

Ideas for the Future of Community Care in Victoria

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Introduction

Thank you for the opportunity to participate in today's forum. We all need to work together to ensure that community care services provide the assistance that older people want—and in a way that is sustainable into the future.

The Bracks government has a strong commitment to supporting older Victorians to lead active lives in their community and remain independent for as long as possible. This commitment is not limited to the majority who are still fit and healthy, but is very much focused on people who may be more frail and living with disabilities. Community care services play a key role in supporting this group.

I have two reasons for speaking today:

- to launch *Who Gets HACC*, a publication on the characteristics of people receiving services from the HACC Program in Victoria in 2002-03; and
- to describe the Victorian Government's vision for the future of community care for older people and people with disabilities.

Launch of *Who Gets HACC*

This morning I am launching a new publication from the Aged Care Branch of DHS. *Who Gets HACC* is a statistical overview of the estimated 200,000 people who received HACC services during 2002-03 in Victoria.

The source of the data is the National HACC Minimum Data Set. The collection of this data in Victoria is the responsibility of the Aged Care Branch of the Department of Human Services. Ultimately, you, the service providers here today, have provided all the material in this report. *Who Gets HACC* demonstrates that your efforts have been worthwhile.

Data collection is sometimes regarded as just a burden on service providers or a distraction from their primary goal of delivering services. Not so. Unless we know who we are providing services to, we cannot know whether we are being effective. And our efforts at reform will not be soundly based.

The HACC MDS is now in its third year. The response rate has been steadily rising, and now exceeds 90 percent of Victoria's 500 HACC providers. That is, the great majority of agencies now keep up-to-date records on all their HACC clients, and are able to extract an electronic summary of these records every three months to transmit to the Department.

This is a huge achievement, considering that most HACC agencies are a good deal smaller than, for example, public hospitals, with their long history of patient records and information management.

The picture of our clients painted by this report is of great importance in thinking about future directions. For example:

- It shows whether the program is reaching the full diversity of the target population, including Aboriginal people and people from non-English speaking countries, when compared to their proportions in the Victorian population.
- It shows how the average hours of service are distributed across the range of clients (the majority of people receive an average of only a few hours a month, while a high-needs minority receive considerably more).
- It shows the way people move in and out of the HACC service system (thus services like home nursing have a much higher turn-over than home care or personal care, but all services have a steady turn-over).

Future directions for community care in Victoria

The Australian Government's Minister for Ageing, Julie Bishop, recently released a statement on the Community Care Review, *The Way Forward*.

While I am pleased that this document proposes a number of directions to improve the operation of the community care system, I'd encourage further development of the overall concept. It is good to hear the Minister's renewed commitment to consultation with State and Territory Governments and with service providers in developing and implementing the directions set by the Australian Government.

This year, the HACC Program in Victoria is worth more than \$380 million in funds from the Australian and Victorian Governments. Last year, almost half of this—nearly \$170 million—was contributed by the State, including \$42 million above the matching requirement. Victoria also allocates over \$6 million to the Aged Care Assessment Program.

As all of us know, services funded through the HACC Program in Victoria play a vital role in supporting people with disabilities of any age. They are able to remain at home, in control of their lives and connected to their communities.

The balance of care in Victoria is decisively weighted in favour of community services. This has been true since the mid 1980s. Victoria has always had fewer residential aged care beds than other states, compared to the size of its population. Successive State governments have invested heavily in community-based care over the last twenty years.

This investment is only partly accounted for through the HACC Program. We have also invested in the Post Acute Care Program, community health services, carers programs and rehabilitation services. More recently, we have put substantial investment into innovative projects that reduce the risk of hospital admission for people with chronic and complex conditions.

The Victorian Government has a large stake in the future shape of the community care system in this State. Making it work effectively is a high priority.

Our priorities for community based care are simply stated, though not so simply achieved. They are:

- Equity
- Access
- Reshaping services and the service system for the future.

Equity

This year, through the HACC Program, \$380 million in public funds will be allocated to nearly 500 agencies to provide services across Victoria.

So it is important to be sure that the funds are being distributed equitably.

In the first place, that means equitable distribution across all geographic areas of the State.

This is done by calculating how many people in any area are likely to be eligible for HACC services. The target population, broadly speaking, consists of older people and people with disabilities living in the community. Their numbers come from the Census and the ABS Disability & Ageing Survey, and are then modified by a formula (the Relative Resource Equity Formula or RREF).

