delivered Meals	16,260	20,000
Assessment & Care Mgmt	N/A	258,960
SSR HACC Response Service	N/A	18,000

Table 5.2.b: Recommended expansion of Priority 1 activities, 2004-05

ACTIVITIES	Units	\$
Home Care	7,424	185,971
Personal Care	157	4,496
Property Maintenance	1,235	45,003
Allied Health	2,365	173,969
Nursing Blair	2,460	158,498
Nursing Non Blair	112	6,978
Delivered Meals	27,778	35,000
Assessment & Care Mgmt	N/A	152,7312
SSR Training	N/A	4,000
SSR HACC Response Service	N/A	18,000

Table 5.2.c: Recommended expansion of Priority 1 activities, 2005-06

ACTIVITIES	Units	\$
Home Care	7,595	194,964
Personal Care	158	4,639
Property Maintenance	1,713	63,981
Allied Health	2,652	199,961
Nursing Blair	2,351	155,284
Nursing Non Blair	112	7,152
Delivered Meals	42,522	54,853
Assessment & Care Mgmt	N/A	132,918
SSR Training	N/A	4,000
SSR HACC Response Service	N/A	18,000

5.3.3. Allocation process, 2003-04

The funding allocations recommended below are in accordance with DHS's *Purchasing and Funding e-guide*.

Catchment	Name of Agency	Allocation Method	Home care (hours)	Personal care (hours)	Property Maint (hours)	Allied Health (hours)	Nursing Blair (hours)	Nursing Non Blair (hours)	Delivered (meals)	ACM (\$)	SSR (\$)
Colac-Otway	Colac-Otway Shire Council	Direct	205		281					\$29,985.40	
Colac-Otway	Otway Health & Community Services	Direct			127					\$5,000.00	
Greater Geelong	City of Greater Geelong	Direct	4,501		1,125				16,260	\$119,998.56	
Greater Geelong / Surf Coast	Barwon Health	Direct				1,254	1,114			\$35,000.00	
Greater Geelong / Queenscliffe	Bellarine Community Health Service	Direct				279				\$15,000.00	
Surf Coast	Surfcoast Shire	Direct	941		309					\$19,982.45	
Surf Coast	Hesse Rural Health Services	Direct					64				
Surf Coast	Lorne Community Hospital	Direct					32				
Corangamite	Timboon & Dist. Healthcare Service	Direct					103			\$3,003.91	
Corangamite (67%)/Moyne (33%)	Terang & Mortlake Health Service	Direct				63					
Moyne	Moyne Shire Council	Direct	818							\$3,009.74	
Moyne	Moyne Health Service	Direct		161							
Warrnambool	Warrnambool City Council	Direct		465						\$22,007.90	
Southern Grampians	Western District Health Service	Direct				279					
Southern Grampians	Southern Grampians Shire Council	Direct								\$2,944.53	
Southern Grampians	Balmoral Bush Nursing Centre	Direct						66			
Southern Grampians	Coleraine & District Health Service	Direct					56				
Glenelg	Glenelg Shire Council	Direct	491	358	140					\$3,027.82	
Glenelg	Casterton Memorial Hospital	Direct					24				
Glenelg	Dartmoor Bush Nursing Centre	Direct						49			
Glenelg	Heywood Rural Health	Direct					16				
Regional	Karingal Inc (HACC Response Service)	Direct									\$18,000
Total			6,956	984	1,982	1,875	1,409	115	16,260	\$258,960.31	\$18,000

5.4. Priority 2

Priority 2 is to increase the quantity and quality of 'HACC Basic' services for people from CALD backgrounds and develop new collaborative direct service delivery arrangements between mainstream, multi-cultural and ethno-specific organisations.

5.4.1. Introduction

The initiatives addressing Priority 2 over 2003-06 are presented below. The regional strategy is:

- Developed with reference to the statewide strategy co-ordinated by DHS Central Office and outlined in Section 1.7.1.2
- Based on an analysis of the data and information about the CALD communities in this Region.

There are over 30 groups of CALD communities in the BSW; these communities, in the main, are diverse, yet small. Australian Bureau of Statistics 2001 Census shows that the majority of CALD communities in the Region reside in the Barwon sub-region with the most of these communities in the City of Greater Geelong. The number of CALD communities in the South West sub-region is very small and spread over the five municipalities.

All CALD communities in the Region experience disadvantage in relation to access to HACC services. The regional MDS data demonstrates that all CALD communities are under represented in all HACC services. It is important that people from CALD communities have fair access to HACC services provided by mainstream service providers.

