

Home and Community Care (HACC) Program

# Hume Regional Plan, 2003-06

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

December 2003



## Glossary of terms

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

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Appendix A – Timeline for developing the Victorian HACC Program Annual Plan, 2003-04

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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
<b>TOTAL</b>	<b>\$11,188,055</b>	<b>\$11,711,065</b>	<b>\$12,437,152</b>

Note: Growth allocations include those for the HACC Response Service

#### 1.7.1.2. Victoria's additional commitment

##### ***Redressing funds inequity between regions***

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

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

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

***Improving services for people from culturally and linguistically diverse backgrounds***

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

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

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

**1.7.2. Research & development**

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

**1.7.3. Minor capital**

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

## Section 2 – Ministerial Priorities 2003-06

### 2.1. Introduction

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

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

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

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

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

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

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

### 2.2. Evidence and rationale

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

There are two main reasons for the Ministerial Priorities:

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

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

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

A detailed rationale for the Ministerial Priorities can be found in the *Better Planning and Funds Allocation for the Home and Community Care Program in Victoria*, Appendix 1, at <http://www.health.vic.gov.au/agedcare/hacc>

The following sections provide a summary of the demographic and service provision data underpinning the Ministerial Priorities.

### **2.2.1. What do the data tell us?**

#### **2.2.1.1. Priority 1**

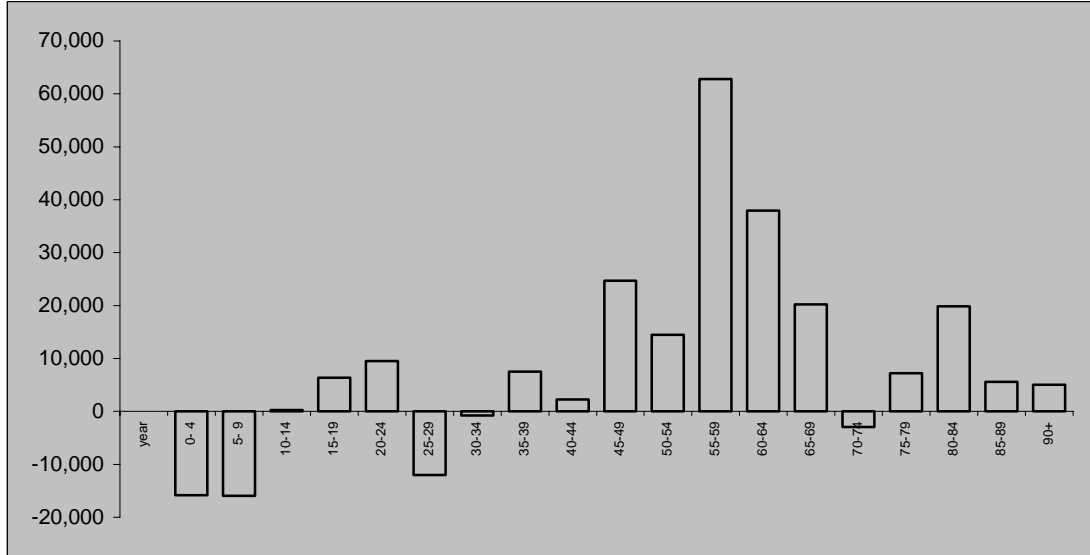
Projected changes in population and target groups indicate that growth in demand for HACC services will come predominantly from older age-groups. Not only does the rate of disability increase with age, but the rate of uptake of HACC services is also much higher among older persons, relative to the prevalence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

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

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

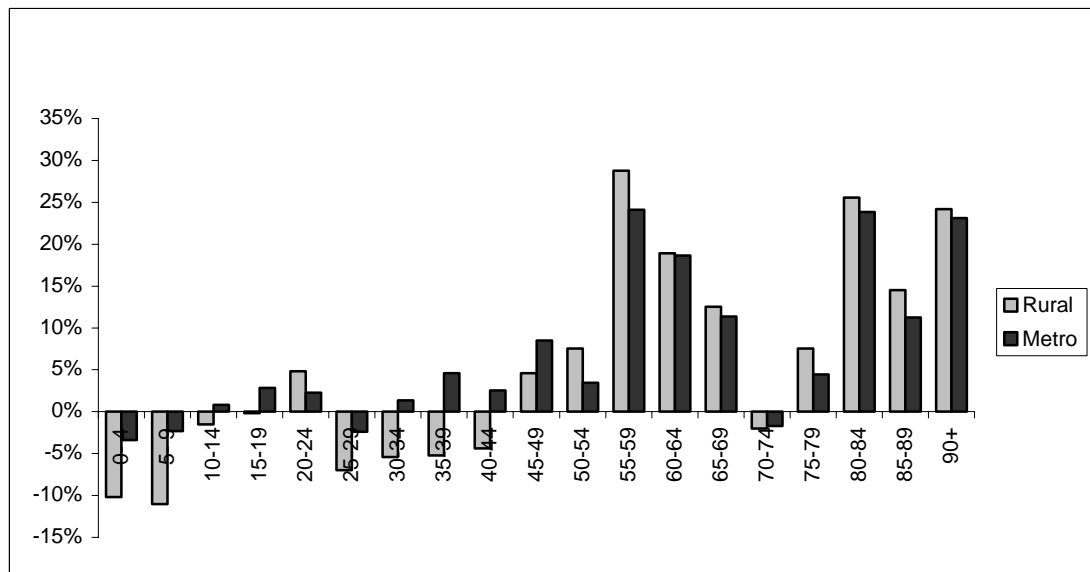
Figure 2.1 shows the projected change in age groups between 2001-06. There are:

