

Home and Community Care (HACC) Program

Gippsland Regional Plan, 2003-06

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

December 2003



Glossary of terms

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

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Section 1 – HACC Regional Plan 2003-06

1.1. Context of the Regional Plan

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

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

1.2. Purpose of the Regional Plan

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

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

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

These are the subjects of the present Regional Plan.

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

1.3. Consultation with the sector

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

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

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

1.4. What is the HACC Program?

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

1.5. Characteristics of HACC service users in Victoria

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

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

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

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

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

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

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

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

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

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

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

1.6. Better planning & funds allocation

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

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

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

1. Focused Ministerial Priorities for HACC growth funds

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

2. Consistent three year planning

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

3. More diverse means of funds allocation

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

4. Automatic allocation of minor capital

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

5. More focussed research and development program

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

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

1.7. HACC budget

1.7.1. Service expansion - recurrent funding

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

1.7.1.1. Joint Commonwealth/State commitment

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

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

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

Note: Growth allocations include those for the HACC Response Service

1.7.1.2. Victoria's additional commitment

Redressing funds inequity between regions

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

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

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

Improving services for people from culturally and linguistically diverse backgrounds

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

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

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

1.7.2. Research & development

The intention is to allocate 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.

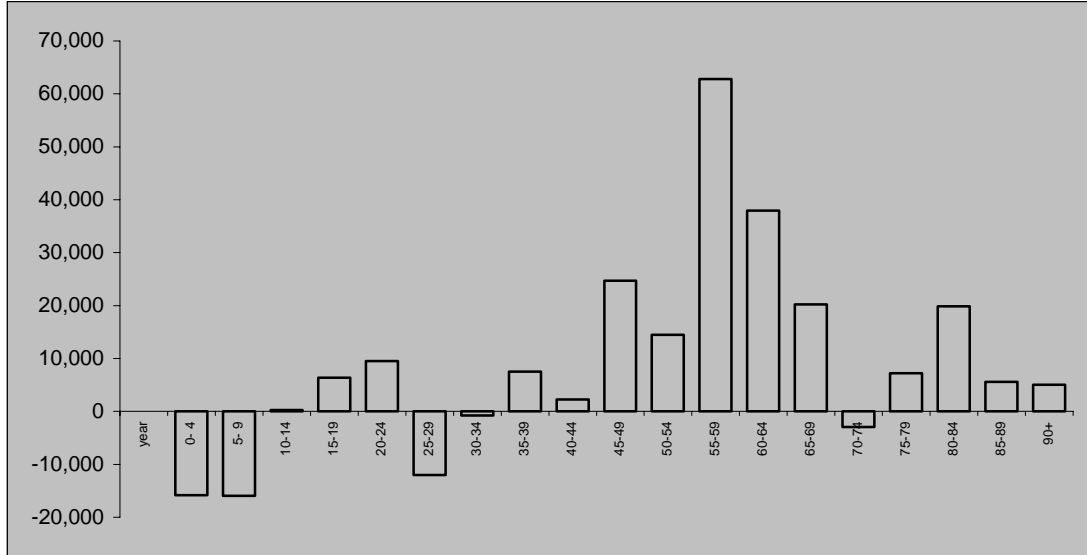


Figure 2.1: Changes in population groups 2001-06 Victoria
 Source: Department of Infrastructure *Victoria In Future*

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%.

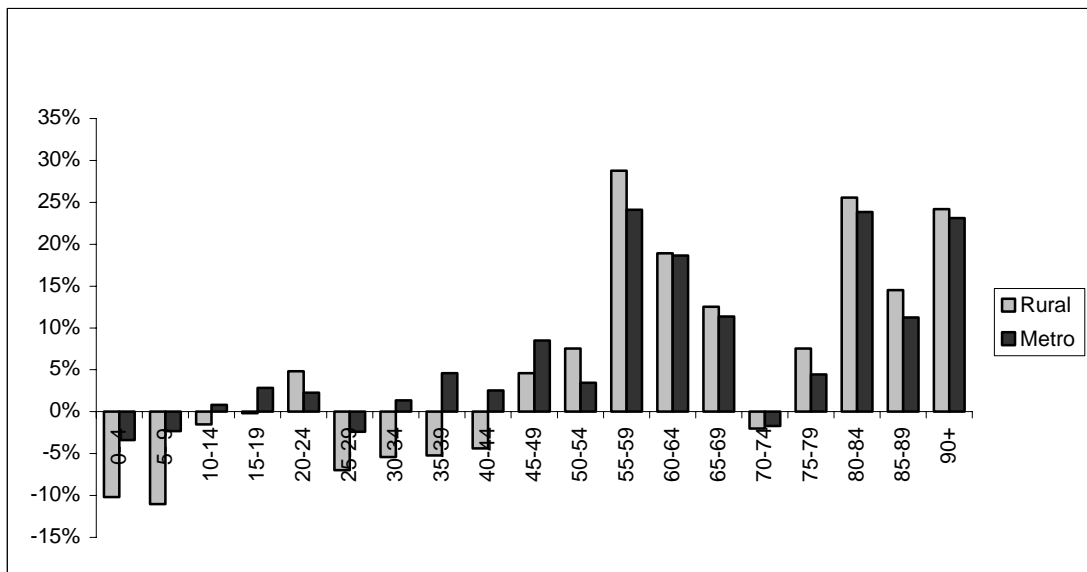


Figure 2.2: Comparison of population group changes: Rural and metropolitan regions
 Source: Department of Infrastructure *Victoria In Future*

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.

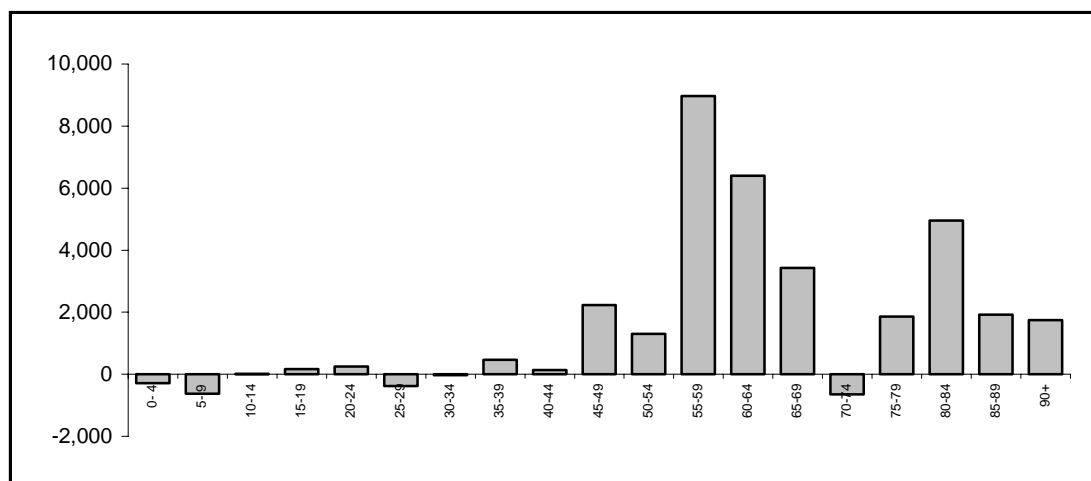


Figure 2.3: Changes in the estimated number of persons with a disability, 2001-06
Source: Department of Infrastructure *Victoria In Future* and 1998 ABS *Disability, Ageing and Carers Survey*

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.

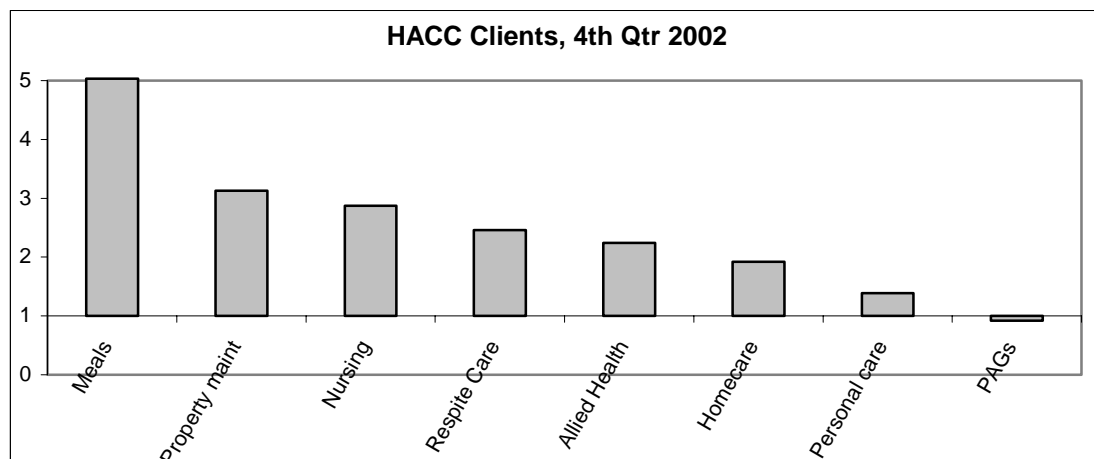


Figure 2.4: Ratio of rates of service provided to English/LOTE clients

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

In order 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, service supply and demand. This picture has been used to anticipate where the demand will be greatest between 2003-06 and 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 (HACC Minimum Data Set)
- Funding

The additional regional data included:

- Project register, Recurrent Rollover Funding per agency for 2003-04
- An adjustment to discount for non-HACC service delivery in Bush Nursing Centres in East Gippsland
- HACC Planning Surveys of HACC Providers in Gippsland
- Quarterly Output Collection data.

3.2. The Region's HACC sector

3.2.1. The Region's local government areas

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

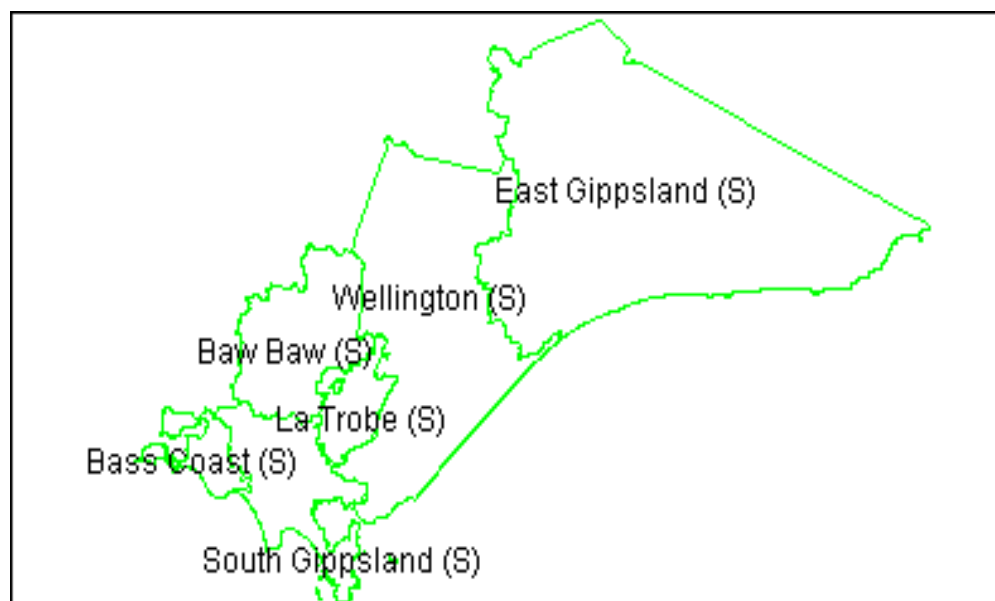


Figure 3.1: Local government areas in Region

3.2.2. The HACC sector

Within the six local government areas, DHS funds 38 HACC providers. HACC providers are a diverse group and include:

- 6 local governments
- 3 stand alone Community Health Centres
- 9 Hospitals (7 of which also have associated Community Health Centres)
- 5 Bush Nursing Centres
- 10 non-government agencies
- 2 CALD specific agencies
- 3 ATSI specific agencies of which one has responsibility for a statewide program.

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

The Region also provides funding (through Primary Health) to support the work of four Primary Care Partnerships (PCP). They are East Gippsland PCP, Central West PCP (Baw Baw and Latrobe Shires), South Coast Health Services Consortium (Bass Coast and South Gippsland Shires) and Wellington PCP. HACC providers are active participants of these alliances.