The Department reviewed the formula in 2000, in an extensive consultation with service providers. A more accurate formula, that adds weighting for ethnicity, indigenous status, socio-economic status and health status, was introduced in 2001-02. The RREF directs growth funds each year preferentially to regions with high concentrations of people in the target group with poor health and limited resources.

A similar formula is used to reduce inequities *within* regions. Population figures weighted by socio-economic and health status guide regional office consultations and funding recommendations. Other local factors are also taken into account.

The Regional Formula introduced in 2001-02 showed that Northern, Western and Southern Metropolitan regions were relatively under-funded. This is because these regions have high concentrations of people with disabilities in the lower deciles of socio economic status and poor health status.

These regions also have relatively high concentrations of people from culturally and linguistically diverse backgrounds, and Aboriginal people.

Although the Regional Formula was steadily improving the situation, I decided to speed up the process in 2003-04 by allocating \$1 million of unmatched state funding to under-funded regions.

To sum up: Good progress has been made in improving the equity of resource distribution across Victoria. Probably no other State has advanced so far. Nevertheless, there remain challenges. Recently available data from the 2001 Census shows that the rate of population growth in certain outer suburbs had previously been under-estimated. We need to consider how those movements can be taken into account in future allocations of funds.

The general directions are clear: we are moving towards a situation where the level of availability of HACC services will not depend on whether a person lives in the city, or in an outer suburb, or in rural Victoria.

Over time, these measures will help address the intense demand felt by agencies in under-funded regions. But they will not answer the fundamental question of whether the pie was big enough to begin with. This is why the Bracks Government felt it was so important to contribute additional funds to the HACC Program since its election in 1999: \$42 million above the matching requirement in our first term, \$69 million in the second term.

Access

A person's access to community care services can depend on demographic factors such as ability to speak English. A government concerned about fairness must take this very seriously.

Our analysis of HACC clients against the broader population in Victoria shows that two groups need careful attention:

- People from culturally and linguistically diverse backgrounds; and
- Aboriginal people.

Aboriginal access

As Minister for Aboriginal Affairs, I have a particular interest in Aboriginal people's access to HACC services. And I have a particular interest in building the capacity of Aboriginal controlled organisations to meet the needs of their communities.

In 2003–04 I approved a package of initiatives instigated by the Victorian Indigenous Committee on Aged Care and Disabilities (VICACD) to develop a firm evidence base for improving the delivery of HACC services to Indigenous communities. The strategy is called Going Forward Together.

A needs analysis is now well underway. It will provide a coherent picture of Indigenous communities, their characteristics, distribution, current access to HACC services, and identified service needs across the State.

The Department and VICACD will evaluate a range of models for service provision for Indigenous communities against the criteria of sustainability and acceptability to those communities.

The Department and VICACD are working to strengthen the consultation networks of Aboriginal agencies to ensure they can be effective and proactive.

Meanwhile, recurrent funding to Aboriginal HACC-funded agencies has been increased by \$441,000 in 2003-04, bringing it to \$4.1 million. An additional \$1 million is allocated to mainstream agencies to target their services specifically to Indigenous communities.

I am pleased to be working with VICACD to improve Aboriginal people's access to needed services.

Access for an ethnically diverse population

As shown in *Who Gets HACC* being launched today, Victoria's HACC users are a culturally diverse group. HACC clients in 2002-03 came from over 150 different countries and spoke 80 different languages.

Improving access to HACC services for people from culturally and linguistically diverse backgrounds is therefore a key policy objective.

Twenty-two percent of people attending HACC Planned Activity Groups are of CALD background. This compares favourably to the fact that 21 percent of all Victorians aged 65-plus are from a CALD background.

However, according to the data, people from CALD communities are generally *under-represented* in core services such as home care, nursing, allied health, and delivered meals.

That is why I launched the Culturally Equitable Gateways Strategy in April 2004. The Strategy is a partnership between the Victorian Government, the Municipal Association of Victoria and the Ethnic Communities Council of Victoria.

I decided to allocate \$6 million of State unmatched funding over the next three years to get the Strategy moving.

The first objective is to improve the responsiveness of local governments to people from CALD communities, by forming permanent local partnerships with ethno-specific agencies.