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



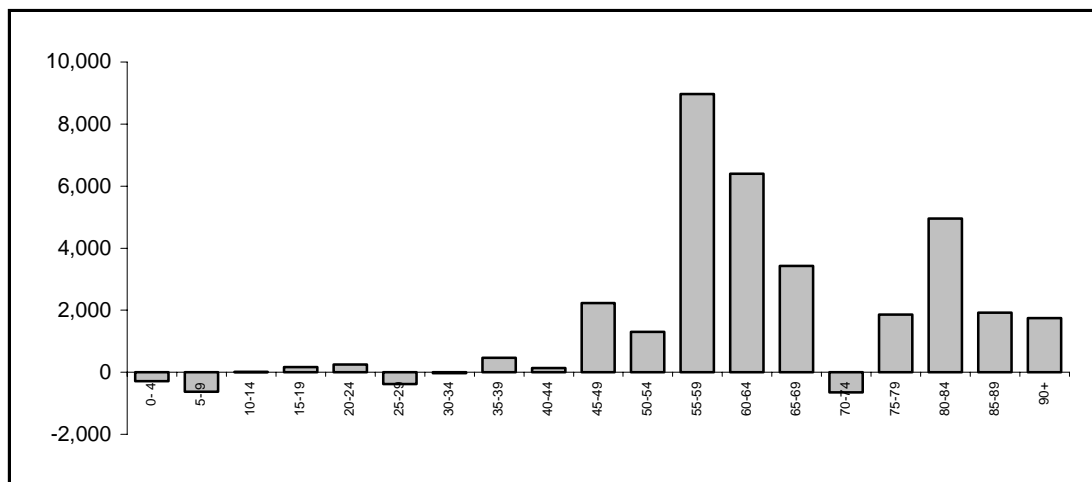
**Figure 2.1: Changes in population groups 2001-06 Victoria**  
 Source: Department of Infrastructure *Victoria In Future*

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



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

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



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

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

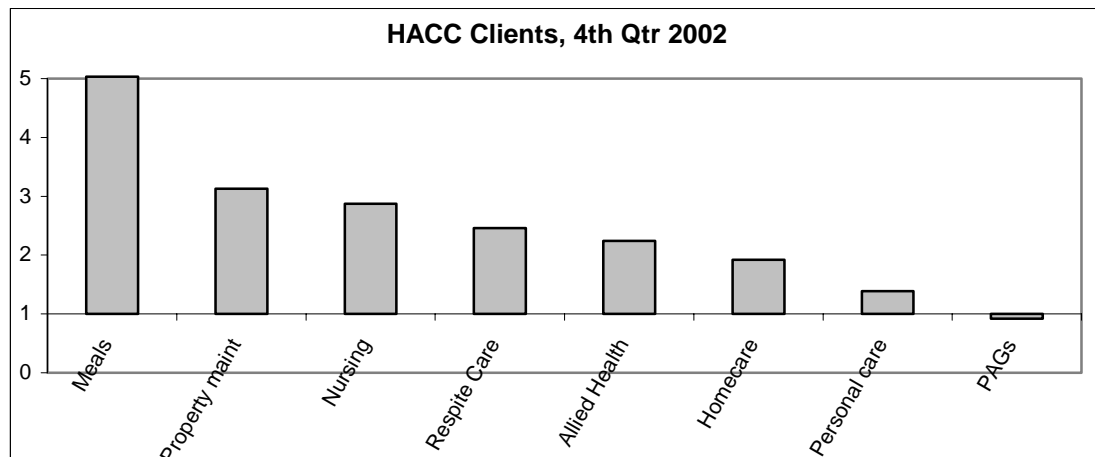
### 2.2.1.2. Priority 2

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

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

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

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



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

Source: *HACC MDS December Quarter 2002 and 2001 Population Census*

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

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

### 2.2.1.3. Priority 3

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

## **2.3. Putting the Priorities into action**

### **2.3.1. Statewide strategies**

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

#### **Developing culturally responsive services**

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

#### **Investing in the HACC workforce**

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

#### **Improving the quality of services**

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

#### **Effective program planning and evaluation**

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

#### **Targeting in the HACC program**

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

#### **Funding and accountability**

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

#### **Investing in research and development**

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

### **2.3.2. Regional strategies**

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

## Section 3 – Regional context

### 3.1. Introduction

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

Primary data sets were used by each Regional Office to develop the Regional Plan. Each Region also included additional local data. The primary data sets included:

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

The additional Hume Regional data included:

- Service provision (including hospital separations) data.
- Funding levels (including Quarterly Output Collection, HACC project register).
- *Victorian Aboriginal And Torres Strait Islander (ATSI) Communities HACC Needs Analysis Project – Hume Region.*
- Population data (including the Australian Bureau of Statistics Social Trends).
- Local Aged Care Plans.

### 3.2. The Region

Figure 3.1 shows the location of Hume Region in Victoria.

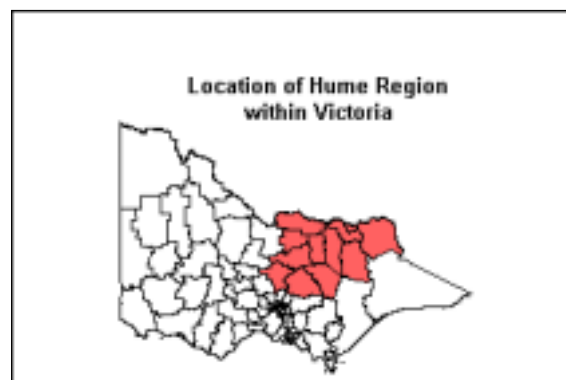
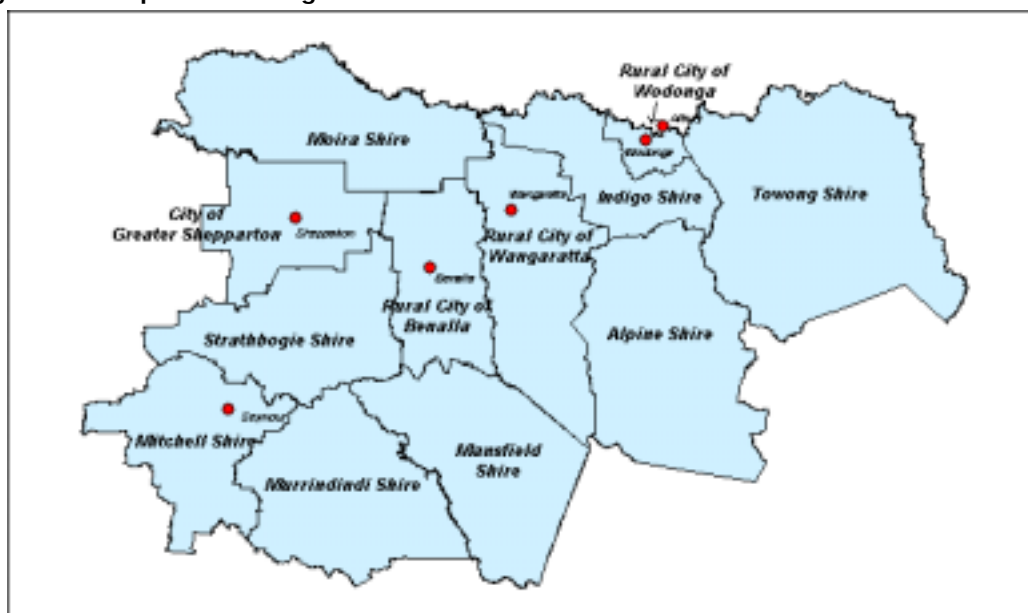