Many of the above 38 HACC funded agencies provide services via numerous outlying offices or sites in order to cover the expanse of the Region.

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.

Gippsland DHS regularly conducts partnership forums and attends the Regional Aboriginal HACC network, Multicultural network, Bush Nursing Centre network and mainstream network meetings. These are all mechanisms for consultation and provide a valuable forum to discuss issues impacting upon HACC service provision. At the recent annual review of HACC training in the Region it was agreed to establish a HACC Training Advisory Committee that will complement the existing training consultation and planning process. This will include a focus on workforce development issues for HACC services.

The Region also encourages agencies to raise issues and concerns at any time and frequently receives communication from agencies regarding policy and practice issues. These issues are then discussed at local, regional or statewide forums as appropriate. The Region is also invited to attend various meetings and forums that provide an opportunity for consultation and advice.

HACC agencies are provided with information midway through the financial year, in relation to service delivery progress against performance targets. This process provides agencies with an opportunity to address service performance issues via the Service Agreement Variation process. Feedback is also provided to agencies in relation to how they are progressing with their MDS data and provides an opportunity to problem solving emerging issues.

In general, agencies have demonstrated a positive approach to addressing performance and data issues and it is likely that this will result in a considerable improvement to the quality of MDS data.

Within the Region, agencies utilise a range of consumer feedback mechanisms. These include supporting HACC clients to understand their rights and responsibilities, undertaking annual consumer satisfaction surveys and program specific customer satisfaction surveys, sending out relevant information to HACC clients on an annual basis, undertaking phone surveys and surveys conducted post assessment to ensure the successful implementation of services upon referral to the service system.

In Gippsland, 100% of HACC agencies have completed training on the National Service Standards Instrument (NSSI) and are beginning an assessment appraisal in relation to the NSSI. The initial training was generally well received and agencies overall are positive about undertaking this process.

3.4. The planning context

3.4.1 Broad planning context

The development of the Regional Plan takes account of the fact that HACC operates and is influenced by the broader human services sector as well as initiatives within the HACC sector. Therefore in developing the Regional Plan, the impact of both the broader human services sector and other HACC planning projects have been considered.

The broader planning process for HACC has been influenced by the following emerging trends and priorities.

3.4.1.1 East Gippsland PCP

The East Gippsland PCP has identified the following priorities in 2002-03:

- Improving the health of the local Indigenous population. Critical to this is improving the way local Koori communities and the mainstream health services work together and to increase the capacity of the three Koori communities to identify and address their health needs
- Improving the health of older people in our communities: East Gippsland has a greater percentage of its population who are aged over 65 years when compared to the Victorian average. It is expected that this population will almost double over the next 20 years and will then make up about 34% of the population in East Gippsland
- Improving the health of elderly people in the community via PCP sponsorship of projects. These projects focus on improving the planning and delivery of services to older people in remote communities and older people with chronic illness and strategies to support the prevention of falls
- Coordinating and supporting agencies to implement the initial needs identification tool (now called the *Service Coordination Tool Templates (SCoTT)* which is part of the PCP's Service Co-ordination initiative). This initiative will improve integrated care for all clients receiving primary care services across PCPs by streamlining management of client information and referral.

Through the service mapping project the East Gippsland PCP has identified in general:

- A lack of access to mental health services
- A lack of General Practitioners (GP) in rural and remote townships
- That this catchment has one of the lowest population densities in Victoria. Therefore travel and distance issues restrict access to specialist services, while time and cost issues impact on all aspects of service delivery
- Social isolation is a key issue. More than 30% of elderly people in East Gippsland live on their own
- East Gippsland has a relatively high number of people receiving the aged pension (13% of all residents in 2000).

3.4.1.2 Central West PCP

The Central West PCP covers the Baw Baw and Latrobe Shires and has identified the following trends:

- In Baw Baw, the percentage of people aged 65 years and over will increase from 13.3% (n=4,786) of the population in 2001 to 16.5% (n=6,243) by 2010
- In Latrobe, the percentage of people aged 65 years and over will increase from 13.0% (n=9,189) of the population in 2001 to 16.6% (n=11,747) by 2010
- The management of diabetes as a major issue in this catchment as indicated by the recent Ambulatory Care Sensitive Conditions Study. The study found that admission rates for diabetes complications occurs in the Central West Gippsland PCP catchment at a rate ratio that is 2.5 times higher than the state. A total of 645 admissions for diabetes complications were recorded in the Central West Gippsland PCP catchment, representing an admission rate of 6.04 per 1000 persons
- That the average co-morbidity index do we know what this is or should it be explained, it has not been referred to before in Central West Gippsland was 3.27, the fourth highest in the State.

3.4.1.3 South Coast Health Services Consortium

The South Coast Health Services Consortium identified that the demand for aged and disabled services will increase substantially and that the community has a relatively high level of socio-economic disadvantage.

3.4.1.4 Wellington PCP

The Wellington PCP has highlighted:

- The high incidence of diabetes, respiratory disease, mental and behavioural disorders in Indigenous people (The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2001). Research indicates that type 2 diabetes tends to occur at younger ages in the Indigenous population compared to the non-Indigenous population and is associated with a lack of exercise and obesity. Diabetes is also associated with heart disease
- The lack of culturally appropriate services and programs for Indigenous people to access. The PCP will continue to work with Ramahyuck Aboriginal Cooperative to develop health screening, physical activity programs and information processes sensitive to the needs of Indigenous people.

3.4.1.5 Development of services for Aboriginal people

DHS Aboriginal Services Plan 2003

The Department of Human Services Aboriginal Services Plan 2003 is a statewide service framework. This document provides the foundation for redevelopment and improvement of service provision for Aboriginal people and identifies the changes required by the Department, mainstream and Aboriginal service providers.

Role of mainstream service providers

Mainstream providers in all regions are pivotal to the provision of successful services and improving the health and wellbeing of Aboriginal people. Mainstream services have a key role in providing access to appropriate services and to achieve this must acknowledge, respect and understand Aboriginal history, culture, and traditions.

The following considerations will assist DHS and mainstream agencies to review their service delivery to Aboriginal people and to develop strategies to improve the appropriateness and accessibility of the services:

- Participation by Aboriginal people and communities in determining their human service priorities
- A culturally competent workforce that understands Aboriginal history, traditions and contemporary issues
- Increased Aboriginal employment within the health, housing and community services sectors
- Formal protocols with local Aboriginal communities with regular review and updating will assist in the delivery of culturally appropriate services
- Undertaking, as part of the annual planning process, a cultural competence audit that focuses on both client services and organizational management processes
- Service providers must establish internal targets, performance indicators and mechanisms for monitoring and evaluation if service delivery for Aboriginal people is to improve.

3.4.2 Regional HACC planning context

The Gippsland Region has a history of considerable consultation with HACC agencies and this has been positive for the development of a partnership approach. The importance of consultation has significantly influenced the current planning process with-in the Region. This year the Region surveyed HACC agencies in order to ascertain agencies' views about the key factors and themes impacting upon service delivery and to identify priorities for service development. The survey form reinforced the Ministerial Priorities for the 2003-06 triennium. 63% of agencies responded to the survey and identified the following themes or factors likely to influence the type of service delivery or level of demand across the Region:

- Significant growth in the ageing population
- More complex and frail clients being managed at home
- Earlier discharge from acute care settings
- Consumer awareness and demand for specialised services
- Limited alternative services to meet the same needs
- Increased waiting lists and delays for assessment and for specific HACC services
- Increase in the number of clients with dementia
- Unemployment and economic issues impacting upon the health status of clients
- Limited availability of CACPS packages and the low level of funds for CACPS packages is increasing the demand on HACC services
- Increase in the number of people who are retiring to the coastal areas of Gippsland
- The Aboriginal population in East Gippsland is four times higher than the state average
- The ageing population requires higher levels of Allied Health, for both the diagnosed conditions and to prevent any further deterioration of health (i.e. falls, diabetes, osteoporosis, cardiovascular disease)
- Lack of transport options is a significant issue in rural areas
- Recruitment of Allied Health staff (particularly podiatrists) has been problematic across the Region and will require collaboration between agencies and the department to achieve better outcomes for the Region as a whole.

HACC training and workforce development

There are some areas within the Region where service providers currently have staff that do not have the minimum standards of qualification. This is likely to influence service delivery and development in the Region. It is intended that this will be addressed over the coming years. The Gippsland HACC Training Advisory Committee will consider workforce development issues such as this and the HACC Training Coordinator will assist agencies in this regard. Strategies will include promotion of traineeships and where necessary advocacy to the Vocational Education and Training System.

The aim is for at least 95% of the Gippsland HACC workforce to have obtained these qualification standards by January 2007. There are some barriers in remote rural areas where staff may have limited work opportunities and the Gippsland HACC Training Advisory Committee will consider ways of addressing these barriers.

3.5. Data

3.5.1. Population

The data in this 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 need for HACC services across the nine regions in Victoria. The RREF is then used to allocate the growth funds between the regions.

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

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

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

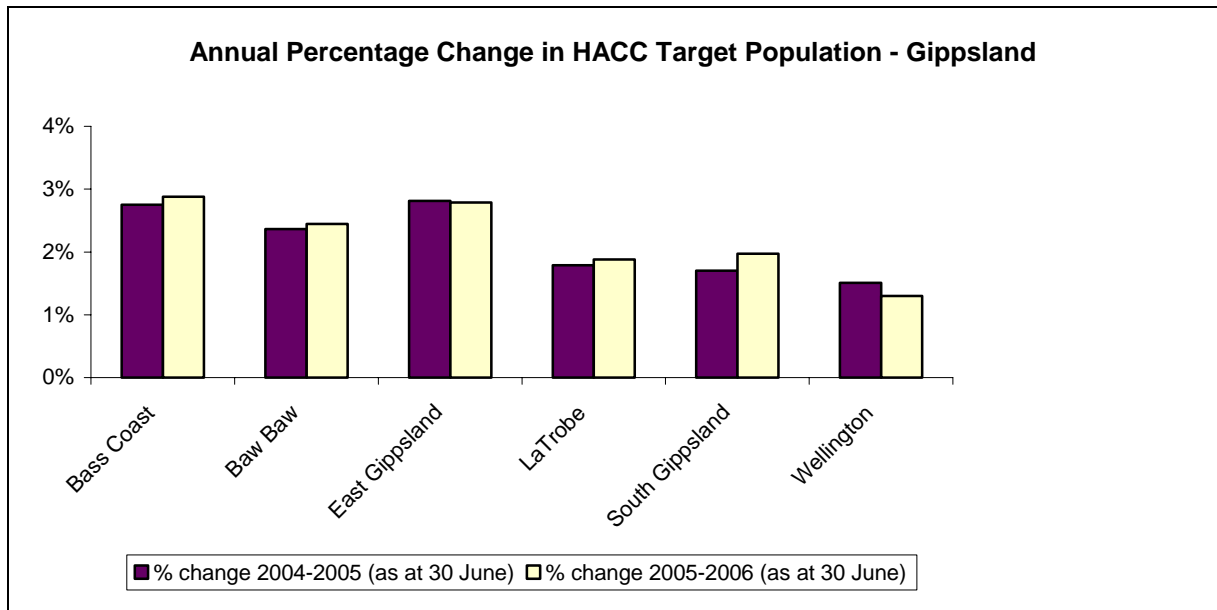
LGA	2003-2004		2004-2005		2005-2006	
	N	% 70+	N	% 70+	N	% 70+
Bass Coast	5,685	68.6	5,842	68.7	6,010	68.9
Baw Baw	5,582	59.8	5,714	60.0	5,853	60.4
East Gippsland	8,141	64.4	8,370	64.8	8,603	65.2
LaTrobe	11,385	60.7	11,589	61.0	11,807	61.4
South Gippsland	4,534	63.8	4,611	64.1	4,702	64.5
Wellington	6,660	60.7	6,760	60.9	6,848	61.1
Total	41,987		42,886		43,823	

*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 30 June each year. This is important in being able to identify where pressure on HACC services might be likely to ease or intensify over time.

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

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



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

3.5.1.2. Special needs populations

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

Data about people from 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

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.

