

Home and Community Care (HACC) Program

Eastern Metropolitan Region 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. Focussed 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 nonrecurrent 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 nonrecurrent 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.

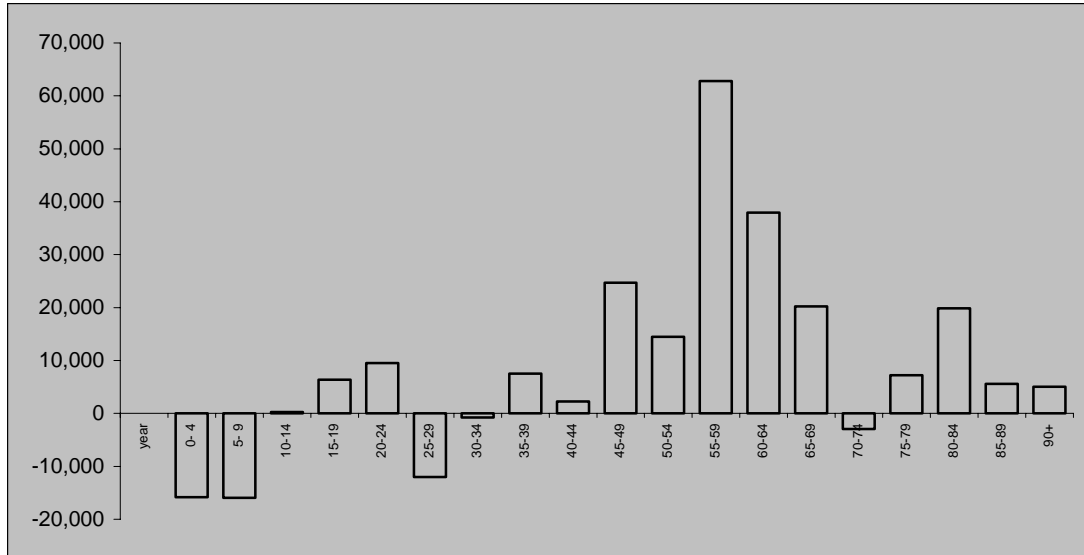


Figure 2.1: Changes in population groups 2001-06 Victoria
 Source: Department of Infrastructure *Victoria In Future*

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%.

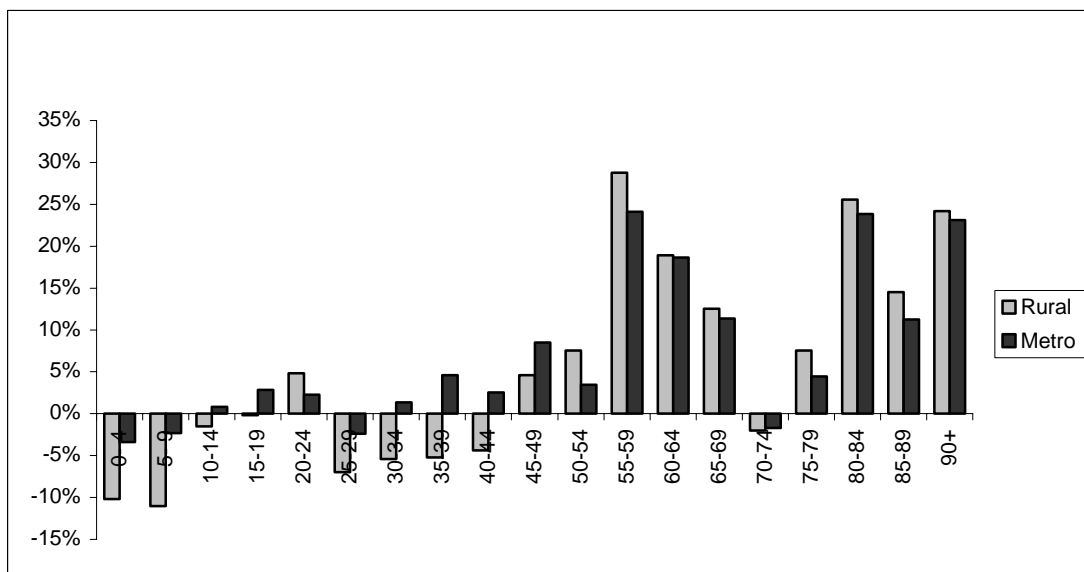


Figure 2.2: Comparison of population group changes: Rural and metropolitan regions
 Source: Department of Infrastructure *Victoria In Future*

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.

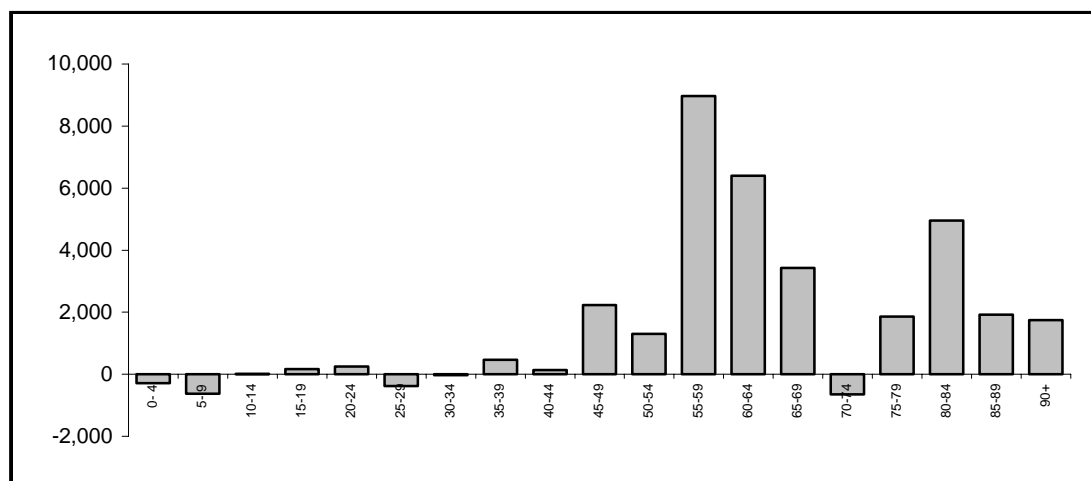


Figure 2.3: Changes in the estimated number of persons with a disability, 2001-06
Source: Department of Infrastructure *Victoria In Future* and 1998 ABS *Disability, Ageing and Carers Survey*

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.

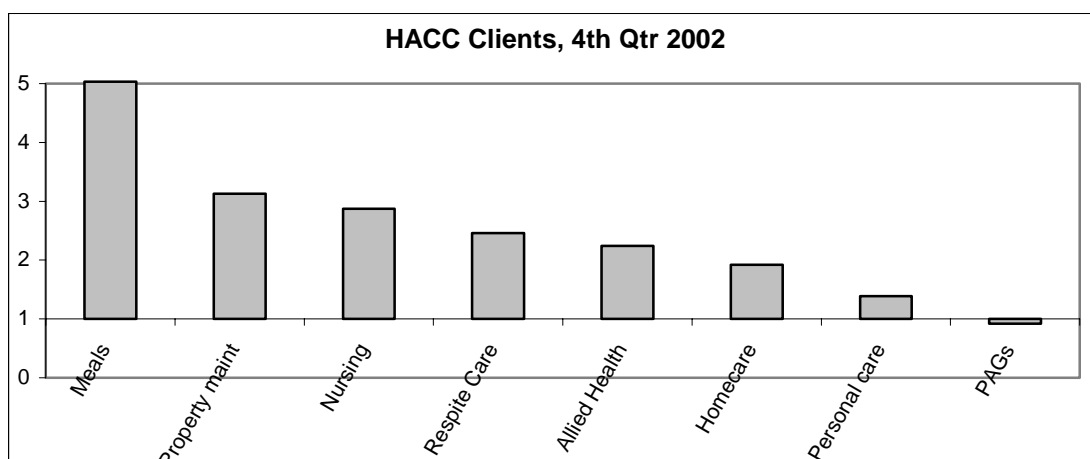


Figure 2.4: Ratio of rates of service provided to English/LOTE clients

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)
- Funding.

The additional regional data included:

- Regional reports
- Regional knowledge about service provision and need
- Budget information
- Outcomes of the 2002-03 HACC Funding Round consultation.

3.2. The Region's HACC sector

3.2.1. The Region at a glance

Eastern Metropolitan Region (EMR) is a large and diverse metropolitan region. The Region includes the City of Boroondara with inner suburbs such as Kew, Camberwell and Hawthorn. While these suburbs are perceived as being relatively affluent there is the ongoing issue of 'asset rich' and 'income poor' elderly people residing in these areas. There are also a relatively high number of boarding houses and supported residential services. The municipalities of Whitehorse, Manningham, Monash, Knox, and Maroondah have some affluent areas but they also contain pockets of residents of a lower socio economic status, particularly in the public housing estate in Ashburton and residents living in integrated public housing across all the municipalities in the Region. In addition, there are clusters of low rental properties and caravan parks scattered across the Region. Geographically, the largest municipality is the Shire of Yarra Ranges, with the semi rural townships of Healesville, Yarra Glen and Warburton.