Figure 3.1 Map of Victoria showing Hume Region

Figure 3.2 provides a more detailed picture of the Region. The major population centres are Wodonga, Shepparton, Wangaratta, Benalla and Seymour, which are linked by the major road and rail systems.

**Figure 3.2. Map of Hume Region**



### 3.2.1. The HACC sector

Within the 12 local government areas, DHS funds 52 HACC providers. HACC providers are a diverse group and include:

- 12 local governments
- 3 community health centres
- 15 hospitals
- 2 multi purpose services
- 1 Bush Nursing Centre
- 1 Bush Nursing Hospital
- 16 non-government agencies
- 2 ATSI-specific agencies.

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

These 52 agencies provide HACC services from 67 campuses/sites. Only one provides a cross regional service.

Ninety five percent of agencies have completed training and are beginning an assessment against the HACC National Standards Instrument.

The Region has four primary care partnerships that provide a planning and co-ordinating support role in the primary care sector, including HACC.

### **3.3. How the Region communicates with the sector**

In order to manage and support the HACC sector effectively, the Region engages a number of strategies to develop and sustain partnerships and to enhance sharing of local knowledge. These strategies enable the Region 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.

#### **3.3.1. HACC advisory groups**

Hume Region has four sub-regional HACC advisory groups that meet bi-monthly. Membership of the groups includes all HACC services, Department of Veteran Affairs, Aged Care Assessment Service, Psycho-Geriatric Assessment Team, Carers Respite & Information Service and disability advocacy services.

These groups are charged with:

- Identifying service demands, gaps and issues
- Providing advice to the Region
- Networking and sharing information
- Identifying and initiating service development activities.

#### **3.3.2. HACC special purpose advisory groups**

Hume Region has several specific purpose HACC advisory mechanisms. These cover the following services:

- Allied Health
- Nursing
- Food services
- Workforce development
- ATSI services.

### **3.4. The planning context**

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

#### **3.4.1. Broad regional planning context**

##### **3.4.1.1. Principles**

Hume Region has identified five management imperatives that are common to all units and programs across the Region. These imperatives are:

- Quality – pursuing continuous improvement
- Staff Support – ensuring a stable, supported workforce
- Leadership – demonstrating strategic leadership
- Program Planning – developing strategic program planning across the Region
- Knowledge Management – enhancing timely and appropriate information.

#### **3.4.1.2. Impact of geography**

There are some significant geographic features of the Region that influence service planning and delivery. The Region is bordered in the north by the Murray River and in the east by the Victorian Alps. In the northern half of the Region, the Warby Ranges separate the Goulburn Valley from the northeast area. In the southeastern end of the Region, the Eildon Weir presents a barrier between the Alexandra and Yea areas and the Northeast.

The Region comprises twelve local government authorities covering an area of 40,427 square kilometres. It has an average population density of 6.08 people per square kilometre compared to the state average of 20.02.

There are certain difficulties due to the fact that there is no one main population centre. There are several sizeable towns and rural cities, which means that services have to be split as equitably as possible across the Region to ensure best possible coverage.

Fifty nine percent of the Region's population reside in small rural/remote communities with populations of less than five thousand people. Consequently, services sometimes only cover a small part of the Region and this disadvantages many communities.

#### **3.4.1.3. Economic base**

There is a range of industry that contributes to the economy within the Region. Albury-Wodonga has a large industrial base. Much of this industry has been located in the area due to government decentralisation initiatives and proximity to both Sydney and Melbourne via major transport links. The western half of the Region relies heavily on dairy and citrus production concentrated around Shepparton. Recent major investment has also occurred in state of the art food processing plants in Shepparton, Strathmerton, Tatura and Nathalia. Cropping and livestock industries are prevalent in the central, south and southeast areas, such as Euroa, Murchison, Nagambie, Seymour, Alexandra and Yea. Wine production is spread around the northeast, particularly around Rutherglen and Wangaratta. The light industry base is very strong. Wangaratta in particular is dependant upon wool and fabric processing plants. These plants are major employers.

Tourism activity is another substantial contributor to the local economy. The Murray River in the Region's north, and the winemaking areas of the northeast, provide for year round tourism related industry. The winter months provide for massive activity in and around the Victorian Alps.

#### **3.4.1.4. Health issues**

##### ***Disability adjusted life years***

An analysis of health data shows that the life expectancy in the Region is the same as the state average for males and just under the state average for females.

The top three Disability Adjusted Life Years (DALYs) for males and females are cardiovascular disease, cancer and mental disorders.