It is anticipated that between 2003-06 there will be an increase in the number of people aged 65 + speaking a language other than English at home.

The key issues for HACC service providers in relation to CALD communities are:

- Enhanced service linkages
- Culturally/friendly gateways to services
- Leadership and sectoral development
- Capacity of the service to respond to the needs of new and emerging CALD communities.

There are two CALD HACC funded service providers in the Region. One is the Geelong Ethnic Communities Council, which is a region-wide organization, funded to provide services across a broad spectrum of community groups. The other is the Australia-Polish Community Services, a statewide organization, which provides Planned Activity Groups to Polish people in the Barwon sub-region.

Additional recurrent funding in Priority 1 is recommended for allocation to various mainstream agencies to ensure people from CALD communities have increased access to HACC basic and health services in 2003-06. These mainstream service providers will not have specific CALD targets, as participation rates will be monitored through the HACC Minimum Data Set reports.

In addition funding is recommended for 2003-04 to the Geelong Ethnic Communities Council to develop a HACC cultural awareness-training program and implementation strategy to enhance and assist mainstream service providers to deliver relevant HACC services to CALD communities across the Region.

In 2004-05 the Region recommends providing Geelong Ethnic Communities Council with additional fixed term recurrent funding to implement the above strategy over 2004-05 and 2005-06.

5.4.2. Project proposals

The recommended projects for 2003-06 are described below:

2003-04 - \$30,000 to be directly allocated to the Geelong Ethnic Communities Council to develop a HACC cultural awareness-training program and implementation strategy to enhance and assist mainstream service providers to deliver relevant HACC services to CALD communities across the Region.

Funding for the anticipated increase in service provision to CALD communities has been provided to agencies, and is included in the funding allocations for Priority 1. CALD funding has been incorporated into Priority 1 as follows:

- 2003-04 - \$85,000: funding for CALD Assessment and Care Management in all local government areas (except Queenscliffe), funding for Priority 1 services for CALD across the Barwon South-Western region
- 2004-05 - \$35,000: funding for Priority 1 services across the Barwon South-Western region
- 2005-06 - \$25,000: funding for Priority 1 services across the Barwon South-Western region.

5.5. Priority 3

Priority 3 is to increase the quantity and quality of HACC services for Aboriginal and Torres Strait Islander (ATSI) communities.

5.5.1. Introduction

A brief analysis of ATSI communities and the issues that have been prioritised for 2003-06 is provided in Section 3.5.1.4. It should be noted that the ATSI proposals have been developed via a two-pronged process:

- The development of statewide program/service development projects through the Victorian Indigenous Committee on Aged Care and Disability (VICACD)
- The development of recommendations for local service expansion and development through the local Networks in partnership between DHS regional offices and local communities.

5.5.2. ATSI statewide directions for service development

In 2002-03, VICACD identified four themes for Statewide and cross regional ATSI projects. They were:

- Workforce development
- Data
- Organisational capacity
- Lack of access.

During 2002-03, HACC initiatives to address these priorities included:

- ATSI Training Initiative to provide accredited training in Certificate III in Community Services (Aged Care) to HACC workers in Aboriginal agencies. Groups of workers in Loddon Mallee and Hume Regions have completed their training with the metropolitan group to finish their course in October 2003
- A project delivered by Victoria University to assist Aboriginal agencies to develop and implement a strategy to improve their capacity to meet data reporting requirements and to improve the quality of their data
- ATSI HACC Policies and Procedures Project to develop policies and procedures manuals to support agency-level implementation of the Victorian HACC Program Manual
- ATSI Needs Analysis Project in Loddon Mallee, Hume and Western Metropolitan Regions, and in selected areas of Barwon-South Western and Grampians Regions, has identified the service needs of Indigenous people in these areas and made recommendations for consideration in the development of the regional plans
- ATSI Communication Strategy Project developed and implemented strategies for communicating information about HACC services for Indigenous people via brochures and posters at main points of entry to the service system.

On 10 April 2003, VICACD recommended building on this service development work to support ATSI communities over the next three years. The focus recommended was:

- Implementing workforce development strategies
- Improving understanding, and collection and use of data
- Enhancing organisational capacity.

VICACD members consulted with their regional networks about these service development proposals and reported back to VICACD on 19 June 2003.