Figure 3.1 shows the local government areas in the Region.

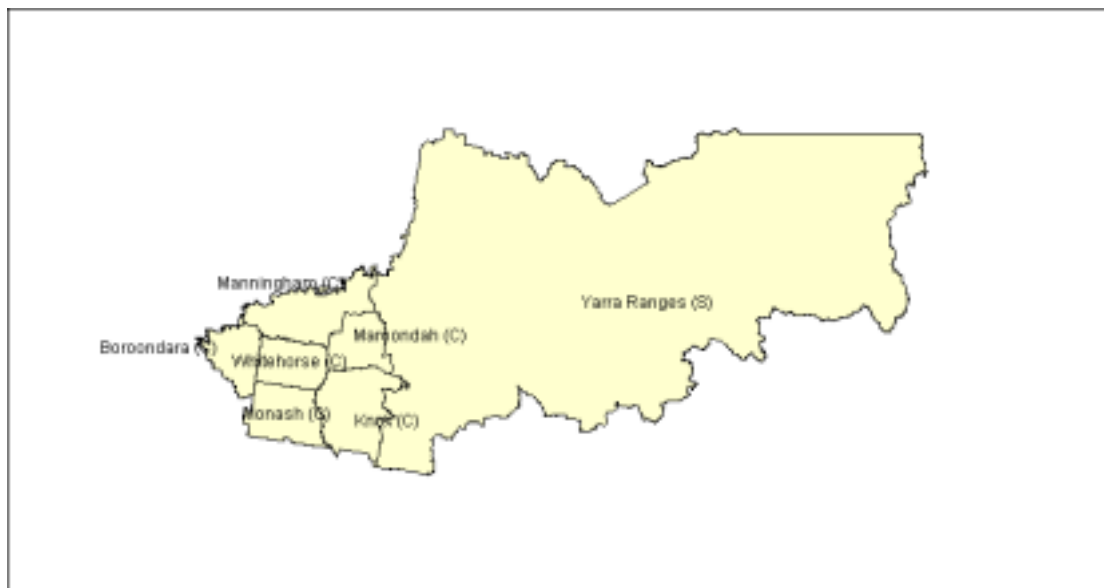


Figure 3.1: Local government areas in Region

3.2.2. The HACC sector

EMR provides funding to 88 HACC providers (including Royal District Nursing Service). HACC providers are a diverse group and include:

- Seven local governments
- Seven community health centres
- Three hospitals/networks - Eastern Health Care Network (Peter James Centre and Yarra Valley Community Health Service); the Sisters of Charity Health Services (St George's Hospital, St Vincent's Hospital) and Peter MacCallum Cancer Institute
- 56 non-government agencies
- 14 CALD agencies.

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

Of the 88 agencies, two are statewide and ten have a cross regional service provision focus.

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.

EMR regularly consults with the HACC sector, that is, service providers and consumer organisations, through a range of forums:

- HACC Planning Forums
- The Eastern Transport Access Network (ETAN)
- EMR Training Advisory Committee
- Groups of service providers including local governments, community health centres and Planned Activity Group providers.

The following working groups have been established to address specific issues:

- Migrant Information Centre HACC CALD Network - the key advisory and consultative body in the Region in relation to CALD issues
- EMR Disability Respite Network
- Equity and Access Steering Committee
- Eastern Volunteer Recruitment Project
- Metropolitan Koori HACC Network.

In addition, clients and carers were consulted in 2002 via a questionnaire to ascertain their views and needs in relation to HACC services.

3.4. The planning context

In developing proposals for HACC service expansion, the Regional Plan takes account of the broader human services sector as well as initiatives within the HACC sector.

3.4.1. Broader planning issues

Across the Region, issues such as homelessness, complex clients and high need clients remain important factors that need to be considered in the planning process. For the middle and outer suburbs, transport to HACC services is a prevalent issue.

3.4.2. HACC planning

The outcomes of planning processes conducted in 2002-03 with the sector (in the context of the HACC Funding Round) have been taken into account in the development of the Regional Plan, 2003-06. Consistent with the Ministerial Priorities for 2003-06, basic HACC services including Home Care, Personal Care, Allied Health and Property Maintenance were identified as priorities.

3.4.3. CALD planning

Discussions held at the HACC CALD Network meetings identified access to HACC services, in particular in-home services, as being important. Over the past three years a number of strategies have been implemented to improve the responsiveness of mainstream agencies to clients from CALD communities, including:

- All HACC funded agencies in the Region are required to complete and submit a HACC Cultural Plan. There has been a 100% response rate to this initiative
- The Migrant Information Centre has been recurrently funded and supported to develop the following:

- ◇ A regional database to monitor and analyse HACC Cultural Plans
- ◇ Regular newsletters
- ◇ A HACC CALD Network with regular Network meetings
- ◇ A project to improve access to Planned Activity Groups by CALD clients
- ◇ A multicultural education project to explore how to improve access of CALD communities to HACC in-home services in two local government areas.

3.4.4. ATSI planning

The largest population of ATSI people in the Region reside in the Yarra Ranges. HACC services for this community have been expanded over the past three years. This Regional Plan will build on these services and develop additional strategies for Indigenous clients in other municipalities in the Region. Regional meetings have identified a growing population of Indigenous people living in the municipalities of Whitehorse and Knox. Therefore the Region proposes to develop a strategy to extend services to these communities.

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.

According to population projections, the HACC (WREN) population in the Region will be relatively stable for the period 2003-06.

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

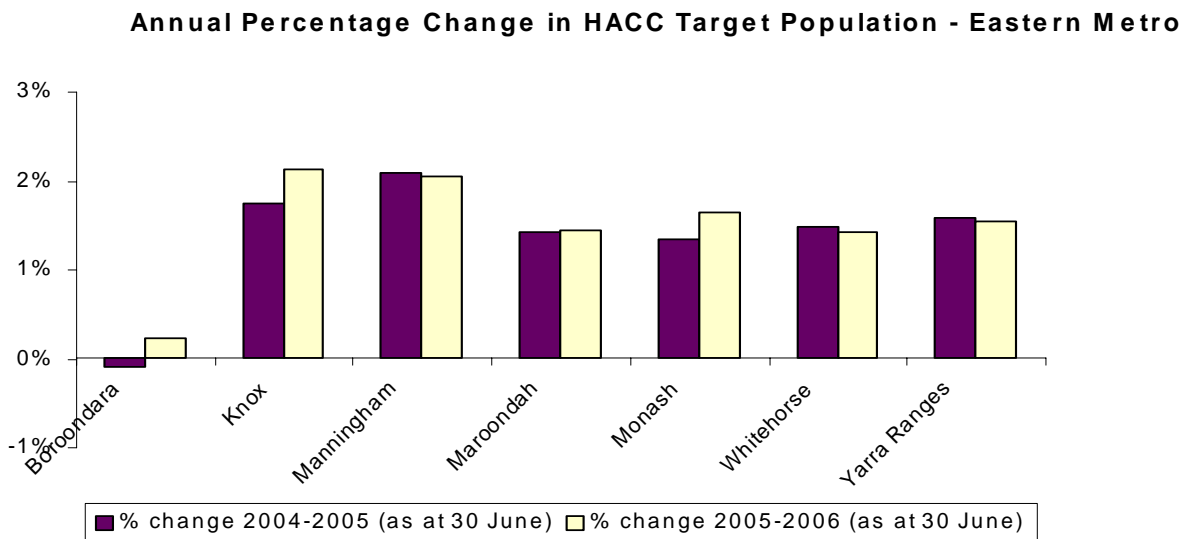
LGA	2003-2004		2004-2005		2005-2006	
	WREN pop'n	% 70+	WREN pop'n	% 70+	WREN pop'n	% 70+
Boroondara	17,525	61.3%	17,508	60.7%	17,548	60.2%
Knox	17,753	48.0%	18,062	48.3%	18,445	48.7%
Manningham	13,145	53.2%	13,420	53.9%	13,695	54.7%
Maroondah	13,276	56.6%	13,464	56.8%	13,657	57.0%
Monash	22,729	59.1%	23,035	59.4%	23,417	59.9%
Whitehorse	22,226	64.4%	22,556	64.6%	22,879	64.7%
Yarra Ranges	16,915	49.2%	17,182	49.4%	17,448	49.6%
Total	123,569	56.5%	125,228	56.7%	127,089	56.9%

* 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 is 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 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 target 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.

The Region has a diverse population, with the CALD communities comprising 20.73% of the regional 65+ population. HACC matched MDS data (by country of birth) identifies 105 CALD communities in EMR.

Figure 3.3 below shows that, according to HACC MDS data, people with a CALD background in EMR are under-represented in HACC Basic services – Home Care, Personal Care, Property Maintenance, Delivered Meals, Nursing and Allied Health. Conversely, people from CALD backgrounds have a higher usage of Planned Activity Groups in the Region.