Table 3.2: 2001 Census: Top 10 Languages Spoken at Home by People Aged 65+ in Victoria (by place of usual residence)

Language	Bass Coast	Baw Baw	E. Gippsland	Latrobe	South Gippsland	Wellington	Total
English	4,810	4,169	6,563	6,702	3,511	4,973	30,728
Italian	142	105	112	352	119	45	875
German	49	39	67	192	46	44	437
Dutch	48	64	43	174	60	34	423
Polish	8	26	6	105	6	36	187
Maltese	6	-	15	129	-	3	153
Greek	9	9	15	81	9	3	126
Ukrainian	6	3	3	55	-	9	86
Croatian	6	3	-	34	-	3	46
Hungarian	-	3	3	19	3	6	34
Other	453	349	401	791	282	456	2,732
Total	5,537	4,780	7,228	8,634	4,036	5,612	35,827

Source: ABS 2001 Census.

CALD settlement patterns in Gippsland

Gippsland and particularly the Latrobe Valley has had many migrants settle in the area from the wave of migrants that came after the war in the period from 1947 to 1952. A large number of this group came from the Displaced Person camps of Western Europe and chose Gippsland due to the availability of work. Migrants who came to the area from Italy and Greece came later and over a longer period that lasted well into the 1960's.

As a consequence of this pattern of migrant settlement there has been a substantial increase in the CALD aged population in Gippsland over recent years. An even more dramatic rise is forecast over the next ten years because many of these migrants are now reaching the age of 80 years, an age at which a marked increase in the use of community, health and aged care services can be expected.

Current trends and issues in CALD service provision

According to the 2001 Census shown in Table 3.2 above there are 5093 CALD residents aged 65 years or more in Gippsland. The largest CALD 65 plus population, 1932, is situated in Latrobe City and represents 5.4 % of the over 65 population in the Region. However this group represents 22.4% of the over 65 population in the Latrobe City and therefore is a significant population. Whilst other local government areas have a smaller aged CALD population, approximately half that in Latrobe, they still represent a large proportion of the regional HACC target population. For instance this group represents 13% of HACC Target Population in the Bass Coast, Baw Baw and South Gippsland Shires, 9% in East Gippsland and 11.5% in Wellington.

It is well documented that HACC services are not utilised equitably by the CALD communities when compared with the broader HACC population. Whilst this may be due to cultural reasons, such as preferring that family members provide these services, there are also other reasons. These include a lack of culturally appropriate service provision, people from CALD backgrounds lacking the knowledge of the type of services available and lacking knowledge of how to access these services.

In addition to the normal issues associated with advancing age, this group of people is also experiencing numerous difficulties resulting from having settled in a community with different language and cultural expectations. As the CALD population ages they face a range of social and emotional issues which may impact upon their health:

- Some may lose their ability to speak English or understand English and revert to their primary language
- The death of a partner or spouse
- Separation from their children as they move away for work or education
- Inappropriate expectations placed on their children in the provision of care/support
- Reduction of their support networks due to the death or health deterioration of others in their social group.

HACC service provision for CALD

There are two primary CALD services in Gippsland, the Gippsland Migrant Resource Centre (GMRC) and the Korumburra Italian Senior Citizens Centre. The Gippsland Migrant Resource Centre (GMRC) is centrally located in Morwell and also has an office in Sale. It provides services to these local populations and across the Region, while the Italian Senior Citizens Centre, based in Korumburra, caters for seniors in the surrounding area.

While the respective constituents of these agencies are well catered for, the agencies only provide limited HACC services. This and the fact that the CALD population is dispersed across the Region means that it is not possible for them to cater for the whole CALD aged population. It is therefore essential that mainstream providers increase and maintain a keen focus on how they can engage and respond to the health needs of the aged CALD population.

Over the last two years 100% of HACC funded agencies that are required to complete a HACC cultural plan have done so. The GMRC currently provides the Ethnic Services Development Program and is assisting and supporting agencies to review and complete their HACC cultural plans. The aim is for all HACC agencies to have completed and or reviewed their HACC cultural plan by January 2004. The assistance provided by GMRC includes cultural awareness training to agency staff and education in relation to the language services available to the CALD population and service providers. The aim is to increase the use of language services which to date have been under utilised.

Overall the focus upon the HACC CALD population is increasing and agencies appear to be developing an awareness of the need to change their practices to cater for this group. To assist with this, cultural awareness training was provided by Action on Disabilities for Ethnic Communities (ADEC) to staff in east Gippsland and further training is planned for the coming year.

In addition to the work currently being undertaken by agencies across the Region, it is considered necessary to undertake strategies to educate and inform CALD residents in Gippsland regarding HACC services. This local initiative will link in with the statewide CALD communication strategy and will need to be developed in partnership between mainstream, CALD agencies and relevant agencies across the PCP alliances. The aim of this strategy will be to increase the number of CALD residents who utilise mainstream HACC services.

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

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

Table 3.2: Experimental estimates of total Indigenous population

LGA	0-49	50-69	70+	Total
Bass Coast	130	16	8	154
Baw Baw	276	33	7	316
East Gippsland	1,016	107	15	1,138
Latrobe	770	65	13	848
South Gippsland	127	23	2	152
Wellington	318	38	8	364
Total	2,637	282	53	2,972

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.

HACC service provision for Indigenous people in Gippsland

The 2001 ATSI refined estimates detailed in Table 3.2 indicated that there is a total of 335 ATSI people aged 50+ in Gippsland. The largest ATSI population of 36% (122 people) is in East Gippsland followed by Latrobe with 23% (78 people) of the Indigenous population. Therefore 60% (200 people) of the total Indigenous HACC population reside in these two shires. Alternatively, Bass Coast has 7.2%, Baw Baw 12%, South Gippsland 7.5% and Wellington 13.7% of the ATSI HACC Population.

There are three HACC funded Indigenous agencies in Gippsland, Lake Tyers Aboriginal Health and Community Services Association, Ramahyuck Aboriginal Cooperative and Gippsland and East Gippsland Aboriginal Cooperative (GEGAC). Ramahyuck is based in the Wellington Shire and is funded to provide a statewide support to the Victorian Indigenous Aged Care and Disability (VICACD) Committee. The other two are located in East Gippsland, with Lake Tyers servicing the local community and GEGAC funded to service the local community and the Region as a whole.

Over the past 12 months the Koori Regional Development Officer has made good progress in terms of arranging training of HACC staff for Certificate III in Community Services and data management.

Over the last year there has been an increase in the identified need for HACC services in the Baw Baw Shire and Latrobe City with an estimated 60 assessments required in Latrobe over the coming year. GEGAC has increased the level of service provided to these areas over the last year however given the distance it is clearly an inefficient use of the existing resources and is placing some pressure on the Assessment and Care Management service in particular.

It is important to note that 50% (approximately 167 people) of the Indigenous HACC population reside in the Latrobe, Baw Baw, Bass Coast and South Gippsland Shires. Therefore 50% of the service provision should be provided within these Shires and the other 50% between East Gippsland and Wellington Shires.

At present the primary service provider for the Region is Gippsland and East Gippsland Aboriginal Cooperative, which is based in Bairnsdale. Given the distance barriers (128 km from Bairnsdale to Morwell and 222km from Bairnsdale to Wonthaggi) it is not an efficient use of valuable resources and is likely to result in a reduced level of service to the outer-lying areas. The benefits of local service provision can be measured by a more efficient use of resources and having a local presence is likely to enhance promotion of the service and therefore increase the use of HACC services by the Indigenous population across the Region.

3.5.2. Funding

To complete the picture of the Region, the proportion of the existing HACC recurrent funding has been compared to the proportion of the HACC target population by local government area (see columns 4 and 5 in Table 3.3). The comparison provides a picture of relative HACC funds equity 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: HACC funding by local government area, 2003-04

LGA	2003-04				
	Recurrent \$ (000)	Current \$ per capita	% of recurrent budget (actual)	WREN %	Growth \$ (\$000) via WREN
Bass Coast	2,138	376	11.2	13.5%	87
Baw Baw	2,300	412	13.4	13.3%	86
East Gippsland	4,347	534	22.4	19.4%	125
LaTrobe	4,839	425	25.1	27.1%	175
South Gippsland	2,403	530	12.2	10.8%	70
Wellington	2,870	431	15.7	15.9%	102
Total	18,897	451	100.0	100.0%	645

Note: The dollars for each LGA exclude statewide funds. Statewide funding will be incorporated into the Regional Plan for 2004-06 when the Plan is adjusted for 2004-05.

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 recommendations about the application of growth funds for equalisation across local government areas.

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

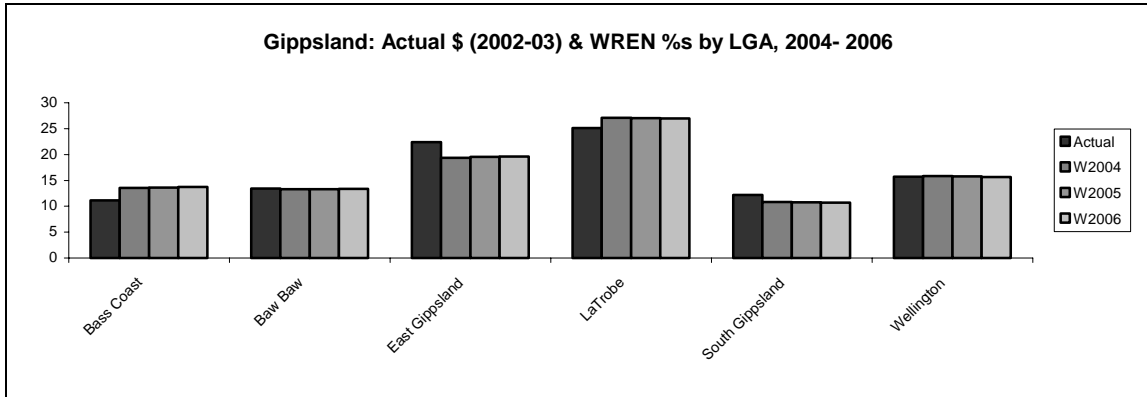


Figure 3.10: Proportion of actual recurrent budget (30 June 2003) and WREN population proportions 2003-06 by local government area

Section 4 - What do the data tell us?

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

4.1. Data analysis

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

4.1.1 General

The HACC target population is expected to grow in all local government areas between 1.5% and 3% per year for the next three years. The East Gippsland, Bass Coast and Baw Baw shires are expected to see the highest level of growth in the HACC population during this period of around 2.5% to 3.0% as indicated in Figure 3.2.

In recommending allocations for growth funding in each local government area, the Region took account of the above population data and the analysis of the existing HACC only funding (see Section 5). This data clearly shows that Bass Coast is the top priority for growth funding in comparison with all other local government areas, whilst South and East Gippsland are the lowest priorities for growth funding.

In recommending allocations for growth funding for HACC activities in each local government area, the Region considered the total activity funding per head of WREN population by local government area, the MDS figures which show the per capita service provision of 'Priority 1' activities by local government area (see Section 5.3), and a comparison of Quarterly Output Collection Data.

This data shows that:

- Nursing is a priority in Baw Baw, Latrobe, Wellington and to a lesser extent Bass Coast
- Personal Care is a priority in Baw Baw and Latrobe and to a lesser extent Bass Coast
- Assessment and Care Management funding is relatively evenly spread across the local government areas and East Gippsland, Latrobe and South Gippsland are the highest priorities
- Allied Health is clearly the standout top priority in East Gippsland and to a lesser extent in Bass Coast
- Home Care is a priority in Bass Coast, Wellington and Latrobe
- Delivered Meals are a priority in Baw Baw, East Gippsland, Latrobe and South Gippsland
- Property Maintenance is a priority in Bass Coast, East Gippsland, Latrobe and South Gippsland.

4.1.2 Data analysis regarding CALD

The CALD HACC population represents 22.4% of the HACC population in Latrobe Shire and therefore is a significant group. The CALD population in other shires is between 9% and 13% of the HACC target group and although widely dispersed makes up a reasonable proportion.

Considering the dispersed nature of the CALD population across the Region, it is essential to develop service provision through mainstream services. This is in line with current service development goals and structures and is being addressed via cultural awareness training and cultural planning.