### Hospital admissions data

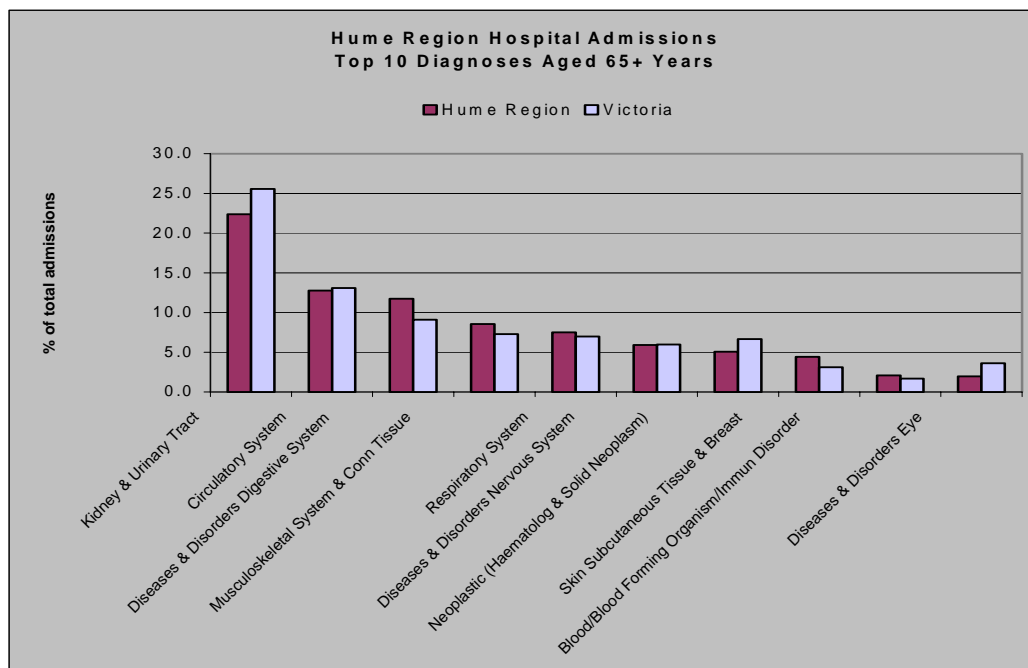


Figure 3.3 Hospital admissions top 10 diagnoses for people aged 65+, 2001-02

- There were 5,594 admissions for Kidney & Urinary Tract issues in 2001-02, making up 22% of admissions for the 65 years and over age group
- The male and female reproductive systems together accounted for 525 or 2.1% of admissions for people aged 65 years and over
- Injuries and poisonings from the toxic effects of drugs, combined with alcohol and drug use or alcohol and drug induced mental disorders, accounted for 345 admissions of people aged 65 years and over in 2001-02. This was the equivalent of 1.4% of the total admissions for this age group.

Source: Victorian Admitted Episodes Dataset, 2001-02

### Alcohol & drug treatment services

- People aged 65 years and over made up 0.6% of all clients attending Alcohol & Drug Treatment Services in 2001-02
- This proportion of clients is a decrease from 1.0% of clients in 1999-2000.

Source: Alcohol Drug Information Service (ADIS), Drugs Policy & Services Branch, DHS (draft report).

### Mental health services

- There were 825 clients aged 65 years and over who accessed mental health services during 2001-02
- People aged 65 years and over made up 19.8% of the total number of mental health services clients in 2001-02
- The local government areas with the largest proportion of all mental health services clients accessing aged mental health services were Indigo Shire (37.0%), Alpine Shire (30.1%), followed by Towong Shire (23.8%) and Rural City of Wangaratta (23.5%).

Source: Mental Health Branch, DHS, 2001-02.

### **3.4.1.5. Transport**

Road transport is the major link between regional localities. The Hume Highway traverses the Region from Kilmore in the south to Wodonga in the north. Other major roads include the Murray Valley Highway, Goulburn Valley Highway, Maroondah Highway and the Ovens Highway. A large airport, located in Albury, provides access to commercial interstate and Melbourne flights. The Sydney/Melbourne rail link runs parallel to the Hume Highway and provides daily passenger and freight services to capital cities. Many of the residents of the Region's southern townships commute to employment in the metropolitan area, via the Hume Highway.

Public transport is almost non-existent outside of medium to large towns. With 59% of the Region's population living in small rural/remote communities the cost of commercial bus and taxis services is prohibitive. Many HACC clients depend on limited community transport services supplied by service providers.

Over the past few years Hume Region has undertaken several HACC funded community transport projects. These projects have identified the lack of accessible transport options as one of the most significant barriers for the HACC target group in accessing HACC and other services.

The Community Transport component of the service sector is under resourced. Running costs, maintenance and replacement of vehicles impose an ongoing financial burden on service providers. This issue is compounded by the lack of a co-ordinated approach between DHS Programs and other government departments. This issue has been identified as a statewide issue.

## **3.4. 2. Regional HACC planning context**

### **3.4.2.1. Aged Care Assessments (population aged 70 Years and over)**

- There were 2,657 aged care assessments undertaken in 2001-02
- The assessment rate per 1000 of the population aged 70 years and over was 114.2 in the Region, compared to 129.0 in regional Victoria and 126.8 in Victoria
- The highest rates of aged care assessments were in Rural City of Wodonga (155.0) and City of Greater Shepparton (129.7)
- The lowest rates of aged care assessments in 2001-02 were in Towong Shire (70.7), Moira Shire (94.8) and Murrindindi Shire (95.4).

Source: Victorian Aged Care Assessment Program Evaluation Reports (July1999-June 2002), Lincoln Gerontology Centre.

### **3.4.2.2. Home & Community Care clients**

- During 2001-02, there were 7,785 people aged 65 years and over that accessed HACC services
- The largest proportions of HACC clients aged 65 years and over live in City of Greater Shepparton (21.6%) and Rural City of Wangaratta (15.2%) with the smallest proportions in Towong Shire (1.7%) and Mitchell Shire (3.5%)
- 24.3% of people aged 65 years and over accessed HACC services in 2001-02
- The highest proportions of people aged 65 years and over accessing HACC services were in Murrindindi Shire (32.9%), Rural City of Wangaratta (29.0%) and Alpine Shire (27.5%)

- The lowest proportions of people aged 65 years and over accessing HACC services were in Mitchell Shire (11.1%) and Towong Shire (12.8%).