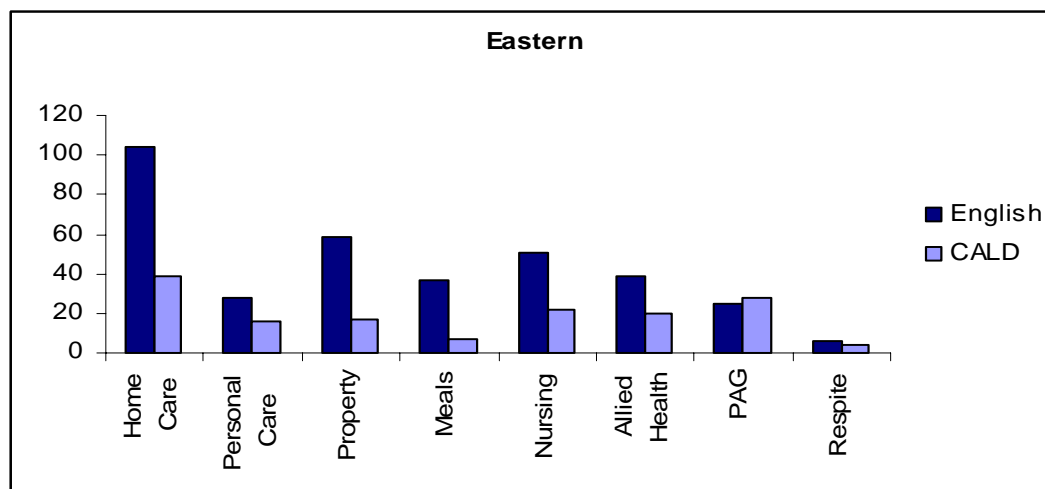


Figure 3.3. HACC clients, English versus non English speakers
Source: MDS 2002

Two of the seven local government areas in the EMR have CALD 65+ populations greater than the Victorian average of 20.6% per local government area. These are Manningham with 35.19% and Monash with 27%.

The four largest EMR CALD communities as a percentage of the total EMR population (identified by language spoken at home) are:

- Italian, 5.2%
- Greek, 3.79%
- Chinese (Chinese languages – Cantonese, Mandarin, Other), 2.72%
- German, 1.79%.

These communities are dispersed across all local government areas except for the Shire of Yarra Ranges (CALD 65+ population is 12.26%) and Maroondah, (CALD 65+ population is 10.22%). Yarra Ranges and Maroondah do not have significant Greek or Chinese populations. The projected growth to 2006 across Victoria, of ethno-specific populations greater than 5,000 persons in the 65+ age cohort includes the above four communities. Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) data identifies the Chinese as the community with the most recent migrants, the majority of whom live in the municipalities of Manningham, Whitehorse and Monash.

There are 28 CALD communities (Appendix C) that have statistically small populations in the Region. These communities may be experiencing greater disadvantage in relation to access to HACC services because populations are dispersed in small numbers across the Region. The proposed regional HACC CALD project will work with the CALD sector to explore options about how to improve access to culturally relevant HACC Basic Services.

As previously stated, there are 88 funded agencies in the Region:

- 100% have developed and implemented the HACC Cultural Planning Tool to support the implementation of CALD initiatives
- The Migrant Information Centre provides sector wide support to HACC agencies and ethno-specific agencies
- There are 13 ethno-specific agencies
- Two agencies provide an equity and access focus targeting the primary health care and sub-acute sector
- Six mainstream agencies are implementing CALD initiatives in partnership with local CALD communities.

The key issues for the CALD community are:

- Contributing to a systemic approach to create a sustainable CALD service system enabling support to be provided to ethno-specific community groups within resource constraints
- Investigating and further developing partnership initiatives to ensure equity and access to HACC basic services by CALD communities
- Adopting models of practice that cater for the increased frailty of CALD HACC eligible people.

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.

LGA	0-49	50-69	70+	Total
Boroondara	169	21	12	202
Knox	331	47	2	380
Manningham	88	13	3	104
Maroondah	303	28	4	335
Monash	281	26	11	318
Whitehorse	216	42	11	269
Yarra Ranges	738	95	18	851
Total	2,126	272	61	2,459

Table 3.2: Experimental estimates of total Indigenous population

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.

The Indigenous frail aged HACC target population has been defined as people aged 50+ years. This is due to the life expectancy of the Indigenous population being about 20 years lower than the general population.

Although the Indigenous population constitutes a low proportion of the total population (0.25%), with 2,459 people, the Region has a small but significant number of Indigenous people.

The population is distributed unevenly throughout the Region with a significant majority (64%) residing in the three outer eastern local government areas of Yarra Ranges, Knox and Maroondah.

The Shire of Yarra Ranges, with a little over one third of the Indigenous population, contains a concentration of Indigenous people that form an identifiable community in the vicinity of Healesville.

In line with Victoria as a whole, Indigenous people in the Region have a younger age profile than the general population. Whereas 9% of the non-Indigenous population in the Region is aged 70+ years, this is the case for only 2% of the Indigenous population. However, a significant proportion (14%) is within the HACC ATSI frail aged target group of people aged 50+ years. This is a higher figure than the statewide proportion of 10%.

Of the ten metropolitan local government areas in which there are more than 50 Indigenous people aged 50+, two of these local government areas are in this Region. Within this age cohort, there are 113 people in Yarra Ranges, 53 people in Whitehorse and 49 people in Knox.

3.5.2. Service provision

The analysis of the service provision data focuses 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 3.4 – 3.7 below show the per capita service provision per annum of 'Priority 1' activities by local government area. The per capita data is derived from the HACC MDS by dividing the number of service hours per funded activity by the number of clients for each local government area. The line across the bars represents the regional average.

Figures 3.4 – 3.7 and Figures 3.8 – 3.9 provide a picture of the relative levels of service across each local government area, and relative to the regional average.

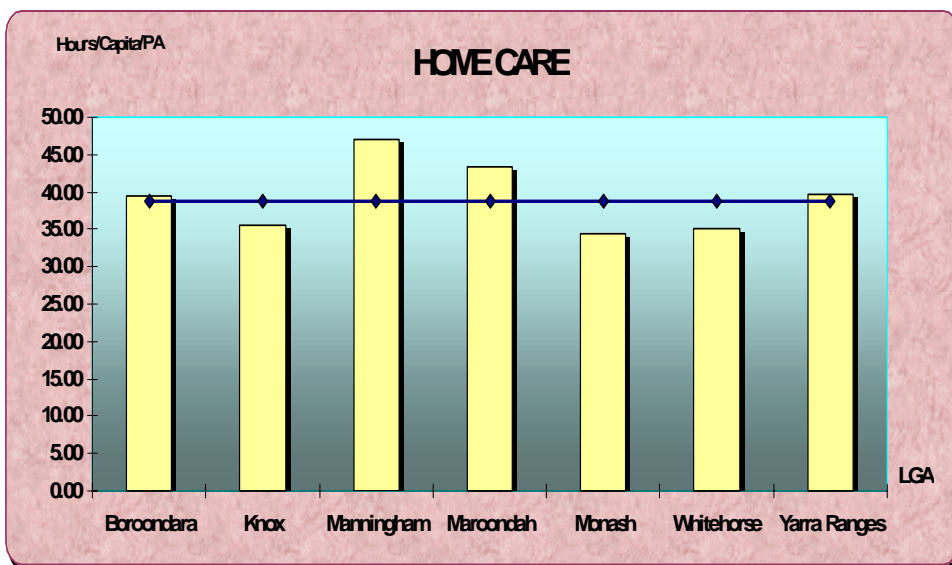


Figure 3.4: Hours of Home Care Per Capita Per Annum Compared to Regional Average
Source: MDS 2002

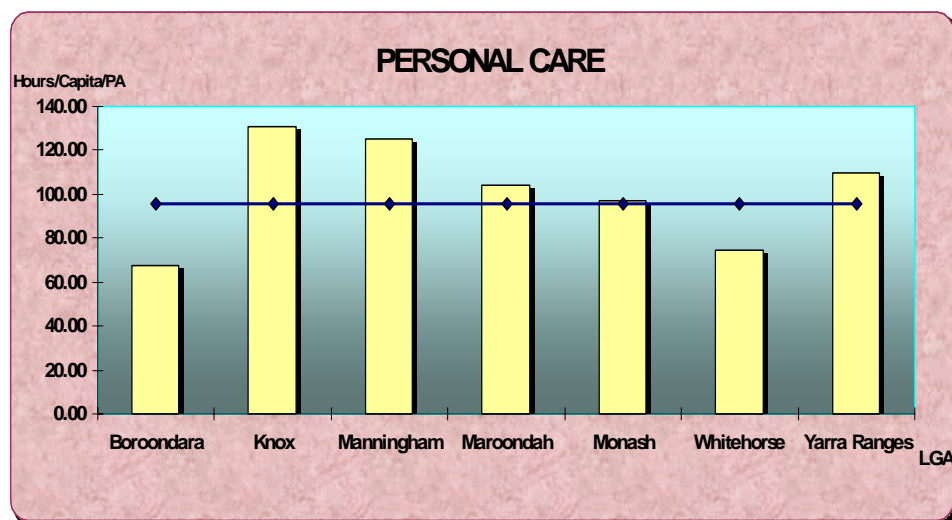


Figure 3.5: Hours of Personal Care Per Capita Per Annum Compared to Regional Average
Source: MDS 2002