4.1.3 Data analysis regarding ATSI

50% of the Indigenous HACC target population reside in Latrobe, Baw Baw, Bass Coast and South Gippsland Shires and are between 90 and 150 minutes drive from Bairnsdale where the primary Indigenous agency is situated in the Region. Given the barriers of distance it is considered essential to develop local service provision to the Indigenous Community through mainstream and/or Indigenous specific service providers across these local government areas.

Future development of Indigenous HACC services

Given the current issues identified in Section 3, there is a need to focus the future development of Indigenous HACC service delivery towards the following aims:

- To increase the use of HACC services by Aboriginal people
- To develop appropriate partnerships between mainstream providers and the local Indigenous community
- To implement workforce development strategies and increase the number of Aboriginal people working in the community care sector via the use of traineeships or similar mechanisms.

DHS recommends that these aims can be achieved by the creation of an Aboriginal HACC Liaison/Assessment position. This position would work with mainstream and Aboriginal providers and Aboriginal people across the Shires of Bass Coast, Baw Baw, South Gippsland and Latrobe. This position would work in conjunction with and complement the role of the Koori Regional Development Officer (KRDO).

The KRDO position aims:

- To improve the quality of mainstream services by the provision of cultural awareness training to agency staff and raise issues regarding access or quality of service
- To promote and facilitate the use of mainstream HACC services by Aboriginal people.

The regional directions in HACC are consistent with the objectives of the Statewide and Regional Aboriginal Service Plans. In addition, it would appear that local service provision can be easily and efficiently achieved through the development of a partnership between mainstream and Aboriginal service providers. There are currently no locally based Aboriginal HACC Services in Baw Baw, Bass Coast, Latrobe or South Gippsland and the establishment of an Aboriginal HACC Liaison/Assessment position is likely to provide major long term benefits to the community.

4.2. Conclusion

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

Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
1	Increase funding to HACC Training	2004 to 2006	<ul style="list-style-type: none"> Increase use of traineeships and use of Vocational Education and HACC Training 	Increase standard of HACC services and the qualifications held by HACC staff
		2003	<ul style="list-style-type: none"> Re-establish HACC Training Advisory Committee 	As above and address workforce development issues
1	Utilise a funds equalisation process	2003 to 2006	<ul style="list-style-type: none"> Reduce growth funding to local government areas with high levels of comparative funding and provide an increase in funding to local government areas with low funding levels. 	To achieve reasonable equalisation of size and type of HACC service provision across Region
1	Project to investigate efficient vehicle change over	2004	<ul style="list-style-type: none"> Investigate most efficient means of vehicle changeover Investigate partnership or other options for vehicle use that will increase level of transport to and service provision to HACC clients 	Reduce the cost of vehicle change over upon HACC funds Reduce cost to agencies of PAG vehicles and increase amount of HACC transport to clients.
1	Increase HACC Response Service across Region	2003 to 2006	<ul style="list-style-type: none"> Increase is proportional to reallocation of Personal Alert Victoria (PAV) units (funded by Aged Care) 	Increased client independence. Increased monitoring and service provision to vulnerable clients across Region.
2	Increase awareness of HACC mainstream services	2004	<ul style="list-style-type: none"> Pilot project, targeted communication strategy to inform and educate CALD population regarding HACC services. 	Increase the quantity and quality of HACC services being delivered to CALD population by mainstream services.
2	Increase awareness of Language services	2004	<ul style="list-style-type: none"> GMRC continues to promote language services to mainstream service providers 	Increase use of language services by mainstream services and CALD population.
2	Project to review outcomes of cultural planning	2004	<ul style="list-style-type: none"> Ascertain the impact of cultural planning upon service standards & level of delivery to CALD population across the Region 	Increase the quantity and quality of HACC services being used by CALD population
2	Promote CALD Ageing with PCP's	2003 ongoing	<ul style="list-style-type: none"> HACC agencies to canvas the needs of the CALD ageing population with PCP's 	PCP's recognise CALD Ageing population as a priority for Health Promotion activities
3	Fund a Koori HACC Liaison Position	2004 to 2006	<ul style="list-style-type: none"> To develop partnerships between mainstream providers and the Indigenous community, increase cultural awareness and promote HACC mainstream services. 	Increase the quantity and quality of HACC services to the Indigenous HACC population via Mainstream & Koori Specific Services

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 DHS' recommendations to address the Ministerial Priorities 2003-06 and to implement the *Better Planning and Funds Allocation* processes.

Broadly speaking, the recommendations address the following questions:

- 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 proposed 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,b,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 have been 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.

It will be noted in Table 5.1.a Recommended Growth Allocation that there is no allocation for Priority 2, in 2003-04. At present there appears to be clear acknowledgement by HACC agencies of priority for services to the CALD population given that 100% have completed a Cultural Plan. However the Region wishes to undertake a study of the impact of the Cultural Plans on the quality and quantity of HACC services. A project to consider this and the future development of service provision to the CALD population will be undertaken, the outcome of which will inform the directions for the out years. A notional allocation of \$15,000 has been made in the out years as shown in Tables 5.1.b and 5.1.c and will be used to implement the recommendations of the study.

Gippsland 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, 2003-2004

2003-04	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Bass Coast	\$ 112,452	\$ -	\$ 7,000
Baw Baw	\$ 71,239	\$ -	\$ 12,000
East Gippsland	\$ 114,687	\$ -	\$ 7,500
LaTrobe	\$ 145,312	\$ -	\$ 23,500
South Gippsland	\$ 33,456	\$ -	\$ 7,500
Wellington	\$ 93,041	\$ -	\$ 2,500
Region Wide	\$ 27,965	\$ -	\$ -
Total	\$ 598,152	\$ -	\$ 60,000

Table 5.1.b: Proposed 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
Bass Coast	\$ 135,521	\$ -	\$ -
Baw Baw	\$ 78,836	\$ -	\$ -
East Gippsland	\$ 92,391	\$ -	\$ -
LaTrobe	\$ 159,901	\$ -	\$ -
South Gippsland	\$ 31,815	\$ -	\$ -
Wellington	\$ 93,277	\$ -	\$ -
Region Wide	\$ 58,912	\$ 15,000	\$ 20,000
Total	\$ 650,652	\$ 15,000	\$ 20,000

Table 5.1.c: Proposed 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
Bass Coast	\$ 144,031	\$ -	\$ -
Baw Baw	\$ 83,618	\$ -	\$ -
East Gippsland	\$ 98,322	\$ -	\$ -
LaTrobe	\$ 168,667	\$ -	\$ -
South Gippsland	\$ 33,589	\$ -	\$ -
Wellington	\$ 97,829	\$ -	\$ -
Region Wide	\$ 60,809	\$ 15,000	\$ 20,000
Total	\$ 686,866	\$ 15,000	\$ 20,000

5.3. Priority 1

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

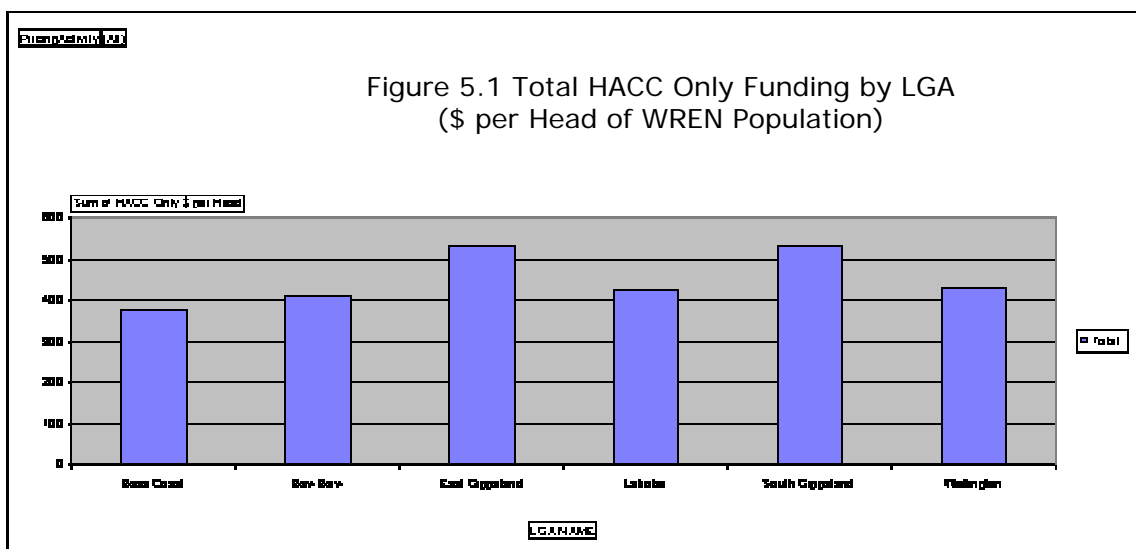
For Priority 1, the following questions are addressed, and recommendations made:

- 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 take (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 and Figure 5.1 below.

Figure 5.1 below shows that there is a marked difference in the level of funding that is currently provided to the six local government areas across the Region. For instance when comparing the total HACC only funding for 2003-04 per head of WREN population, East Gippsland has \$534 and South Gippsland \$530 while Bass Coast has \$376. Using the same comparison Baw Baw has \$412, Latrobe \$425 and Wellington \$431 all of these local government areas have considerably more funding than Bass Coast yet significantly less than East and South Gippsland.



NB. Service provision funding in figure 5.1 includes total funding to the BNC's

When analysing the funding across the Region it is important to consider the impact of service provision in remote rural areas and in particular the Bush Nursing Centres. It is important to note that when the HACC Program was formed in 1985, some services attracted a 'no growth' provision. For Bush Nursing Centres, this meant that a number of services became ineligible for growth funding under the HACC Agreement since they fell outside the scope of the HACC Program. Services provided by Bush Nursing Centres and outside the

scope of the HACC Program include primary care assessment and treatment, accident/trauma stabilisation, palliative care, post acute care, health promotion and services to people outside the HACC target population.

The findings of the *Bush Nursing Centres Project: Final report (2003)* suggest that an adjustment should be made in HACC planning and funds allocation decisions where there is a high concentration of Bush Nursing Centres. The report states that "33% of the Victorian HACC population is under the age of 70 years, however Bush Nursing Centres reported that 73% of people who use Bush Nursing Centres are under the age of 70 years. This suggests that a significant proportion of Bush Nursing Centres' clients are not in the HACC target population, that is, frail older people, younger people with a disability and their carers" (p 24).

In East Gippsland there is an unusual concentration of four Bush Nursing Centres. For planning purposes, the Region proposes to make an adjustment for the proportion of services that are deemed 'no growth'. This will mean that a more realistic comparison of HACC service provision between local government areas in the Region may be made when compared with the WREN Population per local government area.

The proposed adjustment for Bush Nursing Centres in East Gippsland is as follows:

Using BNC Final Report 2003 and the census data contained therein; assume all clients >70 years are within the HACC target population, using the local government area Disability estimate of 21% of East Gippsland population to determine the number of younger clients with a disability; thus a discount of 63% to the total BNC funding in East Gippsland.

When taking this adjustment into account the total HACC funding for East Gippsland divided by the WREN population for East Gippsland is \$489 which is still high in relation to Bass Coast yet considerably less than South Gippsland.

The difference in funding is very large when compared with the size of the annual growth funding for the Region. For example even if the total growth sum were allocated to Bass Coast, equalisation with South Gippsland would still not be achieved in one year alone. Therefore equalisation is likely to take many years to achieve if funds are only distributed according to the WREN formula and considering the expected growth in the Bass Coast area.

The regional office and service providers agree that the equalisation of HACC growth funds across Gippsland is a valid process. The Region recommends that 4% of growth funds be top sliced from the annual regional budget and applied to Bass Coast local government area for the 2003-04 financial year.

The regional office will revise and refine the equalisation methodology over the coming year and undertake modelling prior to the 2004-05 planning consultations.

In 2003-04 the Region adopted the following approach to equalisation and budget distribution:

2003 –04

- The Region will top slice (take off before distribution) funding for “small rural communities”, HACC Training, HACC Response, CALD and Koori priorities and 4% for an equalisation pool
- South Gippsland to receive 50% of the respective WREN allocation
- The funds equalisation pool be allocated to Bass Coast.

5.3.2. 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.

