

Future directions in the HACC Program in Victoria

Speech by Jeannine Jacobson, Manager, HACC and Assessment, DHS Victoria, at the Ministerial launch of Priorities & Future Directions for the HACC Program in Victoria, 11 April 2006

The HACC Program has had a long and honourable history in Victoria.

It is the history of a simple but radical notion: bringing support services to people in their own homes, in order to keep them independent, rather than waiting for the person's situation to deteriorate and lead to admission to hospital or residential care.

It all started sixty years ago with a few innovative local councils and organisations like the RDNS. In fact, Meals on Wheels and Home Nursing are still core services in the HACC Program (although cars have replaced nurses on bicycles).

Today's launch marks a significant milestone in this history.

In a moment Minister Jennings will be making some official announcements about five service development projects.

My task is to sketch out the emerging policy landscape behind all this.

Our figures show that more than 220,000 Victorians are now receiving one or more services from the Program every year, with funding of over \$410 million.

So HACC and other types of community care are large and popular programs.

As average life expectancy rises, it is inevitable that total *demand* for this kind of service will rise. It is often assumed that this means an inevitable rise in the number of people with high levels of functional disability.

The good news is that a growing body of evidence suggests that being physically active, having a nutritious diet and remaining mentally and socially engaged with friends, family and the broader community can reduce the impact on individuals of conditions associated with ageing.

For example, it is in this context that the Department's Aged Care Program introduced Well For Life.

The Well for Life initiative aims to improve nutrition and physical activity for frail older people through training staff in HACC-funded social support services and public-sector residential care services.

It brings together health promotion and opportunities for partnership between aged care and other parts of the primary care sector. To date, Well for Life has funded 48 projects across Victoria.

The evaluators found that it is a groundbreaking program that challenges existing systems, attitudes and practices with the aim of improving the health and well being of very frail older people in aged care settings.

This doesn't mean that the process of ageing can be cheated. It does mean that the impact of its effects may be moderated.

In terms of standard HACC services, the projected rise in the numbers of frail older people translates into a need for home care, personal care, and social support, among other things.

Given these strong trends in demand over the next 5 to 10 years, we are faced with the choice of:

- either continuing pretty much with the existing model,
- or finding new ways of doing things more effectively.

The Victorian department is keen to accept the challenge of innovation.

In fact, the challenge to the HACC Program was set out by Minister Jennings a year ago in a speech to VAHEC. It is the concept of the 'Active Service Model'. The basic idea is quite straight-forward, although the all-important details of program design are never simple.

The challenge is to collaborate with HACC service providers to enable them to move beyond a 'dependency' model to a 'restorative' and 'capacity-building' model.

By a *dependency model*, we mean the assumption that at a certain point older people become progressively less able to manage, and will inevitably need formal support services to take over the tasks of daily living. If you can't vacuum the house, a home care worker will come in and do it for you.

The emerging model is one that *challenges this assumption*.

It proposes a more *thorough assessment* of the scope for improving the older person's ability to manage at home, by considering all relevant factors, particularly the reasons *why* the person is experiencing difficulty in coping in their home environment.

More *creative solutions* can then be considered. With modern advances in rehabilitative techniques, ergonomic and labour-saving equipment, and occupational therapy, recent experience suggests that a great deal can be done to help people cope with functional disability.

Returning to Well for Life. These projects demonstrate what can be achieved if we take a positive approach to the way services are delivered for frail aged people in our community.

Pro-active plans to restore function have resulted in people being able to resume tasks that had become extremely difficult, like carrying the shopping, making beds and getting dressed. Regaining the ability to do these tasks has resulted in real improvements in people's quality of life.

Another major achievement of the Well for Life projects has been to change the way the staff involved in delivering these services view the capacity of older people to improve their functioning, and hold stereotypes of ageing and longevity. The benefits for clients of the Well for Life, and a number of other programs, are clear. We want to re-shape HACC services so that HACC clients feel the benefits of restorative care.

The Department does not have the detailed designs for a new community care service system in its top drawer. On the contrary, we believe that the surest way to proceed is to encourage a variety of ideas to be *tried out* by service providers and *evaluated*.

Grants have therefore been allocated to several different projects.

Some projects, for example, are using HACC Planned Activity Groups to concentrate on improving the nutrition and physical fitness of participants who have been assessed as likely to benefit from such interventions.

Instead of an agency running the PAG in isolation, physiotherapists or OTs may be brought in from the Community Health Centre to provide strength training.

The same clinicians can then monitor the person's progress towards better mobility around the home and the neighbourhood. Another idea is to enrol the HACC client in a walking group, or in a Tai Chi class. A loss of mobility is perhaps the most serious trigger to a loss of independence.

All of these new approaches depend on skilled assessment and the recruitment of workers from a range of disciplines to *collaborate in individual problem-solving* with the client.

In the kind of program that is emerging in Victoria, I believe that local government HACC services will become much more *connected* with community health centres, GPs and geriatricians than they have been.

They will also become more connected with *hospitals—as partners in continuing care*, not as mere outlets for patient discharge. Hospitals are not necessarily good places for older people, but to offer a *realistic* alternative requires the expertise of home-care agencies.

As you would be aware, Victoria is working with the Commonwealth in the *Community Care Reforms*. In fact, my observation over the last several months is that Victoria has been taking a *leading role* in proposing practical ways of improving the system.

Conclusion

Key features of the emerging system that we have been focussing on are:

- Allocation of resources according to the best demographic data on the *pattern of demand* across Victoria;
- Skilled *assessment* of individual need;
- Creating an infrastructure that enables agencies to *communicate* with each other more efficiently (e-referrals, HSD, etc.); and
- *Mobilising services* around the rehabilitative potential of the individual client (the ASM).

This is the context. Now let's hear from some of the practitioners who are making it happen.

Thank you.