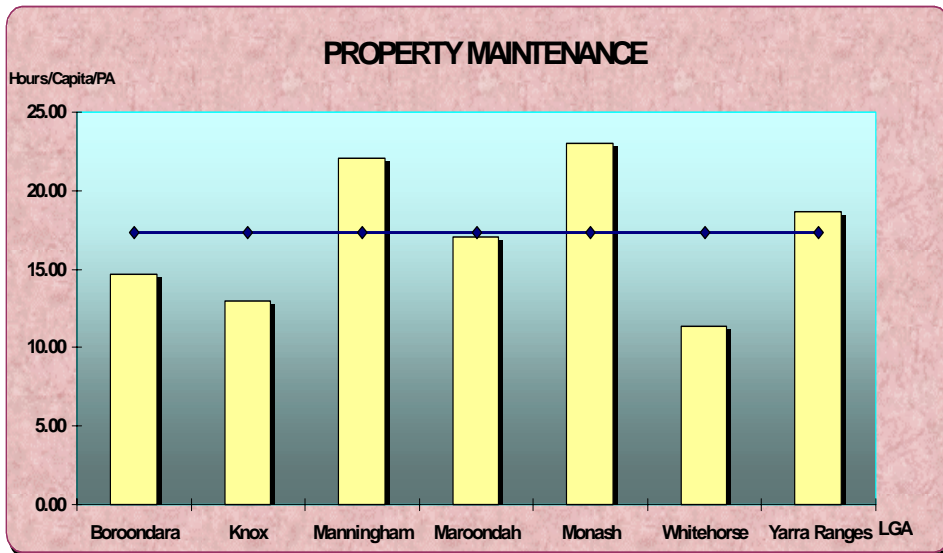


Figure 3.6: Hours of Property Maintenance Per Capita Per Annum Compared to Regional Average
Source: MDS 2002

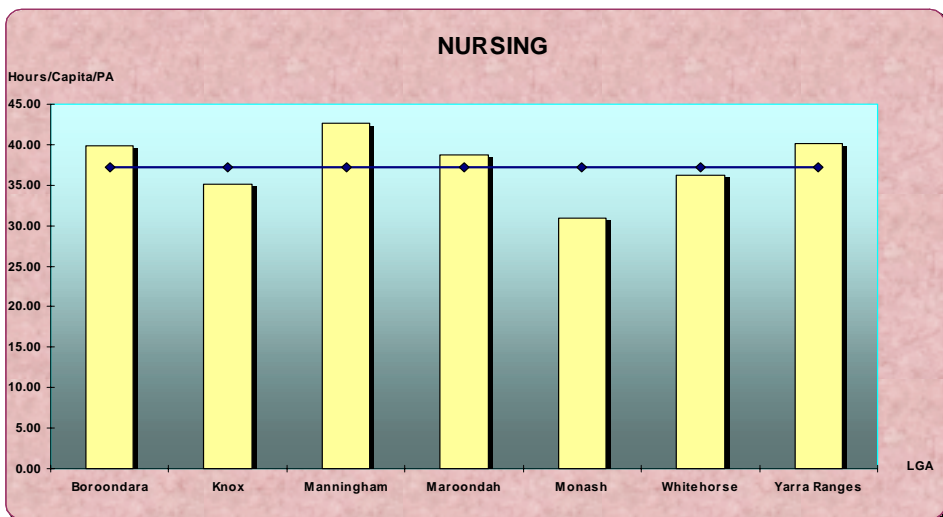


Figure 3.7: Hours of Nursing Per Capita Per Annum Compared to Regional Average
Source: MDS 2002

Figures 3.8 – 3.9 below show the per capita service provision per annum of 'Priority 1' activities by local government area. The per capita data is derived from the 2002-03 Regional HACC Budget dividing by the WREN Population for each local government area.

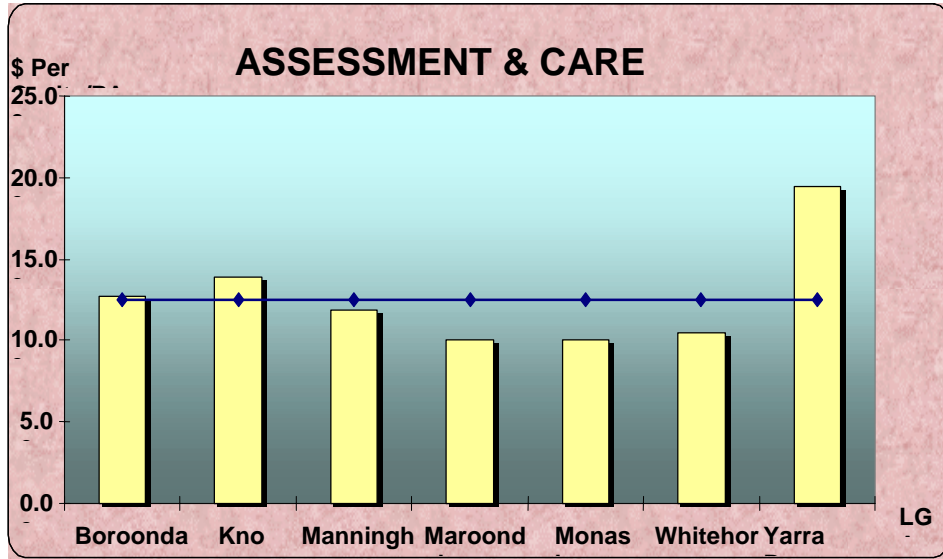


Figure 3.8: Dollars of Assessment & Care Management Per Capita Per Annum Compared to Regional Average
 Source: Regional Budget 2002-03 & WREN Population

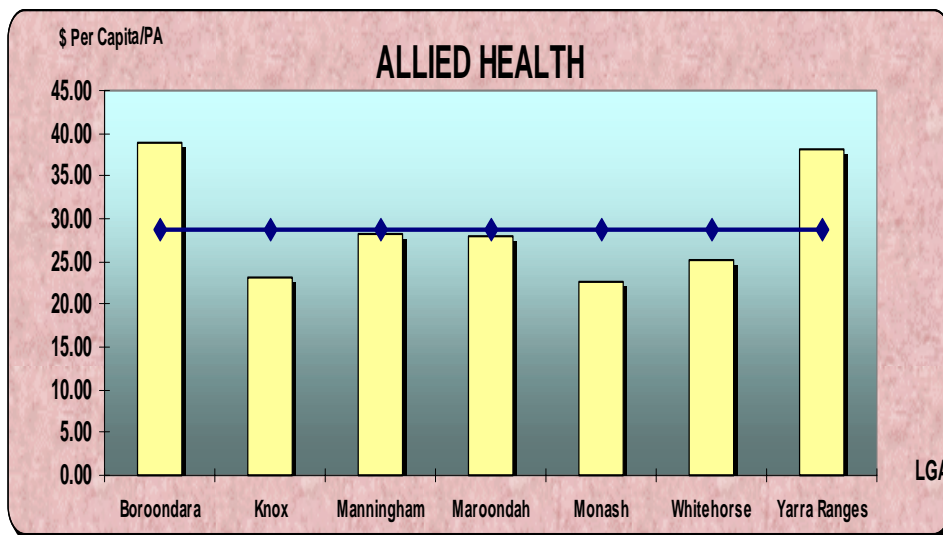


Figure 3.9: Dollars of Allied Health Per Capita Per Annum Compared to Regional Average
 Source: Regional Budget 2002-03 & WREN Population

3.5.3. Funding

To complete the picture of the Region, the proportion of the existing Regional 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

LGA	Recurrent \$ 2002-03	Current \$ per capita	% of recurrent budget (2002-03)	WREN 2003-04
Boroondara	\$10,503,732	\$599	17.7%	14.2%
Knox	\$6,746,593	\$380	11.4%	14.4%
Manningham	\$7,308,755	\$556	12.3%	10.6%
Maroondah	\$6,484,851	\$488	10.9%	10.7%
Monash	\$10,091,460	\$444	17.0%	18.4%
Whitehorse	\$8,703,436	\$392	14.7%	18.0%
Yarra Ranges	\$9,492,344	\$561	16.0%	13.7%
Total	\$59,331,170	\$480	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.