5.3.2.1. Analysis of HACC funding by activity by local government area

When considering funding across the Region by activity it is important to analyse not only the funding within HACC, but funding for the same or similar work through other funding streams such as community health and aged care. The following analysis has included data from other funding streams where relevant and realistic.

Figures 5.2-5.4 compare the level of funding in relation to nursing services for the Region per head of WREN population. Figure 5.2 displays the total nursing funding provided through community health, aged care and HACC funding streams or what may be described as community or district nursing. Figure 5.3 displays the Nursing provided by HACC funding only and Figure 5.4 displays the HACC and aged care funding. It is important to note that these graphs are for selected HACC activities and show only a limited picture of total HACC funds within the Region (for example, block funded activities [Service System Resourcing and Flexible Service Response] are not included and similarly unit priced activities which are not included in Priority 1 have been excluded from these graphs).

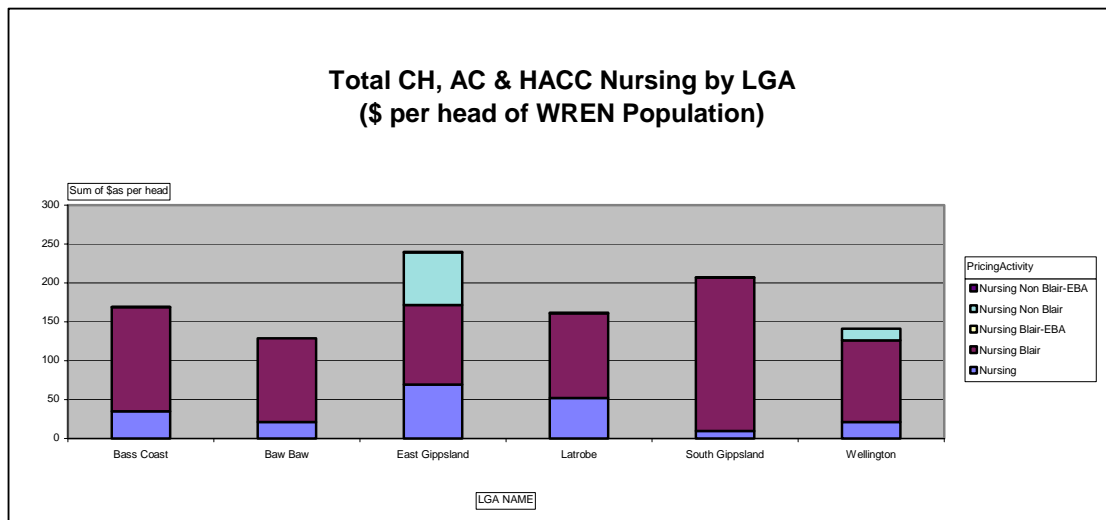


Figure 5.2. Total funding to nursing services per capita

NB. Service provision is slightly inflated in the figure 5.2 by the non-HACC services provided by the cluster of BNC's.

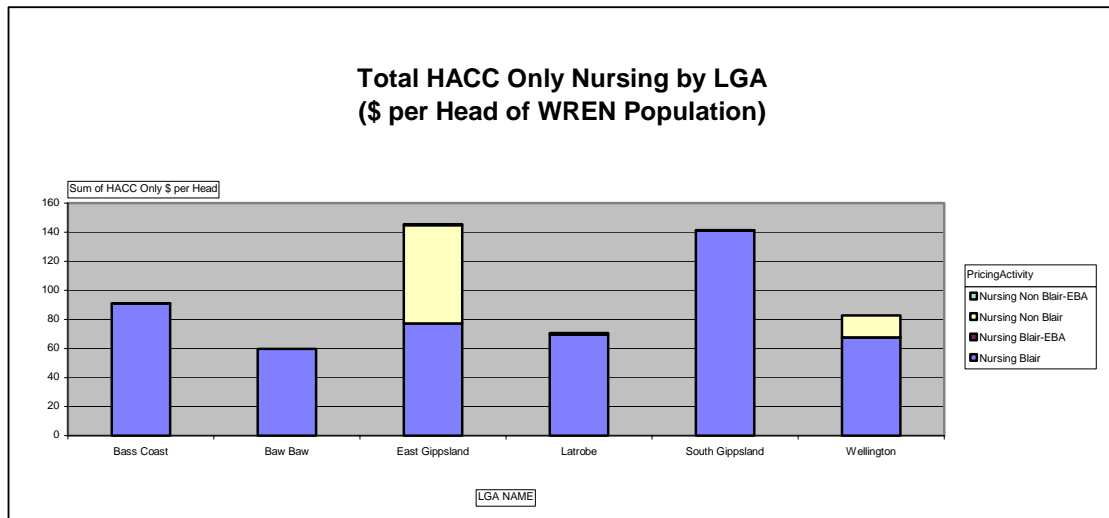


Figure 5.3. HACC Nursing funding per capita

NB. Service provision is slightly inflated in figure 5.3 by the non-HACC services provided by the cluster of BNC's.

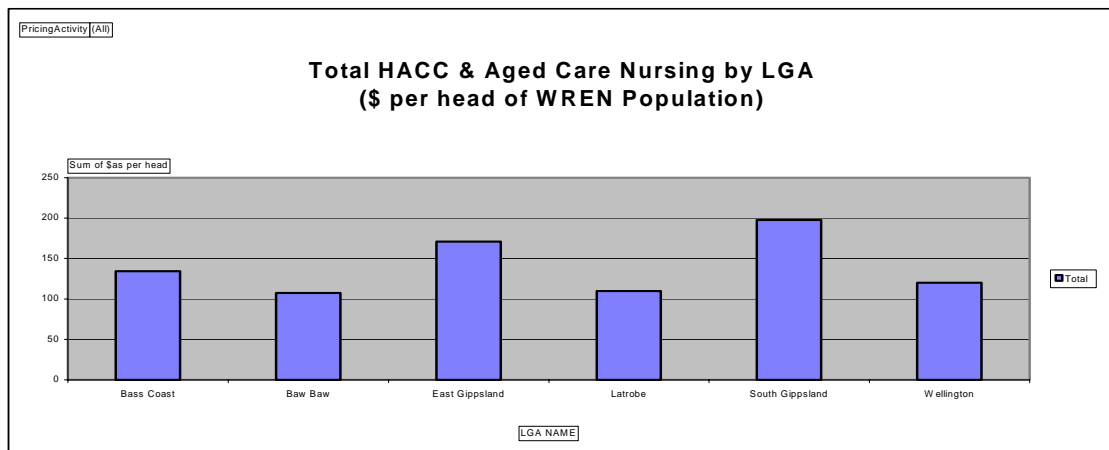


Figure 5.4. Total funding for HACC and aged care nursing services per capita

NB. Service provision is slightly inflated in figure 5.4 by the non-HACC services provided by the cluster of BNC's.

Considering the data, it is clear that East and South Gippsland are very well catered for in regard to nursing and have very high levels of funding through HACC and aged care funding streams in particular. Overall East Gippsland also has a very high level of nursing funding in comparison with other local government areas. However the Bush Nursing Centre funding is just under half of the total funding as shown in Figure 5.3 as indicated above this is somewhat inflated due to the cluster of BNC's in East Gippsland and provision of non-HACC services.

The three figures support the notion that Baw Baw, Latrobe and Wellington Shires are priorities for additional HACC Nursing funding. The figures also show that South Gippsland is the lowest priority for growth to HACC Nursing.

Figure 5.5. compares HACC Funding for Personal Care by local government area per head of WREN population.

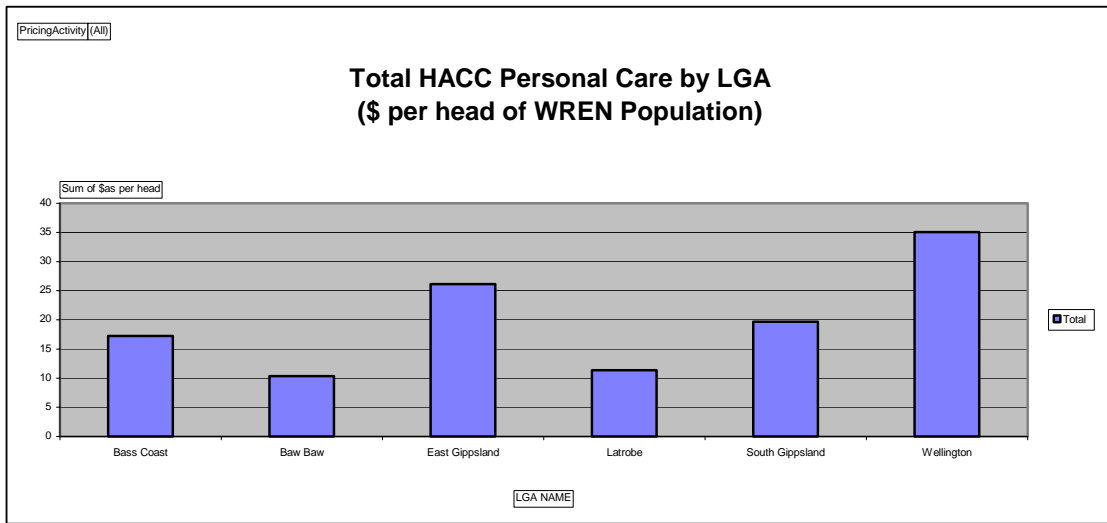


Figure 5.5. Personal Care funding per capita

The data shows that Wellington in particular has a very high level of funding for Personal Care in comparison to all other local government areas. Wellington has three times more funding for Personal Care than Baw Baw. Bass Coast and South Gippsland are both below the median level and thus should be considered for additional funding for this activity.

Figure 5.6 compares the HACC funding for Assessment and Care Management by local government area per head of WREN population.

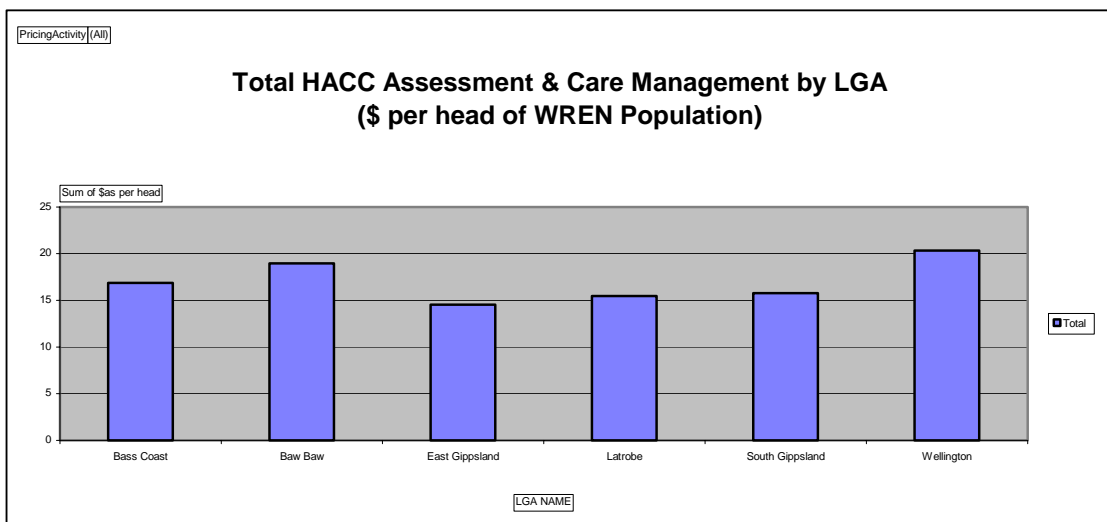


Figure 5.6 HACC Assessment and Care Management funding per capita

This data shows that each local government area has a similar level of funding for this activity with a range of approximately \$6 difference between Wellington (\$20.32) as the highest and East Gippsland (\$14.54) as the lowest funding level

per head of WREN Population. From this data Wellington and Baw Baw are the lowest priority and East Gippsland and Latrobe the highest priority for growth funding for this activity.

Figures 5.7 and 5.8. compare the allied health funding across the Region per WREN head of the HACC population. Figure 5.7 compares the total allied health funding provided by HACC and community health and Figure 5.8. compares HACC only Allied Health funds by local government area.