The areas of service development considered the highest priority during the 2003-06 triennium related to enhancing organisational capacity:

- Continuation of the ATSI Training Initiative: New groups of workers to commence training will receive training in Certificate III in Home and Community Care. Co-ordinators and managers will be offered a choice of Certificate IV in Aged Care, Service Co-ordination (Ageing and Disability) or Frontline Management (at Certificate IV or diploma level) or another diploma course
- A strategy for introduction of the Service Co-ordination Tool Template (ScoTT), and delivery of training for assessment officers
- Consideration of strategies for recruitment and initial training of new entrants to the HACC workforce (eg. the Structured Training and Employment Program, STEP) in conjunction with training providers
- Improving understanding and use of data through the development of a proforma for 'regional reports' to VICACD and DHS
- Strengthening the planning capacity of VICACD through their analysis of the 'regional reports' and other information/data to inform statewide service development decisions.

The next step is for DHS, in consultation with VICACD, to develop a workplan for the triennium, and project briefs to implement the above tasks. It is expected that further service development projects will be recommended each year when the Regional Plans are adjusted.

In addition, VICACD recommended that it should review and redefine its role as the key point of consultation for DHS on ATSI HACC issues in Victoria. The review would include consultation with VICACD and regional network members and DHS central and regional office staff to develop documentation establishing effective processes for the operation of the networks. VICACD has also identified a need for the document to incorporate a three-year strategic plan for the triennium in order for VICACD to be proactive in setting its own agenda.

Other issues referred to each Network for local consideration and action as appropriate were:

- The need to increase the cultural awareness of mainstream agencies to enhance access of ATSI people to mainstream services
- The management of cross boarder service provision
- Planning for seasonal changes in population.

5.5.3. ATSI sector

It is predicted that over the next three years the needs of the ATSI community in BSW will be affected by the following factors:

- Poor health status of Aboriginal people across all age groups
- Shorter life expectancy of Aboriginal people
- Under representation of Aboriginal people in DHS services, including HACC
- Aboriginal people have difficulty accessing mainstream services and therefore have a preference to receive services from Aboriginal Controlled Health Services
- The negative impact of economic disadvantage.

The key issues for the ATSI community are the need to consolidate service development work that has been undertaken in communities over the last few years, allowing ATSI agencies the opportunity to build on the improvements they have made to date, and continue enhancement of service models best suited to their communities.

The needs of ATSI communities in Southern Grampians will be a particular focus, to ensure they have access to the range of HACC services available to other indigenous people in the Region. Similar issues apply to ATSI people outside Greater Geelong, and it is recommended to target funding to their needs within the Barwon sub-region.

The Region funds the following five Aboriginal controlled health services:

- Dhauwurd-Wurrung Aboriginal Elderly Citizens Association, Portland
- Gunditjmara Aboriginal Cooperative, Warrnambool
- Kirrae Health Services, Framlingham
- Wathaurong Aboriginal Cooperative, Geelong
- Winda-Mara Aboriginal Cooperative, Heywood.

The Barwon-South Western Region provided HACC growth funding to each Aboriginal controlled health service in the 2001-02 and 2002-03 financial years to:

- Improve access to services allowing more Aboriginal people to access home based and community support services in their own home, in their own community
- Increase funding in each of the Aboriginal controlled health services in the last two financial years to provide additional capacity to meet administrative and service provision commitments.

5.5.4. Expansion of services

Based on the information in Sections 3 and 4 (particularly the ATSI data in Section 3.5.1.4 and Section 4.2) it is recommended that funding be allocated over the three years to strengthen agency capacity within Aboriginal controlled health services and to expand services through a Flexible Service Response model.

It is recommended to progressively expand HACC services during the triennium, with a focus on communities living in Glenelg and Southern Grampians Shires and the Cities of Warrnambool and Greater Geelong.

5.5.5. Allocation process, 2003-04

The funding allocations recommended below are in accordance with DHS' *Purchasing and Funding e-guide*.

Name of Agency	Method	Flexible Service Response	Service System Resourcing
Dhurwurd-Wurrung Portland Aboriginal ECC	Direct	\$10,000	
Gunditjmara Aboriginal Co-operative	Direct	\$10,000	
Winda-Mara Aboriginal Corporation	Direct	\$10,000	\$10,000
Total Allocated		\$30,000	\$10,000

5.6. Impact of Priorities 1-3 proposals

It is anticipated that the expansion of services for Priorities 1-3 will:

- Assist in redressing HACC funds inequity between local government areas
- Boost the HACC Basic system
- Improve the balance of activity level across the Region
- Improve the responsiveness of services to people from CALD backgrounds
- Increase the quality and quantity of services to Indigenous people.