Eastern Metro: Actual \$ (2002-03) & WREN %s by LGA, 2004- 2006

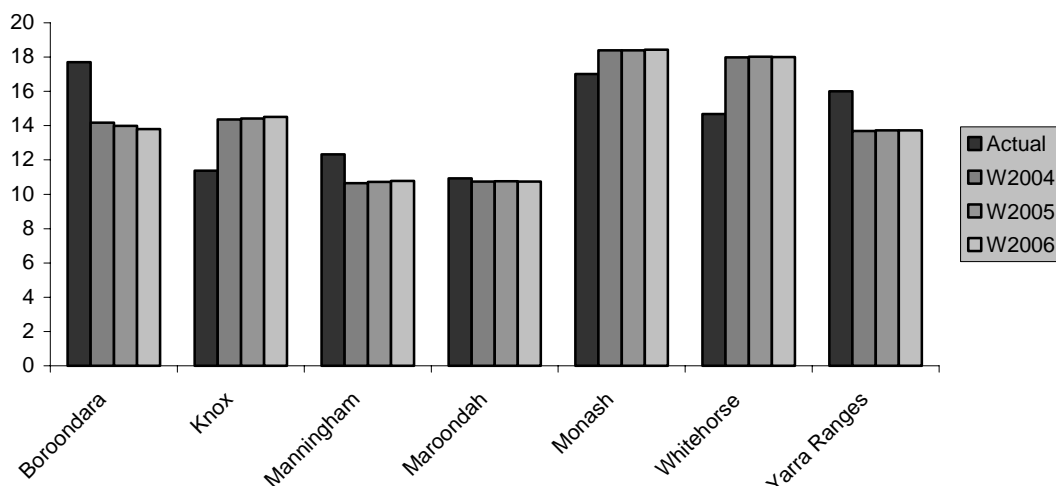


Figure 3.10: Proportion of actual recurrent budget (30 June 2003) and WREN population proportions 2003-06 by local government area

Section 4 - What do the data tell us?

Section 4 of the Regional Plan identifies the conclusions drawn from the data analysis.

4.1. Data analysis

The data provided in Section 3 provides background information about the demographic profile of the Region and HACC service provision.

Data available at a Regional level included:

- Quarterly Output Collection Returns
- MDS Data including CALD and ATSI clients
- Regional Budget and the distribution across Local Government Areas. (Including Nursing and Allied Health)
- Commonwealth Aged Care Packages
- Location of nursing homes.

For general information on population trends, the WREN was used as the basis for determining the HACC target population.

Details of the population data included for the CALD population is included in Appendix C.

Details of the population data included for the ATSI population is referred to in Section 3, Table 3.2

4.1.2 The reliability of the data sources

Quarterly Output Collection returns

This data was carefully analysed, but found to have some fundamental flaws, in particular, missing data, and in some instances, it appeared the negotiated targets were reported as the number of clients receiving services. It was however a useful exercise analysing this data, as it can now be discussed with the sector regarding how the reliability factor can be improved.

MDS Data

The MDS data also has some inconsistencies, but overall was deemed to be more reliable than the Quarterly Output Collection returns. Within the EMR it was decided that the most recent data, i.e. the last two quarters of 2002 and the first quarter of 2003 would be the most reliable, as it appears agencies are now more familiar with the reporting of data than they were when the system was introduced in 2001. The Region therefore used this data to assist with the planning process.

Regional service provision funding

An analysis of the regional service provision funding provided a guide to the current distribution of funds per capita, and the variance from the distribution of the WREN population across the Region. It is acknowledged that the variance is most probably based on historical factors, but this planning exercise provided an opportunity to redress some of these anomalies.

Commonwealth Aged Care Packages and Aged Residential Facilities

Information from this source did not assist the planning process at this stage, primarily because the Community Aged Care Packages are across the whole of the Metropolitan Melbourne, and cross the Region and local government areas, therefore it was not possible to accurately prescribe the location of these resources. Aged Residential facilities and the allocation of beds fell into the same category. More research is required before an accurate picture of this service system could assist the planning process.

Consequently, the data used to develop this plan was:

- MDS Data using the final two quarters of 2002 and the first quarter of 2003
- An analysis of service provision funding.

For Priority 1 for HACC Basic Services the data from MDS was utilised to determine an annual per capita figure for each activity, then compared to the Region wide average (Hourly figure). The exceptions were Allied Health and Assessment and Care Management where a per capita figure was used, based on the total regional service provision funding divided by the WREN.

4.2. Conclusion

The data analysis leads EMR to propose the following strategies:

- Improve the quality of the data collection
- Redress inequity in funds between local government areas
- Improve information on ethno specific communities
- Improve information on ATSI services.

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

EMR HACC Regional Plan 2003-06
(incorporating *HACC Planning and Funds Allocation 2003-04*)

Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
Priority 1 - Home Care/Personal Care/Property Maintenance/Assessment and Care Management	Increase capacity	2003-06	<ul style="list-style-type: none"> Allocate additional resources to all local governments in the Region Increased regional equity to in-home support services for the municipalities of Knox, Whitehorse and Monash. 	<ul style="list-style-type: none"> Increased access to services Enhance the quality of service delivery to clients.
Priority 1 - Allied Health	Allied Health expansion	2003-06	<ul style="list-style-type: none"> To expand Allied Health in the municipalities of Knox Monash and Whitehorse 	<ul style="list-style-type: none"> Increase the number of clients receiving services Enhance the quality of service delivery to clients Reduction in waiting lists Increased equity and access to Allied Health across the Region.
Priority 1 – Nursing	Expansion of Nursing	2003-06	<ul style="list-style-type: none"> To expand Nursing in municipalities where the per capita expenditure is under the regional average. 	<ul style="list-style-type: none"> Increase the number of clients receiving services Enhance the quality of service delivery to clients Reduction in waiting list Increased equity and access to Nursing across the Region.
Priority 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"> Increase client numbers across the Region More services provide.
Priority 2 - CALD	CALD - increase Service System Resourcing	2003-04	Service System Resourcing (\$80,000 fixed-term recurrent. Employment of a project officer, or engagement of a consultant, to work with the sector to develop a range of strategies to increase the participation of CALD communities in HACC basic service provision).	<ul style="list-style-type: none"> Increased understanding of issues facing CALD communities Options identified to improve access to culturally relevant HACC basic services.
Priority 2 CALD	CALD - increase Service System Resourcing	2005-2006	<ul style="list-style-type: none"> Trial service delivery models following outcomes in 2003-04. 	<ul style="list-style-type: none"> Increased access to HACC services by the CALD communities.
Priority 3 - ATSI	ATSI increase Home Care	2003-04	<ul style="list-style-type: none"> Increase Home Care by 380 units in the Shire of Yarra Ranges, and 215 units each in Maroondah, Whitehorse and Knox to keep pace with demand and enable service expansion. 	<ul style="list-style-type: none"> Increase in the number of clients receiving culturally appropriate HACC services Expansion of regional coverage of culturally-specific services in specified local government areas.

EMR HACC Regional Plan 2003-06
(incorporating *HACC Planning and Funds Allocation 2003-04*)

Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
3 ATSI	ATSI - increase Service System Resourcing	2003-04	<ul style="list-style-type: none"> Undertake a fixed term recurrent project from January 2004 to December 2004 to develop a strategy to increase access to culturally appropriate services for indigenous clients in the Region. 	<ul style="list-style-type: none"> Increased availability of culturally appropriate services throughout the entire Region. Increase in uptake of HACC services in both culturally-specific and mainstream settings.
3 ATSI	ATSI – expansion of services	2004-2006	<ul style="list-style-type: none"> Trial service delivery models following the outcomes of the above project. 	<ul style="list-style-type: none"> Increased service to Indigenous clients in EMR.

Section 5 – Regional recommendations 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 EMR's recommendations to address the Ministerial Priorities 2003-06 and to implement the Better Planning and Funds Allocation processes.

Broadly speaking, the recommendations address 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.a-c. 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.

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

The Region recommends allocating funds on a one year fixed term recurrent basis for Priorities 2 and 3 in 2003–04 for projects that will run throughout the triennium.

EMR HACC Regional Plan 2003-06
(incorporating *HACC Planning and Funds Allocation 2003-04*)

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
Boroondara	\$ 98,364	\$ -	\$ -
Knox	\$ 418,083	\$ -	\$ 5,255
Manningham	\$ 83,047	\$ -	\$ -
Maroondah	\$ 99,104	\$ -	\$ 5,255
Monash	\$ 451,966	\$ -	\$ -
Whitehorse	\$ 425,718	\$ -	\$ 5,255
Yarra Ranges	\$ 105,010	\$ -	\$ 9,287
Region Wide	\$ 71,400	\$ 80,000	\$ 80,000
Total	\$ 1,752,692	\$ 80,000	\$ 105,051

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
Boroondara	\$ 122,987	\$ -	\$ -
Knox	\$ 468,666	\$ -	\$ -
Manningham	\$ 103,835	\$ -	\$ -
Maroondah	\$ 123,910	\$ -	\$ -
Monash	\$ 508,003	\$ -	\$ -
Whitehorse	\$ 484,183	\$ -	\$ -
Yarra Ranges	\$ 131,294	\$ -	\$ -
Region Wide	\$ 71,400	\$ -	\$ -
Total	\$ 2,014,279	\$ -	\$ -

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
Boroondara	\$ 133,843	\$ -	\$ -
Knox	\$ 509,433	\$ -	\$ -
Manningham	\$ 113,001	\$ -	\$ -
Maroondah	\$ 134,847	\$ -	\$ -
Monash	\$ 552,209	\$ -	\$ -
Whitehorse	\$ 526,387	\$ -	\$ -
Yarra Ranges	\$ 142,883	\$ -	\$ -
Region Wide	\$ 71,400	\$ -	\$ -
Total	\$ 2,184,003	\$ -	\$ -

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 were addressed and recommendations 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?

The decision to top slice a portion of funding from the regional growth allocation to redress HACC funds inequity is recommended on the basis of data in Section 3.5.3.