Some of the funds will go to the recruitment of bilingual staff for HACC services, including fourteen scholarships for bilingual workers to attain Certificate IV in Home Care or an equivalent qualification.

The Strategy is targeted at encouraging people from CALD backgrounds to seek services from their local councils and at helping councils to tailor their services to meet the cultural requirements of clients from CALD backgrounds. The emphasis is on supporting councils and ethno-specific agencies to work together for the benefit of their clients.

Challenges remain: In particular, we need to solve the problem of improving access for people living in the more isolated parts of rural regions where travel times are very long.

Ideas for reshaping community care services for the 21st century

I talked earlier about the vital role played by Victorian services funded through the HACC Program in supporting people to remain at home, in control of their lives and connected to their communities.

We talk a lot about maintaining people independently at home, but we tend to talk about it as something external to the people who are our clients, and from a 'welfare' mind set. I think this has led to us accepting a suite of services that are predicated on people being passive recipients.

The real question is: How we can reshape our services and our service system in ways that respond to clients as people who want to be active on their own behalf, remain in control of their lives, notwithstanding physical or mental disability?

Consider the **service system as a whole**. To work properly it must have both 'vertical' and 'horizontal' connectedness.

In the 'vertical' dimension, we need better connection between:

- aged residential care services; and
- community care services (HACC, CACPs, EACH, and Respite programs).

This aspect appears to be the main thrust of the recent statements by the Australian Government Minister Julie Bishop.

From my perspective, equally important are the 'horizontal' connections. That is, people want more continuity of care between:

- HACC and related services in primary and community health and disability;
- the hospital sector (acute, sub-acute and post-acute care);
- rehabilitation and opportunities for functional improvement; and
- opportunities for health promotion, and prevention of avoidable disability.

This implies system redesign, not just better coordination between existing services.

With proper national leadership, a systematic overhaul of Australia's aged and community care services should be possible.

We know that fundamental changes to Australia's demography are underway, summed up (inadequately) in the phrase 'ageing of the population'.

We should be thinking of a 21st Century breakthrough in the system of services, equivalent in scope to the Medicare idea of the 1970s. By that, I mean a major rethinking of the role that community care plays in our health system, the way it is financed and administered, and the types of services it delivers.

As shown in *Who Gets HACC*, more than 200,000 Victorians already receive services subsidised by the HACC Program. Two-thirds of these are people aged over 70.

As well, there are other closely related programs in community care such as the Aged Care Assessment Program, CACPs, Respite for Carers and Post Acute Care. ACATs are currently assessing over 50,000 people every year, half of whom are aged over 80 years.

So it is already the case that many more people are being assisted with community care services to remain in their own homes than are living in aged residential facilities.

Research (and common sense) show that the success of home-care services depends on a *close working relation between community care, primary medical care, and specialist clinical services.*

This is particularly true as HACC clients become more frail and dependent, and more likely to require short-term hospital admission.

Building a system for the future requires an immediate focus on the following key features:

- Better navigation for people and service providers
- Assessment of need
- Identifying the optimal balance of services
- A new paradigm: home care as active intervention

Taking each of these in turn:

Navigating a complex system

The Victorian Government is now two years into its active development of Primary Care Partnerships (PCPs).

PCPs are a vehicle for rationalising access to the bewildering variety of community care services from the consumer's point of view.

Our vision is one in which, in any part of the State, an older person or anyone else can confidently approach their local council, community health centre or GP with an enquiry about what primary health or community care services are available.

Consumers should have confidence that all the relevant agencies know enough about the range of options to be able to guide and assist them to find the right service.

In some suburbs and country regions, this is already the case. Community care agencies in these localities are already well advanced in piloting an electronic Statewide Services Directory, which will eventually be available everywhere. Right now, the picture across the State is still far too variable.

We intend to keep working with major HACC providers—particularly councils, home nursing services and community health centres—to gain agreement on the best way of proceeding.

Engaging GPs in this process is a critical part of the agenda because most people with chronic or complex conditions see their GPs regularly each year. Already, GPs in the more advanced Primary Care Partnerships are able to fill out electronic forms embedded in desk-top software when making referrals to HACC agencies.

Agencies such as councils and hospitals will need to define their role in the referral network. The solution will vary according to the existing infrastructure of services. Uniformity is not the goal. Rather, the best arrangement is whatever makes sense to that community from the point of view of making navigation simpler, not more complex.