Source: Hume Region HACC Minimum Dataset 2001-02, DHS.

### **3.4.2.3. Other factors**

Other factors that have influenced Regional HACC planning are:

- An existing three year commitment to increase allied health services to rural communities
- An increasing focus on HACC workforce development, particularly with the establishment of the Regional HACC Training Advisory Committee and the subsequent change to the role of the Regional HACC Training Coordinator
- Emerging ATSI communities in Wodonga and Seymour
- Findings of two regional projects completed in early June 2003. These projects are:
  - The Hume Region HACC Care Planning, Care Coordination and Case Management project
  - The Aboriginal and Torres Strait Islander Communities HACC Needs Analysis project
- Funding inequalities between municipalities.

In addition, HACC planning over the next three years will be influenced by:

- An increasing focus on reducing avoidable hospital admissions
- The implementation of improved service co-ordination practices, processes and tools
- Improving service ability to respond to the needs of disadvantaged groups including CALD, ATSI, and remote/rural communities
- Increasing agency utilization of language services
- Improving catchment and local area service planning.

## **3.5. Data**

The data in Section 3.5 builds a picture of the HACC population (including CALD and ATSI populations), demographic characteristics, service provision and funding 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. Population**

#### **3.5.1.1. HACC population**

##### ***Regional HACC population 2003-06***

Table 3.1 and Figure 3.4 show the relative distribution across local government areas of the HACC target population in the Region.

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

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

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

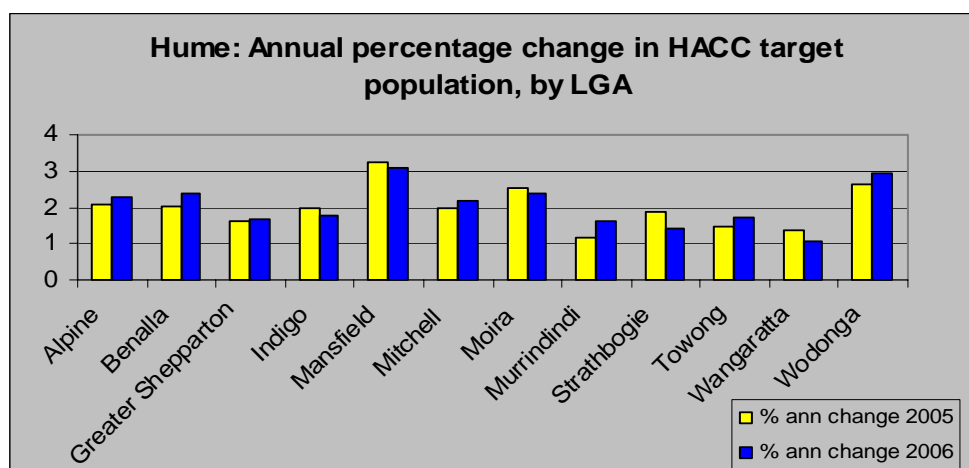
**Table 3.1: WREN population and percentage of WREN that is 70+ 2003-06**

LGA	2003-2004		2004-2005		2005-2006	
	WREN pop'n	% 70+	WREN pop'n	% 70+	WREN pop'n	% 70+
Alpine	2,521	65.1%	2,573	65.2%	2,632	65.6%
Benalla	2,441	63.1%	2,491	63.3%	2,550	63.8%
Greater Shepparton	7,191	55.8%	7,306	55.9%	7,427	55.9%
Indigo	2,108	58.7%	2,149	58.9%	2,188	59.0%
Mansfield	1,175	61.4%	1,213	61.8%	1,251	62.2%
Mitchell	3,443	52.5%	3,511	52.7%	3,588	53.1%
Moira	5,240	65.5%	5,372	65.9%	5,500	66.3%
Murrindindi	2,071	61.3%	2,095	61.2%	2,129	61.3%
Strathbogie	1,979	66.4%	2,016	66.8%	2,044	66.9%
Towong	1,151	64.4%	1,168	64.5%	1,188	65.0%
Wangaratta	4,250	61.0%	4,308	61.2%	4,354	61.4%
Wodonga	3,622	51.5%	3,718	51.5%	3,827	51.8%
<b>Total*</b>	<b>37,192</b>	<b>53.6%</b>	<b>37,920</b>	<b>53.7%</b>	<b>38,677</b>	<b>53.9%</b>

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

Figure 3.4 shows the estimated relative amount of change in the HACC target population by local government area on the 30 June each year. This is important in being able to identify where pressure on HACC services might be likely to ease or intensify over time.

It is clear from Figure 3.4 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 3.4: 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

### ***Age profile 65+ years***

Unless otherwise stated the following interpretation is based on the Australian Bureau of Statistics 2001 Census. At the time of the 2001 Census there were eleven shires within Hume Region, which have since increased to twelve with the split of Delatite Shire into the Rural City of Benalla and Mansfield Shire. This profile refers to Delatite Shire as at the 2001 Census.

This aged profile uses the definition of 'older people' as those aged 65 years and over, as defined by the Australian Bureau of Statistics

(source: Australian Bureau of Statistics Australian Social Trends 2002).

The total population increased from 237,467 in 1996 to 246,722 in 2001, an increase of 9,255 persons or approximately 3%. Victoria's population increased by approximately 6% over the same period, while regional Victoria's population had a smaller increase of approximately 1.9%. The largest proportion of Hume Region's population is found in the City of Greater Shepparton local government area (22.4% or 55,082 persons), and the smallest in Towong Shire (2.4% or 5,944 persons).