Funds equalisation totalling 20% across the local government areas in the Region is recommended. The factors that informed this decision are the current inequitable allocation of regional funds provided to each local government area and population trends.

Local government areas that are currently receiving above their 'share' of regional funds relative to their 'share' of the WREN populations are:

- Boroondara (3.5% above)
- Manningham (1.7% above)
- Maroondah (0.02% above)
- Yarra Ranges (2.5% above).

The 70+ population in Boroondara is expected to decline slightly as a proportion of the Region's 70+ population over the period in 2003-06 (Section 3.5.1.1. - Table 3.1). Apart from Manningham, which will have a small increase, the proportions of the 70+ population in the remaining local government areas will remain relatively stable.

In line with the Ministerial direction to redress intra-regional HACC funds inequity, EMR has 'top sliced' 20% of the growth, for distribution across the three municipalities that receive proportionally less funds than the remaining four municipalities.

The local government areas that will benefit from funds equalisation are those that are currently receiving below their share of regional funds relative to their "share" of the WREN populations:

- Knox (3.0% below)
- Monash (1.4% below)
- Whitehorse (3.3% below).

5.3.3. Recommended expansion of activities – Priority 1

Following the data analysis and conclusions described in Sections 3 and 4, the following activities have been recommended for expansion.

5.3.3.1. HACC Basic

Local governments in EMR provide HACC in-home support services. (The exception is ATSI services which are the subject of 'Priority 3' in this Section.) It is recommended, that all municipalities will receive some growth funding for HACC Basic services in 2003-04, 2004-05 and 2005-06.

In-home support services

(Home Care, Personal Care, Property Maintenance, Assessment and Care Management, Delivered Meals)

It is recommended to grow all these services, with the exception of Delivered Meals in proportion to the existing level of service within each local government area. The aim is to respond to current demand in a gradual way, so that Councils can absorb the growth without putting too much pressure on any one activity. This approach will be reviewed in 2004-05 and 2005-06.

No growth has been recommended for Delivered Meals. Discussions with local governments have indicated that the demand appears to have reduced for this activity. Furthermore, the results of a statewide review of food services are expected to shape service provision in this area in the future.

Health care

(Allied Health and Nursing)

EMR has recommended an allocation of \$379,202 to the Health Care activities of Allied Health and Nursing for distribution on an equal basis to both activities. Factors taken into account in making this decision were:

- There has been no significant growth in these activities in the Region for some time
- Ongoing feedback from the sector indicate that demand continues to outstrip supply
- Current budget allocations and WREN population data indicate there is an unequal distribution of funds between municipalities in both Nursing and Allied Health.

Nursing

For the July/March 2002-03 MDS returns (three-quarters of data) the analysis of the data indicates that there is a variation from the Regional Average in Nursing across all municipalities. The Regional Average has been developed by annualising the hours per capita per annum, establishing the average hours, and then analysing the data using the regional average as a benchmark. This creates an average of 37.25 hours of service per capita per annum.

The local government areas that demonstrate a variation from the Regional average are: Boroondara 39.86 hours; Knox 35.07 hours; Manningham 42.62 hours; Maroondah 38.80 hours; Monash 30.94 hours; Whitehorse 36.19 hours; and Yarra Ranges 40.12 hours.

The three municipalities that are under the regional average are Knox, Monash and Whitehorse. It is recommended to allocate growth funds for the three municipalities that are under the Regional average for Nursing, proportional to the relative discrepancy of each local government area:

- Knox - recommended growth - \$39,790 in 2003-04
- Monash - recommended growth - \$127,040 in 2003-04
- Whitehorse - recommended growth- \$22,755 in 2003-04.

Further analysis may be required to establish the reliability of this data for 2004-05 through to 2005-06. Recommended changes in these 'out years' will be in accordance with this analysis.

Allied Health

Analysis of the MDS data showed a consistent bias in the data, which led to the data being deemed too unreliable to make a sound judgement. Discussions with the sector confirmed this view. The Region used a per capita figure based on Allied Health service provision funding allocations and the WREN population for each local government area. This analysis showed three local government areas Knox, \$23.02 Whitehorse \$25.15 and Monash \$22.52 under resourced relative to the regional average* of \$28.73 per capita. The per capita amount for the remaining municipalities was, Boroondara \$38.84; Manningham \$28.29, Maroondah \$28.09; and Yarra Ranges \$38.18.

The recommended Allied Health funding allocation of \$189,616, will be distributed to:

- Knox (36.85% of the growth Allied Health budget) - or \$69,760
- Whitehorse (23.15% of the growth Allied Health budget) - or \$43,995
- Monash (40.00% of the growth Allied Health budget) - or \$75,861

*The Regional Average for Allied Health was \$28.73 per capita per person. This figure was developed by dividing the WREN population into the total service provision funding allocation for Allied Health. In the Region (\$3,419,923 divided by 123.569 (WREN population = \$28.73 per capita regional average.)

5.3.3.2. Expansion of HACC Basic Services in 2004-05 and 2005-06

The Region is intending to improve the data collection in 2003-04 and to continue to undertake regional research by liaising with agencies to ascertain the factors affecting service levels and service provision. The results of this research may impact on future decisions in allocating regional growth funds.

5.3.3.3. Expansion of the HACC Regional Training Co-ordination Function

EMR is recommending expanding the Regional HACC Training Coordination function to be able to support an increased capacity in delivering the training and workforce needs of the HACC sector in the Region. The Region therefore recommends allocating the maximum recurrent growth allocation of \$30,000 per year to the HACC Regional Training Coordination function over the next three years as follows:

Expanding the capacity of the Regional HACC Training Coordinator

The Region will expand the capacity of the Regional HACC Training Coordinator in 2003-04 from a 0.5 EFT position to a 0.6 EFT position. The funds required to expand the role will be \$5,000 per annum. This expansion will be reviewed in year two.

Regional review of training

Undertake a review of training to ascertain the capacity of funded agencies' to address identified agency-level HACC related training needs; and to develop a model for the Region to support agencies' endeavours to meet their local HACC related training needs.

Through the review this project will:

- Develop effective strategies to increase each agency's capacity to recruit, train and retain staff
- Assist agencies to access traineeships and other training/learning opportunities that are funded from a variety of sources
- Identify HACC specific training needs.

The first phase of the project will be a consultative process managed through the EMR Regional Office that will identify:

- Available training/learning opportunities and how to source these
- Agencies' training/learning needs and priorities as well as their preference for resource models and/or preferred learning formats
- Options for exploring training and learning partnerships where appropriate, and agencies' capacity for take-up
- Optimum resourcing strategies for the Region to support the learning/training needs of agencies, within a developmental framework.

The outcomes of the review will lead to initiatives to implement a model for future training. This project will receive \$25,000 funding in the first year.

In 2004-05 the outcome of the review will lead to the development of a trial to assist agencies with their training needs. The budget for this year will be ascertained following recommendations from the first phase. The budget will not exceed the recommended allocation of \$30,000 projected funding for training in 2004-05.

In 2005-06 there will be an evaluation of the trial, and additional implications for implementation will be identified. The budget for the implementation and the evaluation will be established in the preceding year. The budget will not exceed the recommended allocation of \$30,000 projected funding for training in 2005-06.

5.3.3.4. Summary Priority 1

The Region's recommendations for Priority 1 during 2003-06 are summarised in the tables below. The service expansion recommended in each local government area is depicted in Appendix F. 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	30,659	\$ 749,306
Personal Care	11,853	\$ 331,173
Property Maintenance	2,495	\$ 88,697
Allied Health	2,642	\$ 189,616
Nursing	3,016	\$ 189,586
ACM	-	\$ 132,914
SSR HACC Response Service	-	\$ 41,400
SSR Training	-	\$ 30,000

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

Activities	Units	\$
Home Care	35,511	\$ 889,440
Personal Care	13,783	\$ 394,746
Property Maintenance	2,906	\$ 105,882
Allied Health	2,682	\$ 197,301
Nursing	3,061	\$ 197,235
ACM	-	\$ 158,275
SSR HACC Response Service	-	\$ 41,400
SSR Training	-	\$ 30,000

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

Activities	Units	\$
Home Care	37,682	\$ 967,413
Personal Care	14,627	\$ 429,391
Property Maintenance	3,086	\$ 115,252
Allied Health	2,841	\$ 214,222
Nursing	3,243	\$ 214,186
ACM	-	\$ 172,140
SSR HACC Response Service	-	\$ 41,400
SSR Training	-	\$ 30,000

5.3.5. Allocation process, 2003-04

The funding allocations recommended below are in accordance with DHS' *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)	Assessment & Care Man (\$)	Service System Resourcing (\$)	SSR Training
Boroondara	City of Boroondara	Direct	2,652	671	186			\$8,189		
Knox	City of Knox	Direct	7,220	2,474	472			\$46,173		
Manningham	City of Manningham	Direct	1,844	966	122			\$6,652		
Maroondah	City of Maroondah	Direct	2,362	990	157			\$8,135		
Monash	City of Monash	Direct	5,156	2,974	498			\$22,255		
Whitehorse	City of Whitehorse	Direct	9,586	2,826	673			\$21,802		
Yarra Ranges	Shire Yarra Ranges	Direct	1,839	952	387			\$19,708		
Knox	Knox Community Health Service Villa Maria Society	Invited Submission				972				
Monash	Monashlink Community Health Service	Direct				1,057				
Whitehorse	Whitehorse Community Health Service	Direct				613				
Whitehorse	MECWA & RDNS	Invited Submission					362			
Knox	Royal District Nursing Service	Direct					633			
Monash	Royal District Nursing Service	Direct					2,021			
Region	Yet to be determined	Invited								\$30,000
Region	(HACC Response Service)	Direct							\$41,400	
Total Allocated			30,659	11,853	2,495	2,642	3,016	\$132,914	\$41,400	\$30,000

There was broad agreement to the agency allocation recommendations.