Assessment

A common assessment framework among HACC providers is an essential part of this picture.

Common principles of intake, identification of client needs, and referral to more appropriate services—these are the goals.

Last year we undertook a survey, jointly with the Municipal Association of Victoria, to map the state of practice in client assessment among councils and other HACC service providers. The results will be published in the near future. Briefly, the survey revealed that there is universal recognition of the importance of good, professional assessment in home care services—and that there is quite a range of variation in current practice. This view is supported by the findings of the Auditor General in his report on the delivery of HACC services by local government.

My impression is that most HACC agencies manage the intake and assessment of people needing basic HACC services well. The three areas where more work is needed are:

- Assessment of people with more complex needs or unstable health conditions;
- Identification of needs for services (including rehabilitation) *other than* the basic HACC services; and
- Making appropriate referrals to other agencies.

'Common principles' implies, for example, that HACC agencies would have agreements with each other on when it is appropriate for a Local Government assessor to refer a person with unstable health to an assessment by a home nursing agency.

Likewise, there could be agreements on undertaking joint assessments with the regional ACAT, in cases where the client has been identified as having complex needs.

Or ensuring that an Occupational Therapist from the community health centre is present during a council's home assessment of a person whose bathroom may need modifying.

The next phase of this work among HACC providers and ACATs will be of great importance. Again, the goal is *not* uniformity in the use of any particular tool for assessment, but rather an assurance that there is consistency in the principles, and professionalism in the methods being used.

The right balance of services

There are about a dozen different types of HACC service—home care, personal care, nursing, planned activity group, property maintenance, and so on.

While each is certainly valuable in its own right, at this stage we have no definite knowledge about the optimal mix of these different service types.

Not even the academic researchers in community care can say with any confidence what combination is optimal (or most cost-effective) in order to support the independence of older people at different levels of need, ranging from basic to complex.

On the positive side, we now have some good data that can be analysed. For example, this publication of *Who Gets HACC* shows the pattern of average hours of service going to clients of case-managed care. It shows that HACC Linkages clients who have a family caregiver tend to receive a slightly *higher* level of services than similar clients *without* a carer.

This suggests that the presence of a family carer is the key to enabling some people with complex needs to remain at home. If they had no caregiver, they would be forced to consider a residential facility.

With this kind of data, most of which is already being collected, it is possible to compare the level and mix of services in different geographical areas, taking into account the differences in client demographics.

Just as people have the right to expect that HACC funds will be distributed equitably across all parts of the State, so they should be confident that each local area will have the right balance of basic home-care services.

We know that people in the HACC target population fall into a range of needs and levels of functional dependency. Some need services for a short period at high intensity (e.g. for post-acute care). Others need long-term support at low intensity. A smaller proportion need high levels of services for an indefinite period.

Decisions on how to allocate the available services are taken by individual agencies on the basis of the best information available to them at the time. Some of this information is feedback or advice from HACC program managers. However, we need to recognise the limited nature of the systematic evidence available to any of us, whether in government or in the funded sector.

That is, we have only an imperfect ability to ensure that the supply and packaging of services corresponds to the underlying range in demand. Of course, this is not a problem unique to the HACC program. In fact, much the same is true of hospital services. Developing valid measures of program effectiveness is a notoriously difficult problem for health and welfare services world-wide.

In the next version of the HACC minimum data set, information will be collected on the extent of functional dependency or disability. More information will also be gathered on the essential role of family carers.

This will fill in another essential piece of the jigsaw. It will enable agencies to match the level and mix of services to the client's degree of functional disability—and to monitor the effectiveness of this arrangement over time.

A new paradigm: home care as active intervention

The HACC Program is generally regarded as mainly being about the ongoing 'support and maintenance' of people in the community. I believe it is time for a decisive shift of perspective.

I am certain we all share a philosophical commitment to supporting older people to remain as independent, active and connected as possible. There is strong evidence to suggest that even those who are very frail can improve their capacities and take back control over small but important areas of their life.

Lessons from new practice in residential facilities

For example, we now know that strength training can be remarkably effective for people in nursing homes. Some apparently quite frail and disabled people have regained enough function to get themselves out of chairs, on and off toilet seats, out of bed, and have discovered they can walk again unaided.

We need to ask ourselves:— What does this potential for improvement mean for the delivery of home care services in the future? By these standards, how effective are community care services in assisting people to remain independent and engaged with community life?