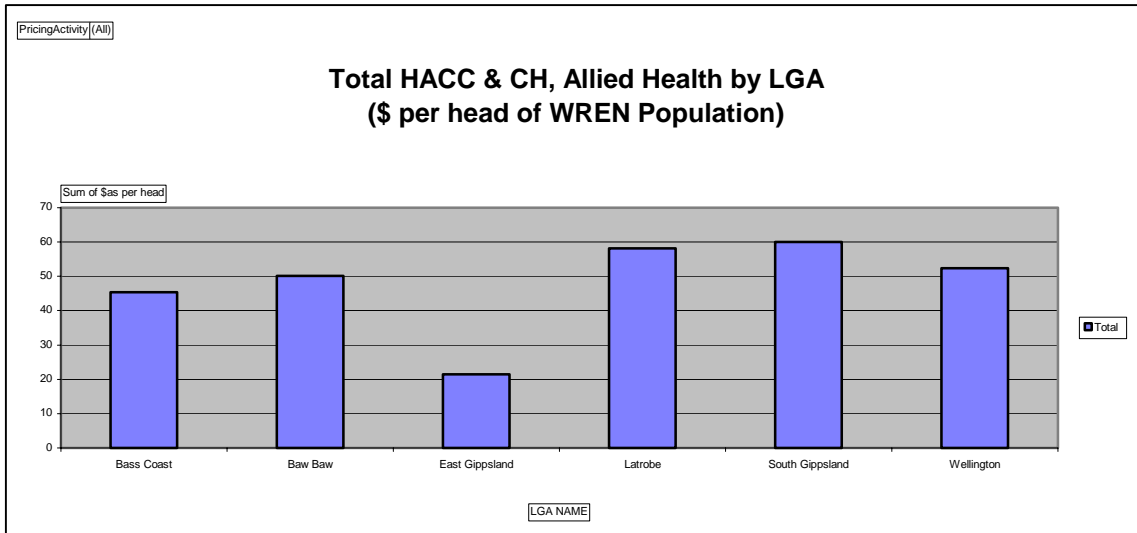


Figure 5.7. Total allied health funding per capita

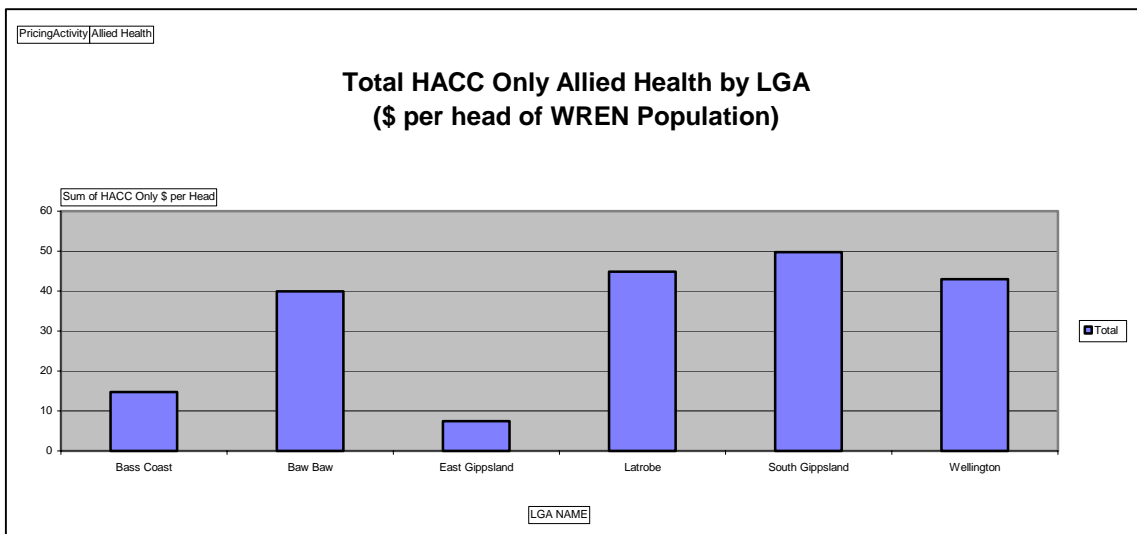


Figure 5.8 HACC Allied Health funding per capita

It is very clear from both charts that East Gippsland has limited allied health funding when compared to the other local government areas in the Region. For instance in Figure 5.7 East Gippsland has approximately one third of the funding provided to South Gippsland and Latrobe. When considering the HACC only funding in Figure 5.8 East Gippsland is clearly the highest priority and Bass Coast could also be considered a priority for funding. South Gippsland and Latrobe are not priorities for funding in this activity.

Figure 5.9 compares HACC Home Care funding by WREN by local government area.

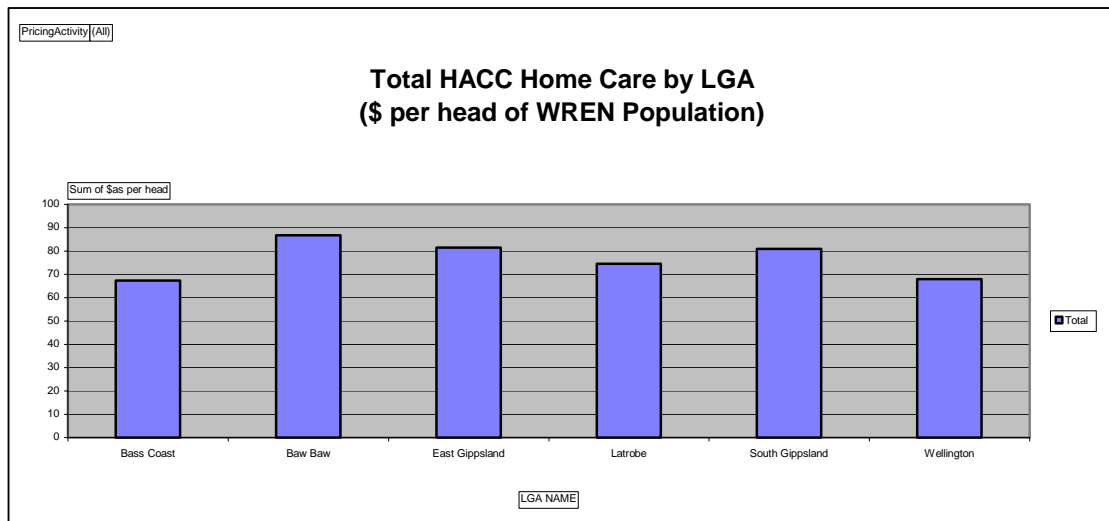


Figure 5.9 Home Care funding per capita

It is clear from this data that Baw Baw, East Gippsland and South Gippsland have high levels of funding for Home Care in comparison with the other three local government areas. Bass Coast, Latrobe and Wellington are all below the median of \$77 and thus are priorities for additional Home Care funding.

Figure 5.10 compares the HACC funding for meals by WREN head per local government area.

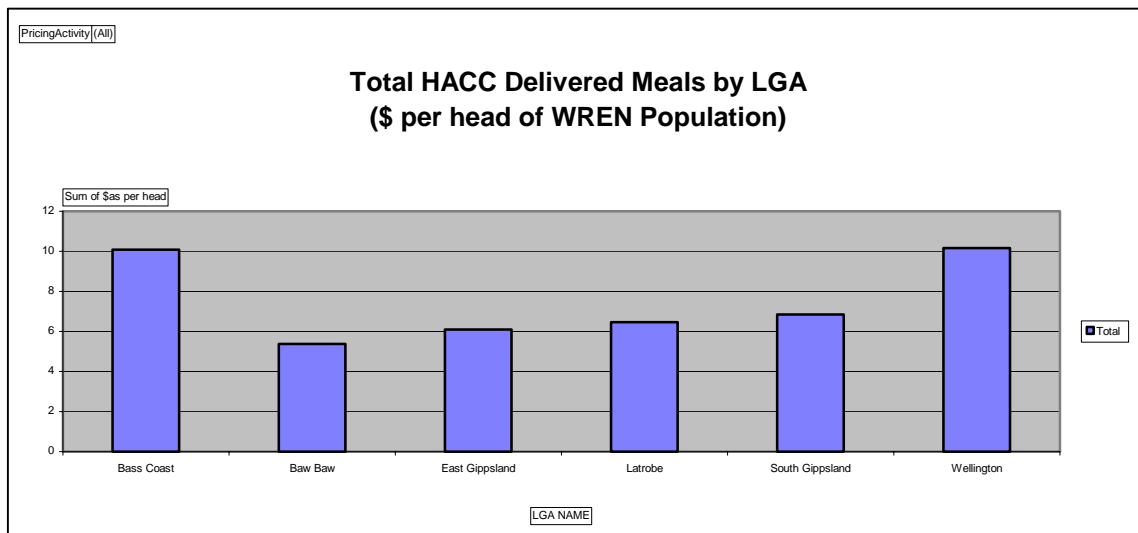


Figure 5.10. Delivered Meal funding per capita

It is clear from this data that Bass Coast and Wellington have higher levels of funding in comparison with the other four local government areas. Baw Baw, East Gippsland, Latrobe and South Gippsland are all priorities for additional Delivered Meals funding.

Figure 5.11 compares the level of HACC funding for Property Maintenance per capita by local government area.

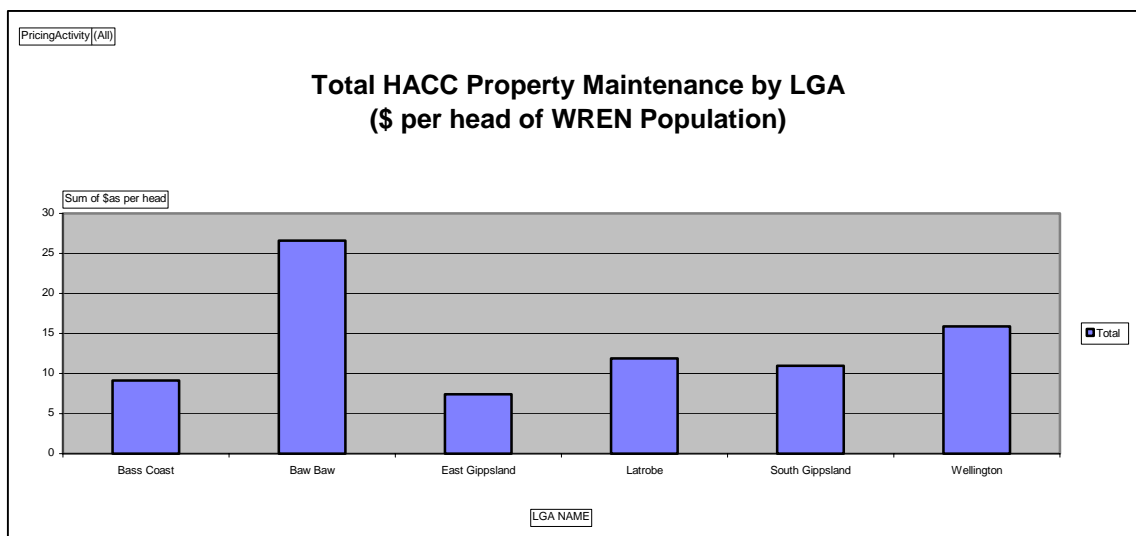


Figure 5.11. Property Maintenance funding per capita

It is clear from this data that Baw Baw has a very high level of funding when compared with all other local government areas and almost four times the funding in East Gippsland. East Gippsland is clearly the top priority but Bass Coast, South Gippsland and Latrobe are also high priorities for this activity.

Summary of \$ per head of WREN analysis

This data shows that:

- Home Care is a high priority in Bass Coast, Wellington and Latrobe
- Personal Care is a top priority in Baw Baw, Latrobe and Bass Coast
- Property Maintenance is a priority in Bass Coast, East Gippsland, Latrobe, South Gippsland
- Allied Health is clearly the top priority in East Gippsland and Bass Coast
- Nursing is a top priority in Baw Baw, Latrobe, Wellington and Bass Coast
- Delivered Meals are a high priority in Baw Baw, East Gippsland, Latrobe and South Gippsland
- Assessment and Care Management is the highest priority in East Gippsland, Latrobe and South Gippsland.