### ***Hume Region population aged 65 years and over in 2001***

- People aged 65+ years represented 13.0% of the total Hume Region population (compared to 14.2% of the total regional Victorian population and 12.6% of Victoria's population)
- The largest numbers of people aged 65+ were found in City of Greater Shepparton (6,556 persons), Moira Shire (4,431 persons) and Rural City of Wangaratta (4,080 persons)
- People aged 65+ made up the highest proportions of the populations in Strathbogrie Shire (19.7%), Towong Shire (17.5%) and Moira Shire (17.4%)
- The smallest numbers of older people were found in Towong Shire (1,045 persons) and the Shire of Murrindindi (1,768 persons)
- The lowest proportions of older people were in Mitchell Shire (8.9%) and Rural City of Wodonga (9.1%).

Figure 3.5 shows the population of older people in 1996 and 2001 by local government area.

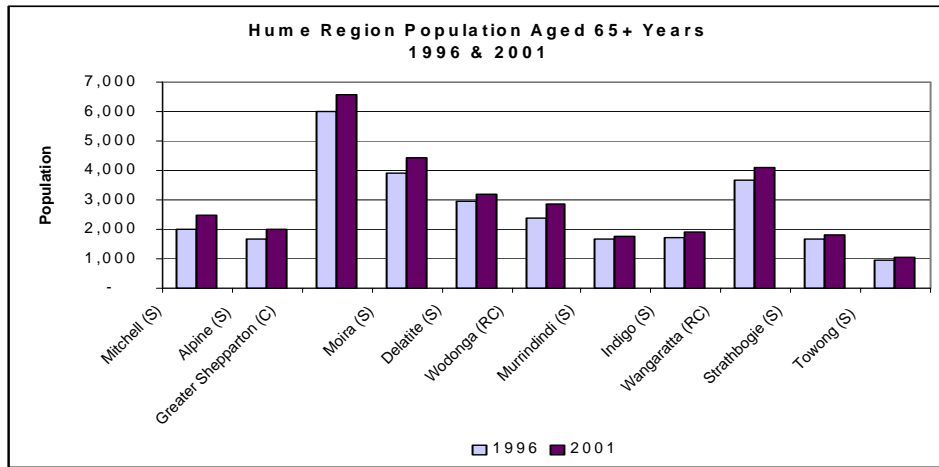


Figure 3.5. Population 65+ 1996 and 2001

### ***The change between 1996 and 2001***

Overall, the number of people aged 65+ years rose from 28,566 in 1996 to 32,086 in 2001, which is an increase of 3,520 persons. Regional Victoria's older population also rose between 1996 and 2001 (by 17,401), as did Victoria's as a whole (by 60,179).

Older people increased as a proportion of the Hume Region total population from 12.0% in 1996 to 13.0% in 2001. This compares to regional Victoria where the older population increase from 13.3% of the total population in 1996 to 14.2% in 2001, and Victoria where people aged 65+ increased from 12.0% of the total population in 1996 to 12.6% in 2001.

The largest increase in the number of older people was in the City of Greater Shepparton, where the number of older persons rose by 572 to a total of 6,556 in 2001. The next largest increase was in Moira Shire, where the increase was 518 persons to a total of 4431. In proportionate terms however, the largest increase in the 65+ year old population was in Towong Shire (2.3%) and Alpine Shire (2.0).

Figure 3.6 shows the change in the proportion of older people in the total population, in Hume Region between 1996 and 2001.

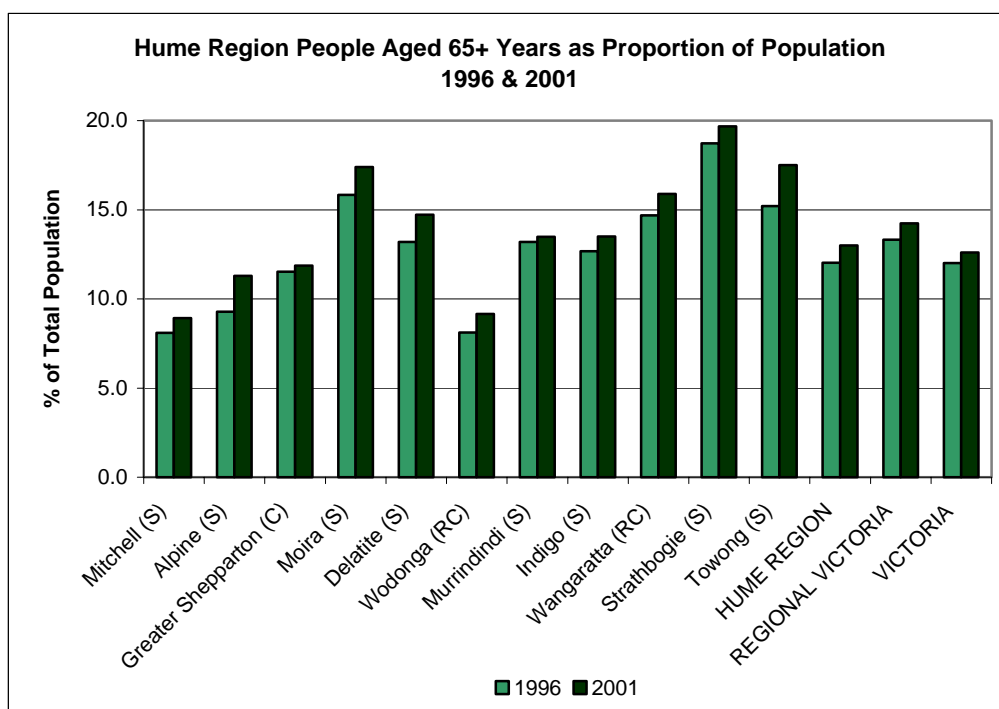


Figure 3.6 Proportion of population 65+ 1996 and 2001

### ***Population projections***

The total population is predicted to increase slowly over the years until 2021, as is the Victorian population. This trend is not evident in all local government areas, as population numbers in Towong and Strathbogie Shires are predicted to decline slightly. The largest growth is projected for Rural City of Wodonga, City of Greater Shepparton and Mitchell Shire.

Source: Department of Infrastructure, Victoria in Future 1996 – 2021. Note some caution should be exercised in using this data, if only for the difficulty in gaining precise accuracy in this area.