Overall, the percentage increase for each activity is summarised in the graph below.

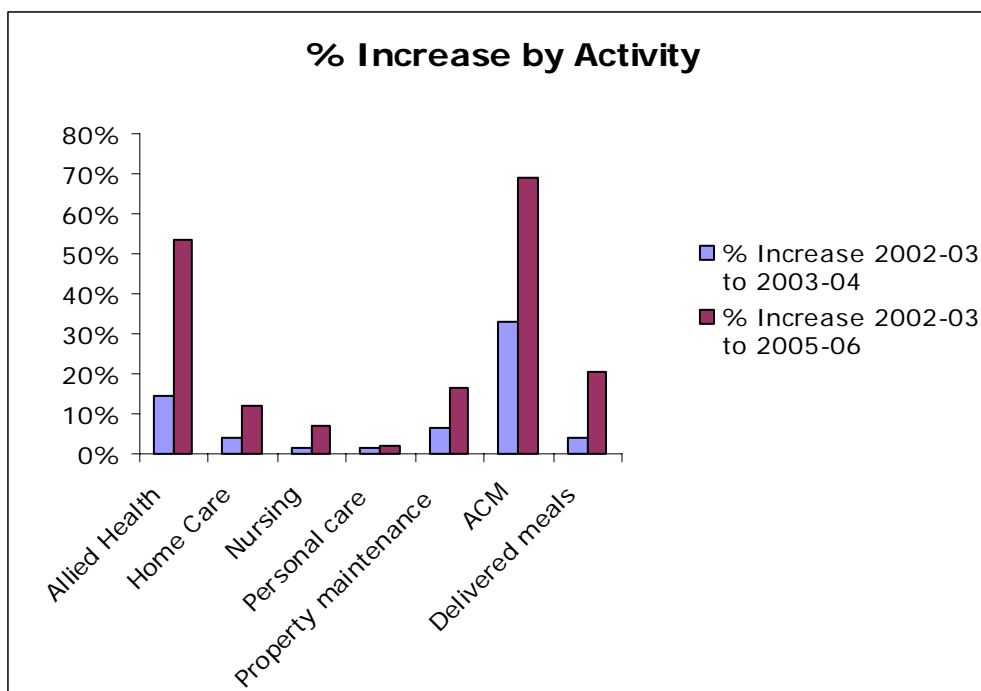


Figure 5.1: Percentage increase of Priority 1 activities, 2003-04 and 2003-06

The table and the graph below provide a summary of the impact of the distribution of growth funding for 2003-06 in each local government area. The first bar shows the recurrent base budget 1 July 2003 (excluding consolidation funds). The second bar shows the recommended recurrent base budget at 1 July 2006 (including consolidation funds) and reflects funding allocations as recommended in this Draft Regional Plan. The third bar shows the WREN population share by local government area for 2005-06; and indicates recommended progress towards redressing HACC funds inequity between local government areas.

Table 5.3: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

LGA	Recurrent \$ 1/7/2003	% of recurrent funding, excluding consolidation 1/7/2003	WREN 2003-04	Recurrent \$ + growth, including consolidation 1/7/2006	% of funding, 1/7/2006	WREN 2006
Colac-Otway	\$1,797,330	7.1%	6.2%	\$2,038,251	6.8%	6.2%
Corangamite	\$1,660,197	6.5%	5.6%	\$2,270,911	7.6%	5.6%
Glenelg	\$1,847,430	7.3%	5.8%	\$2,424,482	8.1%	5.7%
Greater Geelong	\$12,511,871	49.2%	58.5%	\$14,225,376	47.5%	58.5%
Moyne	\$1,480,879	5.8%	4.2%	\$1,683,793	5.6%	4.2%
Queenscliffe	\$715,306	2.8%	1.4%	\$716,153	2.4%	1.4%
Sth. Grampians	\$2,003,056	7.9%	5.3%	\$2,579,168	8.6%	5.3%
Surf Coast	\$1,117,581	4.4%	5.2%	\$1,334,855	4.5%	5.3%
Warrnambool	\$2,314,616	9.1%	7.8%	\$2,691,210	9.0%	7.8%
Total	\$25,448,266	100.0%	100.0%	\$29,964,199	100.0%	100.0%