5.3.2.2. Analysis of HACC service provision by activity by local government area

When considering the allocation of funding to HACC activities an analysis of the relative levels of HACC activity per WREN population per local government area. The following figures were derived from the reported MDS data and there are some obvious inconsistencies when compared with the previous graphs, which were derived from HACC base funding by activity. DHS recognises that MDS can be most valuable when used for planning and the following figures are only one of many possible applications. However the value of MDS is reduced by the current inconsistencies, which highlight the need for further improvement in this area. This will continue to be a focus of DHS over time.

Figures 5.12.-5.18. show the per capita service provision of 'Priority 1' activities by local government area.

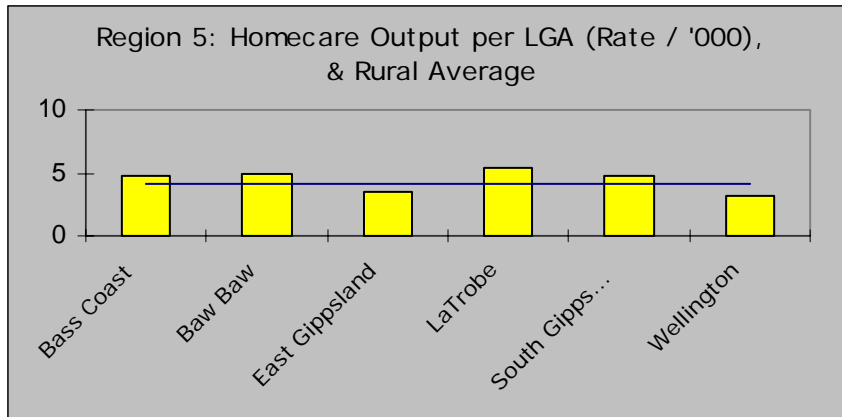


Figure 5.12. Hours of Home Care per 1,000 target population

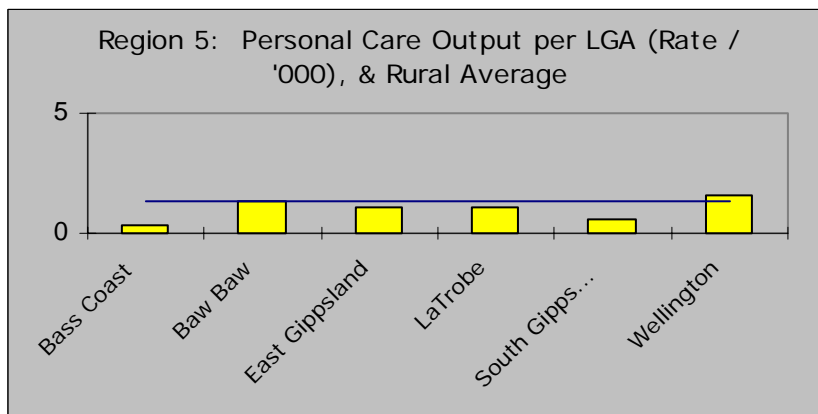


Figure 5.13. Hours of Personal Care per 1,000 target population

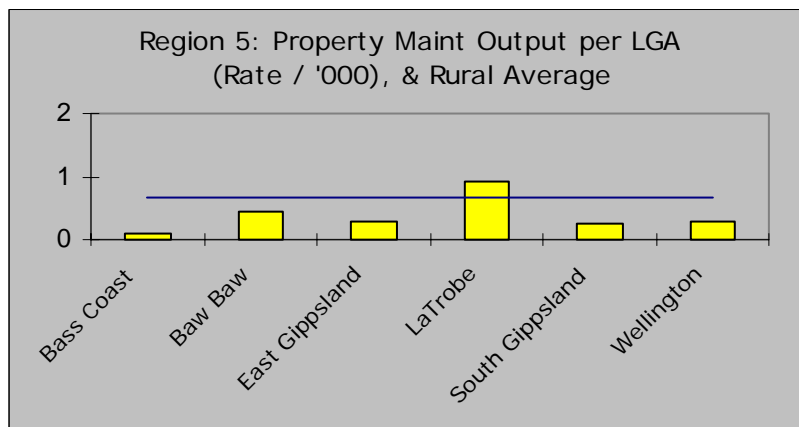


Figure 5.14. Hours of Property Maintenance per 1,000 target population

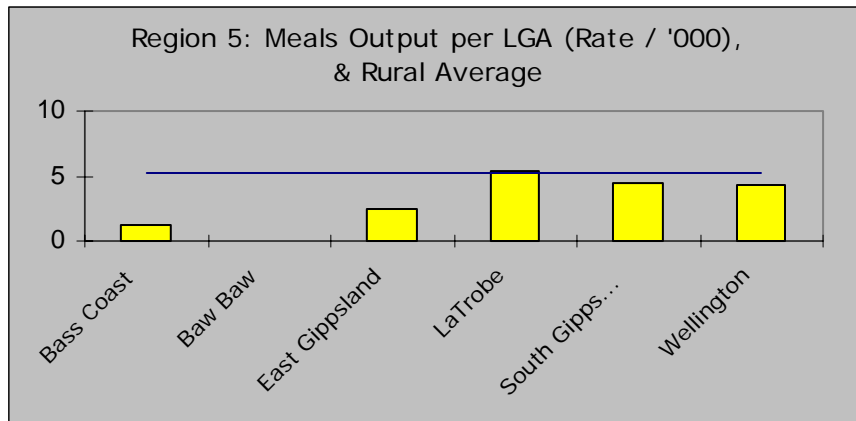


Figure 5.15. Meals per 1,000 target population

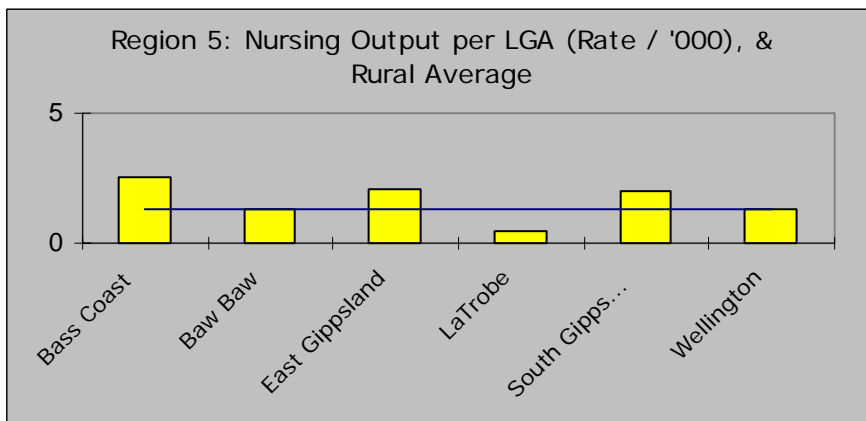


Figure 5.16. Hours of Nursing per 1,000 target population

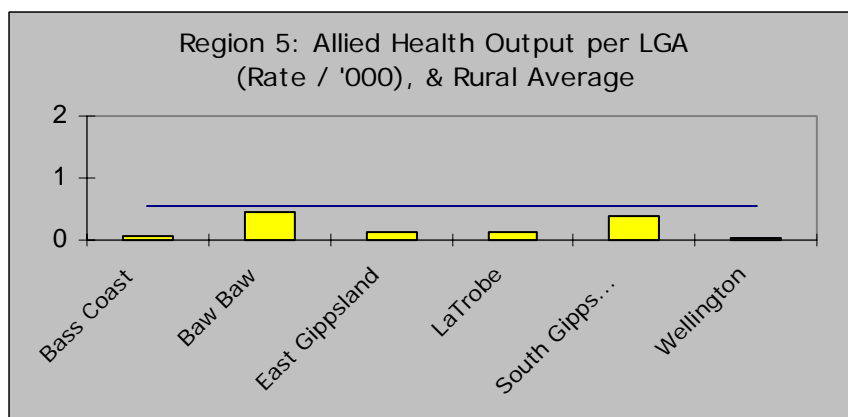
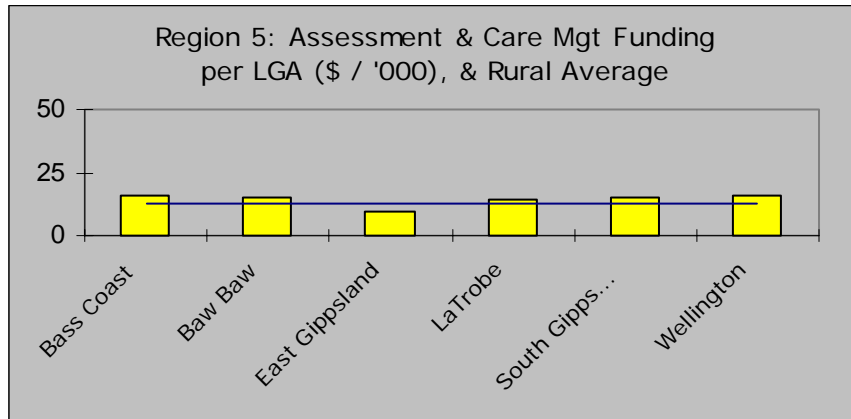


Figure 5.17. Hours of Allied Health per 1,000 target population

Figure 5.18. Dollar of Assessment and Care Management per 1,000 target population



5.3.2.3 Summary of expansion

The tables below are a summary of the recommended service expansion in activities for Priority 1 during 2003-06 across the Region. It should be noted that Priority 1 targets the whole HACC population.

Appendix F provides a summary of the recommended service expansion by activity per local government area.

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

ACTIVITIES	Units	\$
Home Care	2,600	63,544
Personal Care	3,150	88,011
Property Maintenance	1,200	42,660
Allied Health	1,525	109,449
Nursing Blair	2,735	171,922
Nursing Non Blair	115	6,990
Delivered Meals	15,865	19,514
ACM	-	52,519
Flexible Service Response	-	6,993
Service System Resourcing	-	8,586
SSR Training	-	14,465
SSR HACC Response Service	-	13,500

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

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

ACTIVITIES	Units	\$
Home Care	2,270	56,856
Personal Care	3,600	103,104
Property Maintenance	1,400	51,010
Allied Health	1,600	117,704
Nursing Blair	2,850	183,639
Nursing Non Blair	150	9,345
Delivered Meals	18,410	23,210
ACM	-	43,370
Flexible Service Response	-	3,500
Service System Resourcing	-	40,692
SSR Training	-	4,720
SSR HACC Response Service	-	13,500

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

ACTIVITIES	Units	\$
Home Care	2,450	62,899
Personal Care	3,800	111,553
Property Maintenance	1,000	37,347
Allied Health	1,700	128,187
Nursing Blair	3,000	198,137
Nursing Non Blair	150	9,579
Delivered Meals	17,435	22,531
ACM	-	52,325
Flexible Service Response	-	3,500
Service System Resourcing	-	42,117
SSR Training	-	5,192
SSR HACC Response Service	-	\$ 13,500

5.3.3 Recommended allocation 2003-04

The recommended funding allocations 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)	Nursing Non Blair (hours)	Delivered Meals (meals)	Assessment & Care Man (\$)	Flexible Service Response (\$)	Service Sytem Resourcing (\$)
Bass Coast	Bass Coast Shire Council	Direct	600	600	400					\$8,502		
Bass Coast	Bass Coast Community Health Centre	Direct					200					
Bass Coast	BCCHS, BCRH, GSHS, Vision Australia	Invited				450						
Bass Coast	Bass Coast Regional Health	Direct					200		700			
Baw Baw	Baw Baw Shire Council	Direct		600					1,000	\$1,175		
Baw Baw	West Gippsland Health Care Group	Direct				200	535			\$2,000	\$2,086	
East Gippsland	Lakes Entrance Community Health	Direct			300					\$10,098		
East Gippsland	Bairnsdale Regional Health Service	Direct					200			\$4,156		
East Gippsland	Mallacoota District Health and Support Services	Direct		22	100							
East Gippsland	Mallacoota District Health and Support Services	Direct	100	78					200			
East Gippsland	BRHS, LECHS.	Invited				545						
East Gippsland	Omeo District Hospital					80				\$1,086		
East Gippsland	Orbost Regional Health	Direct			100						\$4,907	
East Gippsland	Cann Valley Bush Nursing Centre Inc	Direct						47				
East Gippsland	Gelantipy Bush Nursing Centre Inc	Direct										\$6,033
East Gippsland	Swifts Creek Bush Nursing centre Inc	Direct										\$2,553
East Gippsland	The Buchan Bush Nursing Association	Direct						38				
Latrobe	Latrobe City Council	Direct	300	1500	250				7500	\$7,800		
Latrobe	Moe District Meals on Wheels Inc	Direct							2500			
Latrobe	Latrobe Community Health Service	Direct					1000			\$6,000		\$14,465
South Gippsland	South Gippsland Shire Council	Direct		350	50				3000	\$6,000		
South Gippsland	South Gippsland Hospital	Direct				48						
South Gippsland	South Gippsland Hospital	Direct				52				\$3,255		

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Personal Care (hours)	Property Maint (hours)	Allied Health (hours)	Nursing Blair (hours)	Nursing Non Blair (hours)	Delivered Meals (meals)	Assessment & Care Man (\$)	Flexible Service Response (\$)	Service Sytem Resourcing (\$)
Wellington	Central Gippsland Health Service	Direct	1,330			100	500			\$2,446		
Wellington	Yarram & District Health Service	Direct	270			50	100		965			
Wellington	Dargo Bush Nursing Centre Inc	Direct						30				
Region Totals			2,600	3,150	1,200	1,525	2,735	115	15,865	\$52,519	\$6,993	\$23,051

5.3.4 Priority 1 Recommendations

The funding recommendations contained in the above spreadsheets have been made in line with the summary of data analysis contained on page 40 and modified following information obtained through the consultation process and in line with the Region's decision regarding equity for 2003-04. Stakeholders generally agreed with the Region's proposals to expand HACC services and the method of funds allocated.