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 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.

EMR has undertaken a range of initiatives designed to increase the quality of 'HACC Basic' services for people from CALD backgrounds over the past three years. These include:

- Recurrent funding for the Migrant Information Centre to provide support for HACC ethno specific agencies and mainstream agencies for:
 - Agency Consultancy Support
 - The development of the HACC Cultural Planning Tool Action Plan Database
 - The trialling of a planned activity group cultural specific model
 - Training for Ethno Specific Agencies
 - The staffing and operation of the HACC CALD Network.
- In addition the Migrant Information Centre has been funded to undertake a Multicultural Education Project with the following objectives:
 - To develop an Educational and Information Strategy
 - To develop a feedback mechanism between ethno specific and mainstream providers. Two municipalities have been nominated to participate in this project in 2003-04: The Diverse Meals Project through the City of Whitehorse and the Active Seniors Project through the City of Manningham.

Further plans to continue to support EMR CALD communities are underway and build on current regional projects. The aims are to:

- Enhance understanding and access to HACC basic services
- Improve recruitment and retention of volunteers
- Further understand the link between ethnicity, social support and meals.

These initiatives will continue to be developed and supported by the Region in 2003-06.

Section 3.5.1.3. demonstrates the CALD population is increasing in EMR. It is predicted that over the next three years this will impact on HACC in the following way:

- The majority of CALD groups will be small and geographically dispersed across the Region. This will impact on the way HACC services are delivered.
- The major pressure on the HACC services will be in the local government areas of:
 - Manningham – 35.19% (5,001 65+ persons) total CALD population
 - Monash - 27% (6,483 65+ persons) total CALD population
 - Whitehorse - 19% (4,536+ persons) total CALD population
- The outer local government areas with smaller, but significant CALD communities will also experience pressure in the delivery of services as geographically dispersed communities will also impact on the infrastructure capacity of agencies.

5.4.2. Project recommendations

During consultations with the CALD sector in 2002-03, a number of small, ethno specific services identified the difficulty these small agencies have in maintaining ongoing administration with a relatively small budget, and issues associated with adhering to Departmental requirements (including reporting requirements, providing data in a timely manner and attendance at consultations and forums). These agencies may also operate across regions, and are therefore required to attend relevant forums in more than one region, and submit data to one or more regions, and often more than one funding body.

The Region will consolidate efforts to increase access and continue to look at strategies aimed at being more responsive to CALD communities. Priority 1 service expansion will support all HACC communities, including CALD, communities requiring HACC Basic services.

To support CALD communities to increase participation in HACC Basic service provision, given the current growth, the Region will:

- Work with the CALD sector to review initiatives and determine priorities for the future
- Enhance the Region's understanding of the issues facing CALD communities relevant to their specific needs
- Explore options about how to assist ethno specific communities to improve access to culturally relevant HACC Basic Services
- Scope a project that facilitates small ethno-specific communities developing and building partnerships with mainstream.

It is recommended that EMR will undertake this project through a consultancy or the employment of a project officer. A budget of \$80,000 will be allocated to the project (\$40,000 half-year effect). A reference group will be established to oversee the project.

5.4.4. Allocation process, 2003-04

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

Catchment	Name of Agency	Project	Allocation Method	Service System Resourcing \$
Region	EMR Project	Regional HACC CALD Strategy	Invited	\$80,000

Stakeholders generally agreed with the focus of the proposals.

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 recommendations 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 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 recommendations 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 proposed 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 border service provision
- Planning for seasonal changes in population.

These issues were referred back to each local network for consideration in their planning process.

5.5.3. ATSI sector

Planning for service growth and improved quality of HACC services for ATSI people in EMR has been undertaken in the context of Australian Bureau of Statistics population estimates, the current shape of the ATSI service sector, usage of HACC services by ATSI clients, and issues expected to affect service delivery in the Region.

5.5.3.1. The ATSI service sector

The EMR currently funds a mainstream agency, Yarra Valley Community Health Service, to provide culturally specific HACC services delivered by Indigenous workers. Activities offered are Home Care, Personal Care, Property Maintenance, Planned Activity Group (Core), Assessment and Care Management, Respite (Home and Community) and travel to social support services for elders.

The Aboriginal HACC service has been established within Yarra Valley Community Health Service since 1999. Together with the Yarra Valley Indigenous Health Team it operates from shopfront premises in Healesville. The agency is in the process of building its client base. Currently it services clients in Yarra Ranges and, to a lesser extent, Whitehorse, Maroondah and Knox.

In addition to services funded by the EMR, two cross-regional Aboriginal agencies receive funding through the Northern Metropolitan Region to provide Allied Health, Home Care, Personal Care, Property Maintenance and Respite (Home and Community) into the EMR Region. It has been indicated that one Southern Metropolitan Region-based agency services a small number of clients living in Monash and Knox.

5.5.3.2. Service usage by ATSI clients

While the reliability of information collected through the MDS is uncertain, and there is known significant under-reporting of ATSI clients, it is the only data source available that provides an indication of access to HACC services by the Region's Indigenous population. During the quarter from October to December 2002, 36 ATSI people residing in the EMR were reported as receiving HACC services through 15 agencies.² As would be expected, Yarra Valley Community Health Service in Healesville was the largest single provider of services, followed by the Royal District Nursing Service. Other agencies providing services included:

- 4 councils
- 3 providers of Planned Activity Groups (including one agency that provides social support to HACC eligible clients in Supported Residential Services)
- 2 volunteer resource centres
- 2 community health services
- 1 Indigenous-specific provider (external to the Region)
- 1 Linkages provider.

Of the 36 reported clients, approximately 60% accessed services through mainstream agencies and 40% through ATSI-specific agencies. This pattern is in marked contrast to the draft findings of the Victorian ATSI Communities HACC Needs Analysis Project conducted in 2003 by consultants, Effective Change, which indicated that service usage by ATSI people in mainstream agencies is very low. It is possible there are explanations for this anomaly, including the fact that there are no other options locally for the Indigenous community.

² One ethno-specific agency has been excluded on the basis of likely mis-reporting.

5.5.3.3. Issues expected to affect service delivery in EMR

Population increase

The Regional population is too small for meaningful projections to be undertaken. However, with the number of people in the ATSI frail aged HACC target group (people aged 50+ years) predicted to double over the next 20 years across the State,³ it can be expected that demand for HACC services will increase in the Region for the foreseeable future.

Regional population figures given in Section 3.5.1.4, Table 3.2 suggest that increases in service demand can be expected to be most significant in Yarra Ranges, which has 35% of the Region's ATSI population in the 50-69 years age cohort, and Knox and Whitehorse with 17% and 15% respectively.

Complexity of need

There is much evidence documenting the greater degree of ill health, experienced by ATSI people compared with the rest of the community.⁴ The tendency for needs to be complex, demands a holistic response from the service system, and contributes to service pressures within the Region.

Access to culturally appropriate services

Indigenous-specific services

The draft findings of the Victorian ATSI Communities HACC Needs Analysis Project indicated a high preference for accessing services provided by Koori agencies.

With the Region's Aboriginal HACC service located in the outer part of the Region, and its service coverage in the process of being extended to Whitehorse, Maroondah and Knox access to culturally specific services is restricted for potential clients in large parts of the Region. Cross-regional services provided by Aboriginal agencies in neighbouring Regions help to alleviate this situation to some degree.

At the same time, in the absence of identifiable Aboriginal communities, other than those communities in the Healesville area, locating potential clients in order to determine their needs and target services appropriately has proved a difficult task.

Mainstream services

Enhancing access to mainstream services and developing a culturally competent workforce have been identified as major issues by state and metropolitan-wide forums of Indigenous service providers and by the Indigenous community within the Region. The expectation that mainstream agencies will play an important role in providing services to ATSI people underscores the importance of addressing this issue.⁵

³ Calculated on the basis of ABS population and morbidity data

⁴ Victorian ATSI Communities HACC Needs Analysis Project (Draft), Effective Change, 2003

⁵ Department of Human Services – Aboriginal Services Plan – Final Draft August 2002

Regional initiatives to enhance access to services

During the past three years, the Region has undertaken projects to enhance access to services for ATSI people. Ten cultural sensitivity workshops were held for HACC mainstream providers in 2000-01 via a Service Development grant. The workshops were delivered by ten Indigenous elders and staff from the Aboriginal Health Team in Healesville, who received training in culturally sensitive processes. A three-hour presentation and training manual were developed to assist in conducting the workshops.