### ***The ten year forecast***

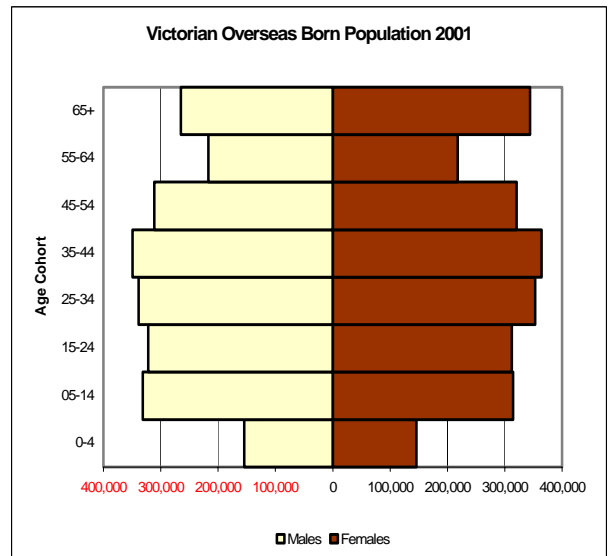
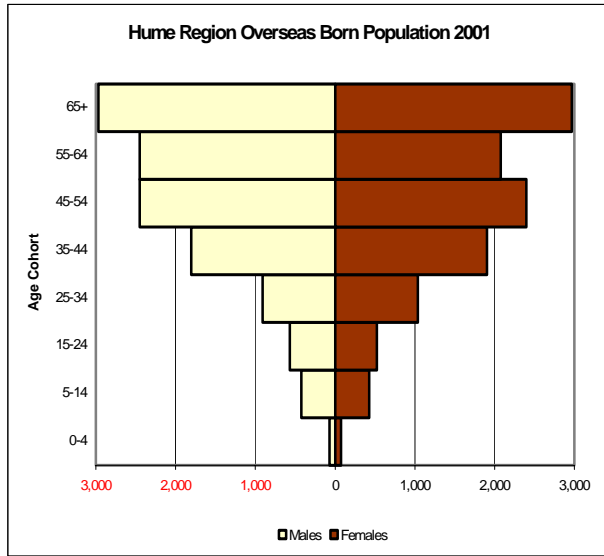
The population aged 65 years and over in Hume Region is predicted to rise almost 12% by 2006 and 28% in the years between 2001-11. This is markedly higher than the 23% increase forecast for regional Victoria and the 21% increase predicted for Victoria as a whole by 2011.

The largest older population growth between 2001-11 is predicted for the Rural City of Wodonga with a 38% increase (10% higher than the Hume Region average and 15% higher than the predicted increase for regional Victoria), and Alpine Shire and Delatite Shire (both 35%).

The lowest increase is forecast for the Rural City of Wangaratta and Murrindindi Shire (both 21% - the same as that forecast for Victoria).



Figure 3.8 and 3.9 show the difference between the age/gender profile of the overseas born population in Hume Region and the whole of Victoria.



**Figures 3.8 (Hume) and 3.9 (Victoria) gender and age breakdown of overseas born population**

As can be seen from the above profiles, the overseas born population in Hume Region is an ageing one when compared to Victoria as a whole.

**3.5.1.3.2. Language spoken at home**

Table 3.2 shows the top ten languages spoken at home by people aged 65+.

**Table 3.2: Language spoken at home**

Language	Benalla	Alpine	Gr. Shepparton	Indigo	Mansfield	Mitchell	Moira	Murrindindi	Strathbogie	Towong	Wangaratta	Wodonga	Total
English	2,108	1,547	5,666	1,688	909	2,192	4,178	1,652	1,749	1,002	3,516	2,440	28,647
Italian	14	235	552	3	4	62	110	15	12	6	263	41	1,317
German	20	49	24	19	35	29	5	27	8	12	52	92	372
Dutch	7	6	39	12	-	6	20	9	3	3	19	27	151
Greek	9	-	68	-	-	8	3	3	-	-	10	-	101
Polish	24	3	7	-	3	24	-	-	-	3	16	18	98
Croatian	-	12	9	8	-	3	6	-	-	6	3	38	85
Macedonian	-	-	53	-	-	-	-	6	-	-	3	-	62
Hungarian	9	-	7	-	-	6	6	-	-	-	7	26	61
Ukrainian	8	3	8	6	-	6	-	3	-	-	10	15	59
South Slavic *	3	3	3	-	-	-	9	-	-	-	3	16	37
Other	145	186	591	256	93	250	298	186	100	68	238	233	2,644
<b>Total</b>	<b>2,347</b>	<b>2,044</b>	<b>7,027</b>	<b>1,992</b>	<b>1,044</b>	<b>2,586</b>	<b>4,635</b>	<b>1,901</b>	<b>1,872</b>	<b>1,100</b>	<b>4,140</b>	<b>2,946</b>	<b>33,634</b>

Source: ABS 2001 Census.

\* not further defined

Table 3.2 indicates that:

- The largest proportions of older people speaking languages other than English at home are found in Alpine Shire (24.3%), City of Greater Shepparton (19.3%) and Wodonga Rural City (17.1%)
- The smallest proportions are found in Towong Shire (8.9%) and Strathbogie Shire (6.5%)
- The largest language groups, other than English, are Italian (26.4%), German (7.4%) and Dutch (3.0%)
- The smallest language groups are Hungarian (1.2%) and Ukrainian (1.1%)
- Languages in the 'Other' category comprise 53% of languages, other than English, spoken at home by this age group.

The final point is important. As the speakers of each of these languages, are too few in number to be recorded in the above table. This presents a unique challenge to HACC services, as it is most probable that these people will be easily overlooked when undertaking service access improvement activities.

#### 6. 3.5.1.4. Profile of the Aboriginal and Torres Strait Islander (ATSI) population

Table 3.3 shows the distribution of the ATSI population in the Region.