5.4. Priority 2

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

5.4.1. Introduction

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

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

5.4.2. Project recommendations

The recommended projects for 2003-06 are:

Catchment	Name of Agency	Activity (Units or \$ for block funded)
Region wide	Gippsland Migrant Resource Centre (direct allocation)	2003-04 \$10,000 in a Service Development Grant for a Pilot Project, CALD communication strategy in at least one local government area with the intention of expansion across the Region in 2004-05.
Region wide	Initiatives in response to the work of the Equity and Access Worker in 2003-04 (invited submission)	Service System Resourcing (\$15,000) in each of 2004-05 and 2005-06

A recommendation for a one-off amount of \$10,000 has been made for a pilot project that aims to engage the CALD HACC target population and/or their relatives by inviting them to attend an educational cultural event where HACC providers will present their services. This is to occur in at least one local government area with the aim of explaining HACC to those who may not be aware of the program.

Additional recommendations utilising existing funds have been made for:

- A project, utilising the existing resources of the equity and access worker at Latrobe Community Health Services, to ascertain the impact of Cultural Planning upon service standards & the impact on levels of service delivery to the CALD population across the Region. The project aims to increase the quantity and quality of HACC services used by CALD population and identify areas of further development to the service system over coming years. Funds of \$30,000 have been notionally allocated for future development in 2004-06.
- A project, in which Gippsland Migrant Resource Centre will utilise the existing resources of the Ethnic Services Development Program, to promote the use of language services by HACC Service Providers across Gippsland.

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 proposed building on this service development work to support ATSI communities over the next three years. The focus proposed was:

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

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

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

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

The next step is for DHS, in consultation with VICACD, to develop a workplan for the triennium, and project briefs to implement the above tasks. It is expected that further service development projects will be proposed 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 boarder service provision
- Planning for seasonal changes in population.

5.5.3. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Delivered Meals (meals)	Assessment & Care Man (\$)	Service System Resourcing (\$)
East Gippsland	Gippsland & East Gippsland Aboriginal Cooperative	Direct	150	840	\$2,801	
Wellington	Gippsland & East Gippsland Aboriginal Cooperative	Direct	60		\$1,034	
Latrobe	Latrobe City Council	Direct				\$50,000

The Region recommends \$50,000 for a Koori HACC Liaison and Assessment Position. The aim is to develop partnerships between mainstream providers and the Indigenous community, increase cultural awareness and promote HACC mainstream services to the ATSI population in the Bass Coast, Baw Baw, Latrobe and South Gippsland Shires.

The Region recommends that the funding be allocated to Latrobe City Council as an interim budget holder while further consultation and work is undertaken by a steering committee of mainstream, Koori HACC providers and DHS to determine the precise nature of this position and the most appropriate auspice.

5.6. Impact of Priorities 1-3 proposals

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

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

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

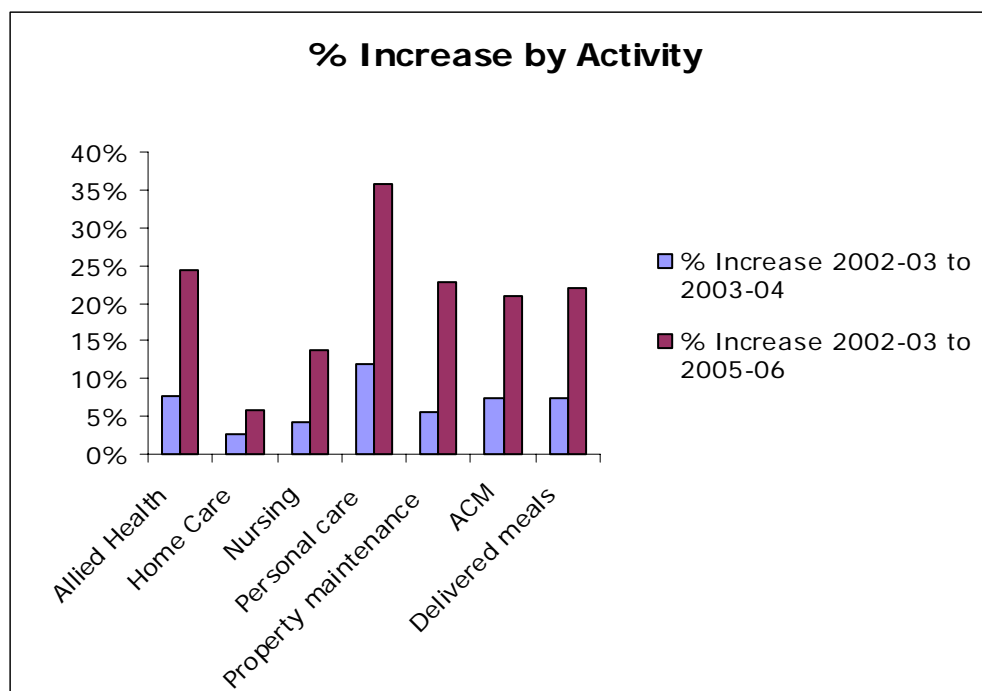


Figure 5.19. Percentage increase of Priority 1 activities, 2003-04 and 2003-06

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 proposed recurrent base budget at 1 July 2006 (including consolidation funds) and reflects funding allocations as proposed in this Draft Regional Plan. The third bar shows the WREN population share by local government area for 2005-06; and indicates proposed 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, excluding consolidation, 1/7/2006	% of funding, 1/7/2006	WREN 2006
Bass Coast	\$2,111,568	11.2%	13.5%	\$2,791,764	12.0%	13.7%
Baw Baw	\$2,537,285	13.4%	13.3%	\$3,084,054	13.3%	13.4%
East Gippsland	\$4,234,623	22.4%	19.4%	\$4,937,185	21.3%	19.6%
LaTrobe	\$4,748,323	25.1%	27.1%	\$5,767,165	24.9%	26.9%
Sth Gippsland	\$2,308,393	12.2%	10.8%	\$3,061,787	13.2%	10.7%
Wellington	\$2,975,862	15.7%	15.9%	\$3,552,328	15.3%	15.6%
Total	\$18,916,053	100.0%	100.0%	\$23,194,283	100.0%	100.0%

Figure 5.20: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

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

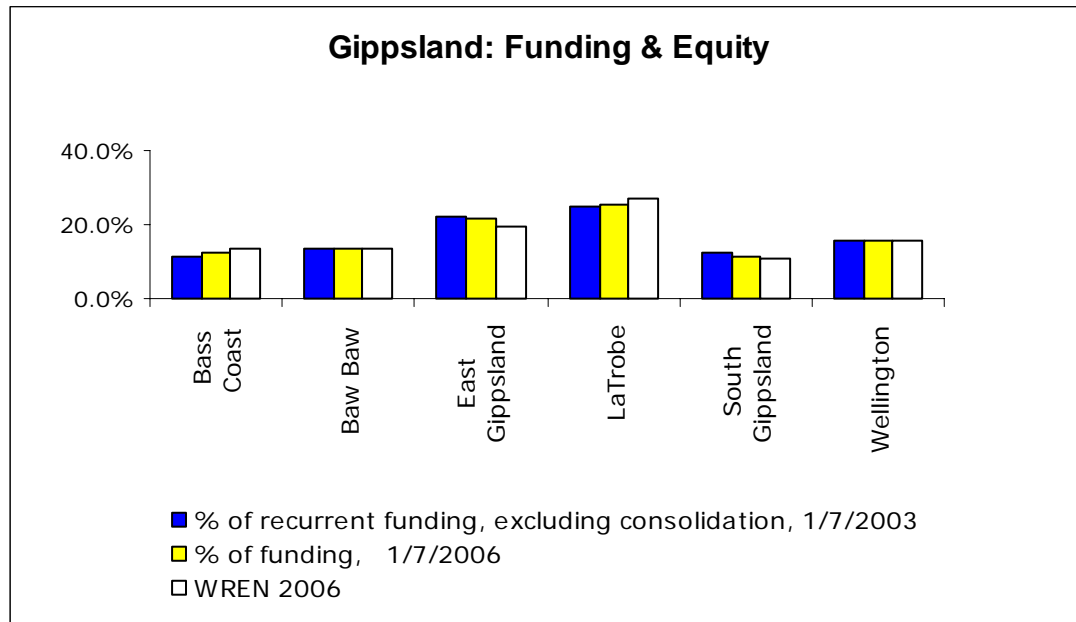


Figure 5.21: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

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.

The following projects are recommended over the next three years:

In conjunction with the existing Equity and Access position in the Region a review of HACC Service provision to the CALD community will be undertaken. This review will consult with staff and managers of HACC services and identify the quantity and quality service provision currently being provided and where improvements are required. This review will work in partnership with the Ethnic Services Development Program at Gippsland Migrant Resource Centre make recommendations for future training or service development.

In addition to the above project \$10,000 has been allocated to implement a CALD communication strategy focusing on informing and educating Gippsland residents from CALD backgrounds about HACC services. This project should be developed with a partnership approach between mainstream and Ethno Specific agencies and across the health sector including the primary care partnership's. The aim of this project is to increase the number of residents from CALD backgrounds who utilise mainstream HACC services. In 2003-04 it is intended that a pilot project is undertaken to trial the approach and to utilise the acquired knowledge to develop a region-wide plan for implementation in 2004-06.

The Region also recommends that \$20,000 be allocated to undertake regional and sub-regional HACC planning. The project will consider the impact of the projected growth in the ageing population across the Region and consider the priorities and type of HACC service provision required in local government areas. The project will work in partnership with HACC service providers and relevant stakeholders and make recommendations for future expansion of the HACC service system in the Region.

Service development initiative summary

Project	Funding	Allocation Method
CALD Communication Strategy, MRC	\$10,000	Direct
Regional & sub-regional HACC Planning, DHS	\$20,000	Direct

6.3. Minor capital discretionary funding

A minimum of 1% of total Program outlays has been established for minor capital.

The Gippsland Region recommends putting 80% of the Minor Capital allocation through the formula and retaining 20% to support agencies through the transition process given that there may be some unintended impact that a small amount of discretionary Minor Capital might ameliorate.

A discretionary minor capital budget of 20% is proposed for the first year only but will be reviewed prior to the 2004-05 funding round to determine whether it will be necessary in future years.

The Region proposes the following criteria to allocate the 20% of minor capital funds:

1. Agencies that will receive less than \$7,000 minor capital funding for the year 2003-04 and that demonstrate an immediate additional need for funding to maintain the existing level of service provision will be given highest priority
2. Applications that demonstrate that the agency cannot expand the existing service provision without additional minor capital resources will be considered a priority
3. Applications for computers, allied health equipment, rent and general operations will not be considered.