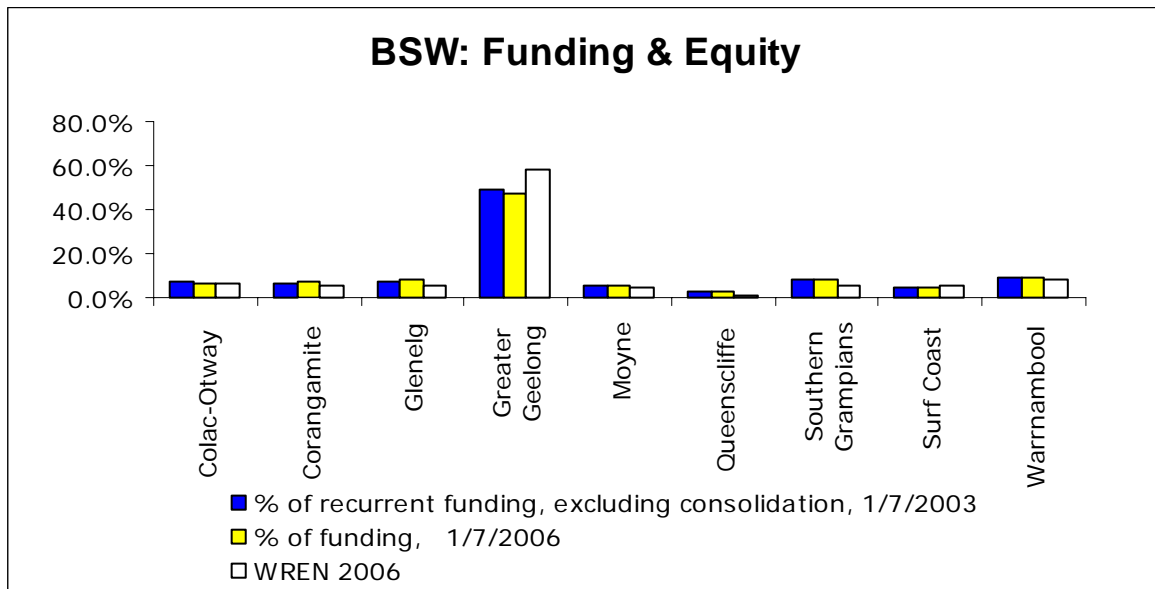


Figure 5.2: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

Progress towards redressing HACC funds inequity between local government areas will be achieved. However, despite the application of an accelerated funds equity model, some of the local government areas that will benefit will remain under-funded according to the WREN at the end of the three years. This is because only a portion of the growth is directed to redressing funds inequity. Further, the effect of consolidating 'HACC-like' services from Aged Care into the HACC Program, has masked the impact. These funds were incorporated into the WREN calculations for 2004-05 and 2005-06 and are relatively high in some local government areas. However, if the WREN formula were applied unadjusted over the three years, the local government areas that are relatively under funded would be further behind at the end of the triennium than they are at the beginning. More time is needed to reach funds equalisation in the Region. The rate of progress will depend on the amount of new funds made available each year and the portion of growth applied to the task.

Section 6 – Non-recurrent funding

6.1. Introduction

This section outlines proposals for the use of non-recurrent funds.

6.2. Regional development initiatives

Up to \$30,000 may be allocated for projects and development initiatives in each of the three years.

The following projects are recommended over the next three years:

Project	Funding Allocation Method
Geelong Ethnic Communities Council to develop a HACC cultural awareness-training program and implementation strategy to enhance and assist mainstream service providers to deliver relevant HACC services to CALD communities across the Region.	2003-04 - \$30,000 direct allocation
The Region recommends working closely with the sector to ease the transition to the new allocation process for minor capital. The aim is to assist agencies develop strategies to manage their infrastructure requirements over the longer term. It is therefore recommended in 2004-05 to allocate funding through a service development grant to investigate the most appropriate and cost effective process for agencies to manage their infrastructure requirements.	2004-05 – up to \$30,000 direct allocation
Conduct a HACC ATSI needs analysis in Warrnambool and districts.	2005-06 - \$30,000 direct allocation

6.3. Minor capital discretionary funding

A minimum of 1% of total Program outlays has been established for minor capital. A minimum of 80% of this allocation will be distributed to all service providers automatically and annually. Up to 20% of the 'regional' allocation may be reserved for discretionary purposes.

It is recommended to reserve 20% of the minor capital allocation in each of the years between 2003-06 for allocation to agencies that have:

- Limited capacity to purchase nursing equipment and vehicles
- Immediate Occupational Health and Safety issues.

Proposals for 2004-05 and 2005-06 are subject to a review of the need for and level of the discretionary allocation.