In addition, the Region's Planning Unit conducted a forum for mainstream agencies to develop partnerships with the ATSI community and identify practical solutions to improve services to indigenous people in May 2001.

5.5.4. Expansion of services

An analysis of Quarterly Output Collection Data indicates that Home Care targets have been over-achieved by Yarra Valley Community Health Service for the past 18 months suggesting that this activity should be given priority in 2003-04. A survey of Aboriginal consumers in 2002 also indicated Home Care was a high priority.

Therefore, in 2003-04 the Region will increase Home Care by 380 units in the Shire of Yarra Ranges, and 215 units each in Maroondah, Whitehorse and Knox to keep pace with demand and to enable service expansion. The allocation of \$25,051 (Full Year Effect) is based on a submission received from Yarra Valley Community Health Service to the 2002-03 HACC Growth Funding Round. EMR recommends to directly allocating these funds to the agency.

5.5.5. Service development initiatives

It is recommended to undertake a fixed term recurrent project over the triennium. The EMR will participate in a Victorian ATSI needs analysis and service mapping project.

Pending the outcome of this project, EMR will explore options and develop culturally appropriate service models to increase access for the Indigenous communities living in the EMR to mainstream services. The project will focus on local government areas that currently have limited access to Indigenous-specific services. An indicative amount of \$80,000 per annum is allocated for this initiative.

5.5.7. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Home Care (units)	Service System Resourcing (\$)
Knox	Eastern Health - Yarra Valley CHS	Direct	215	
Maroondah	Eastern Health - Yarra Valley CHS	Direct	215	
Whitehorse	Eastern Health - Yarra Valley CHS	Direct	215	
Yarra Ranges	Eastern Health - Yarra Valley CHS	Direct	380	
Region wide	Yet to be determined	Invited		\$80,000
Total Allocated			\$25,051	\$80,000

The proposals were agreed to. Stakeholders were satisfied with the proposal to expand Home Care.

5.6. Impact of Priorities 1-3 recommendations

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 service system
- Improve the balance of activity level across the Region
- Improve the responsiveness of HACC basic services to people from CALD backgrounds
- Increase the quality and quantity of HACC services to Indigenous people.

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

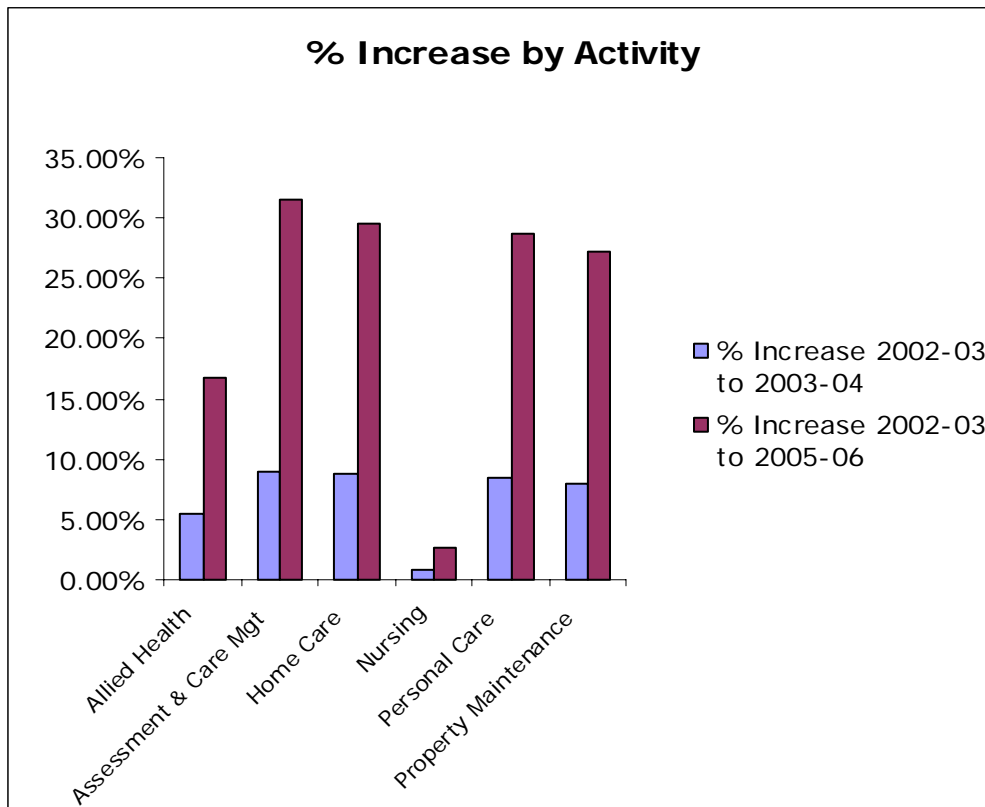


Figure 5.1: Percentage increase of Priority 1 activities, 2003-04 and 2003-06

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
Boroondara	\$10,503,732	17.7%	14.2%	\$11,185,669	17.0%	13.8%
Knox	\$6,746,593	11.4%	14.4%	\$8,212,622	12.5%	14.5%
Manningham	\$7,308,755	12.3%	10.6%	\$7,658,571	11.6%	10.8%
Maroondah	\$6,484,851	10.9%	10.7%	\$6,898,166	10.5%	10.7%
Monash	\$10,091,460	17.0%	18.4%	\$11,692,935	17.7%	18.4%
Whitehorse	\$8,703,436	14.7%	18.0%	\$10,276,782	15.6%	18.0%
Yarra Ranges	\$9,492,344	16.0%	13.7%	\$9,954,447	15.1%	13.7%
Total	\$59,331,170	100.0%	100.0%	\$65,879,192	100.0%	100.0%

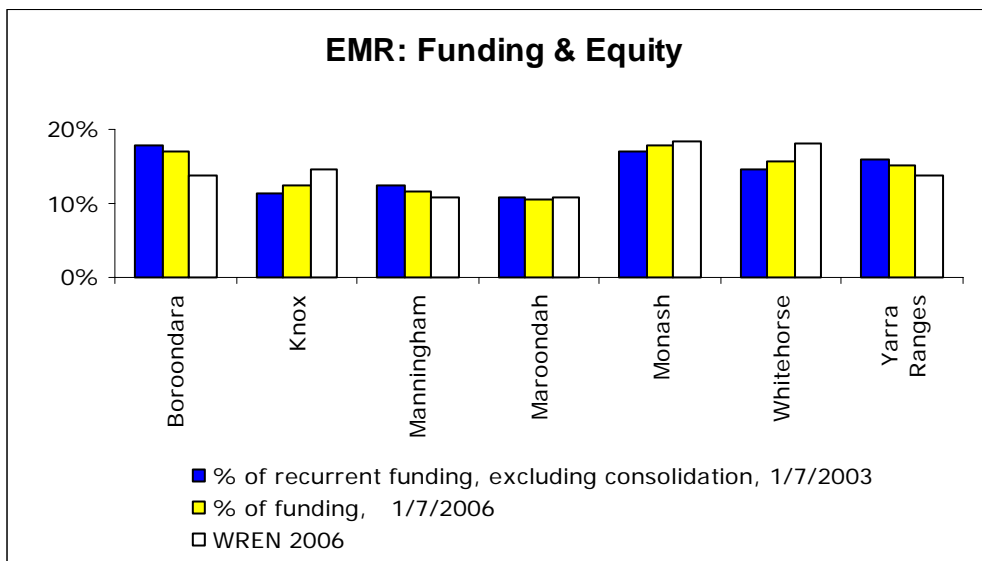


Figure 5.2: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

Section 6 – Non-recurrent funding

6.1. Introduction

This section outlines recommendations 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.

EMR is recommending sponsoring a project to look at HACC CALD workforce issues. Consultation with the EMR HACC training sector has identified CALD recruitment and retention as an issue specifically related to HACC accreditation standards.

It has also been noted that CALD clients will often accept a HACC service if the care worker is from the relevant culture of the client. Due to language difficulties and unfamiliarity with the training system, many care workers from CALD communities are not responding to the need to attain the relevant qualification required to provide HACC services. This project is designed specifically to look at these issues, and work with a relevant training provider, to develop strategies to assist agencies, to assist care workers in this situation.

Registered Training Organisations are offering nationally accredited training within EMR to the existing CALD workforce. The training offers individuals the opportunity to upgrade current certification to Certificate III in the Home and Community Care Stream. Entry-level training to the potential CALD workforce is also available.

The EMR has consequently recommended a partnership project focusing on the recruitment, retention and skilling of the CALD workforce in EMR (six-month Service Development Grant, 2003-04 - \$30,000) with the successful provider. The project will develop appropriate resources to support the HACC CALD workforce.

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.

A discretionary minor capital budget of 20% is recommended in each of the years between 2003-06 to support contingency planning. The introduction of the formulaic approach to minor capital may have unforeseen consequences and the Region proposes to retain these funds for such purposes, particularly for CALD and ATSI projects which may require an increase in minor capital infrastructure.

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