Conversely, what proportion of older HACC clients have become house-bound and immobile because they are not benefiting from any *active plan to improve physical function*?

My sense is that we could do a lot better. We need to identify how to take up this challenge, so that the services of the future have a much stronger focus on restorative goals.

Beyond discharge planning

This government has put a great deal of effort into improving continuity between hospital discharge planning and the prompt supply of home care.

Equally important, and perhaps more challenging, is the task of ensuring that the supply of the traditional home-care services is *not* seen as an end in itself.

Conceptually, we need an integration between home-care services and clinical services with a focus on the maintenance of a reasonable level of physical activity and the restoration of physical and mental function.

Rehabilitation is generally regarded as a medical specialty—a post-acute or sub-acute service that follows a hospital episode for fractured femur, or heart disease, or stroke. Conceptually, there is a gulf between this kind of clinical management and the parallel supply of basic home care services.

But thousands of elderly people are at risk of becoming gradually less active, less mobile, and more dependent—even in the absence of a major setback such as hospitalisation for a bad fall.

Others, having suffered such a setback, may have been successfully referred to rehabilitation in a community health centre, but have dropped out prematurely—perhaps (ironically) because of difficulties in travelling to and from the centre.

'Support and maintenance' is not enough

Supplying home help and meals on wheels indefinitely is not the whole answer to this problem, even though there will continue to be a place for this model of service. An aged and community care system that cannot address these problems systematically is both costly and ineffective.

We have recently finalised a major review of HACC food services (meals on wheels). The reviewer found that there is no evidence that the model of service has been meeting its twin objectives of managing nutritional risk and maintaining social connectedness.

Yet the review also demonstrated a huge *capacity for creativity* on the part of many HACC managers. Their innovations need more widespread dissemination and systemic support.

A similar investigation of home help services might come to similar conclusions. There may be exciting opportunities to convert a passive model of home help into an active model of assisting a sizeable proportion of clients to get active again.

The redevelopment of Victoria's 'day hospitals' in the early 1990s is a good case study in what can be done. Day hospitals had in many cases become mere annexes for respite care. So they were put through a systematic process of redevelopment, to ensure that each such service was offering a personalised care plan of rehabilitation to their patients. The facilities emerged from this process as Community Rehabilitation Centres, essential components of Victoria's system of sub-acute care for older people.

Capitalising on the reach of community care

We need to capitalise on the fact that HACC agencies are in weekly contact with at least 140,000 older Victorians. According to the data, HACC services are now reaching more than half of all Victorians aged over 75 who live alone. So the current service system is already in touch with the most at-risk people in the target population.

Exactly what proportion of frail older people could benefit from a genuinely 'restorative' model of intervention is not known. It would be absurd to make exaggerated claims. However, no one can doubt that there is great scope for experimentation and innovation here.

At the very least, the task for government and HACC service providers is to ensure that the present system is not an impediment to change.

Balancing accountability and innovation

We need to review how current service approaches can be modified to more actively support improvements in people's capacities.

We also need an honest scrutiny of the funding models and accountability requirements imposed by governments themselves. Proper accountability for the expenditure of public funds is clearly an essential requirement of good governance. Forward planning and quantifiable target-setting is also essential.

In thinking about reforms to the community care system, we must take the opportunity to reconsider—and if necessary redesign—the current methods of target-setting and accountability. We also need to revalue some aspects of service delivery that have fallen by the wayside, such as the importance of the relationships between clients and those delivering care. If we find that existing arrangements are contributing to rigidities in the system, or if they make innovation harder to implement, then they must be overhauled.

Conclusion

The Community Care Coalition and the current MAV campaigns have correctly spotlighted the central role of community care, now and in the future.

The next 12 months will see considerable activity in the improvement of home and community care in Victoria. One focus for this will be the renegotiation of Victoria's HACC Agreement with the Australian Government.

This will be an opportunity for both levels of government to collaborate with the innovators in the home and community care field, and shape an aged and community care system that is fit for the demands of the future generation of older people.

I have sketched out some of my views. Now I want to hear your ideas and your perspective on what is being proposed by the Australian Government and the Victorian Government.

Victoria's Departmental Advisory Committee for HACC would be very pleased to receive any submissions that individuals or agencies may wish to put on these questions of system redesign and the future directions of community care.

Thank you.