**Table 3.3: Experimental estimates of total Indigenous population**

LGA	0-49	50-69	70+	Total
Alpine	55	11	1	67
Delatite	174	15	2	191
Greater Shepparton	1,447	129	25	1,601
Indigo	58	7	4	69
Mitchell	279	19	1	299
Moira	211	35	8	254
Murrindindi	66	9	3	78
Strathbogie	67	10	5	82
Towong	31	8	0	39
Wangaratta	140	11	2	153
Wodonga	309	23	1	333
<b>Total</b>	<b>2,837</b>	<b>277</b>	<b>52</b>	<b>3,166</b>

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 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.

#### **ATSI demographics**

There were approximately 2,902 Indigenous people in 2001, representing approximately 1.2% of the total Hume Region population:

- The largest numbers of Indigenous people were found in the City of Greater Shepparton (1,460 persons), Rural City of Wodonga (303 persons) and Mitchell Shire (260 persons)

- Indigenous people made up the highest proportions of the population in the City of Greater Shepparton (2.6%) and the Rural City of Wodonga (1.0%) The smallest numbers of Indigenous people were found in Towong Shire (38 persons) and Indigo Shire (59 persons)
- The lowest proportions of Indigenous people were found in Indigo Shire (0.4% of the total population) and Alpine Shire (0.5% of the total population).

Figure 3.10 shows the distribution of the Indigenous population in 2001.

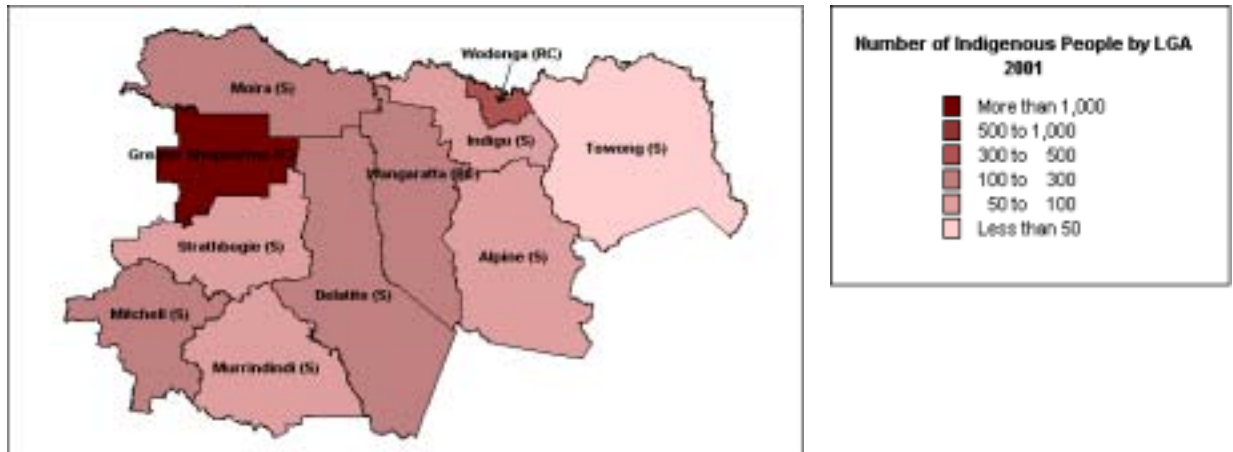
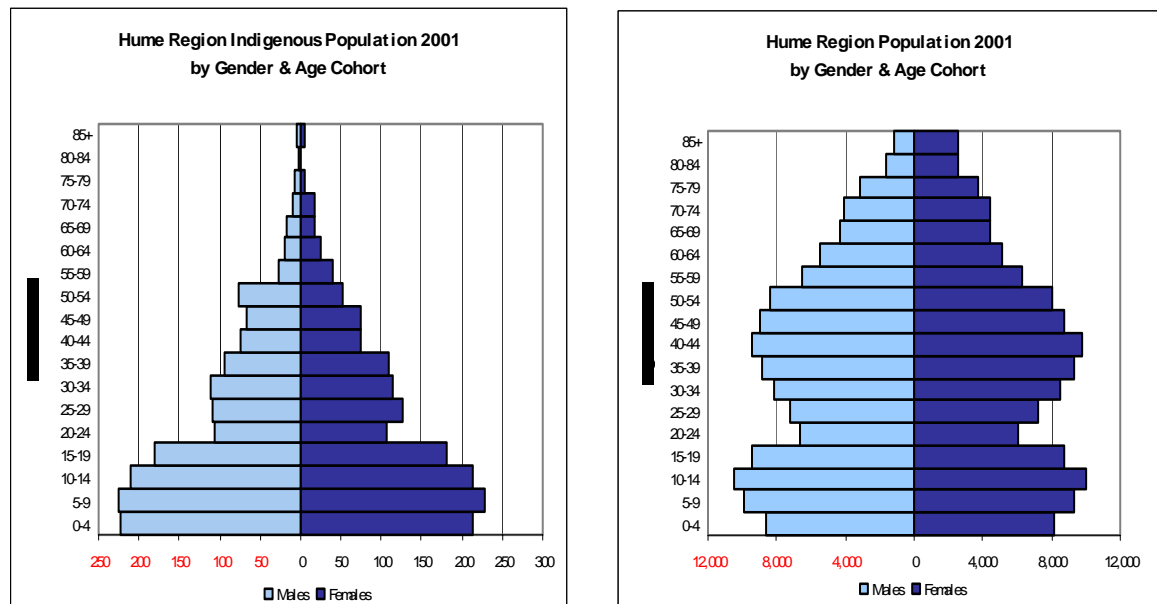


Figure 3.10 Map of indigenous populations in Hume

Figures 3.11 and 3.12 show the Indigenous population by age and gender in comparison to the total population.



Figures 3.11 (Indigenous) and 3.12 (Total) population breakdown by gender and age

Analysis of the above profiles suggest that the number of HACC eligible ATSI people i.e. over 45 years old or people with a disability, will increase significantly over the next three years and continue to grow over the next twenty years.

The figure below shows the populations of Indigenous people in 1991, 1996 and 2001 in Hume Region by local government area.

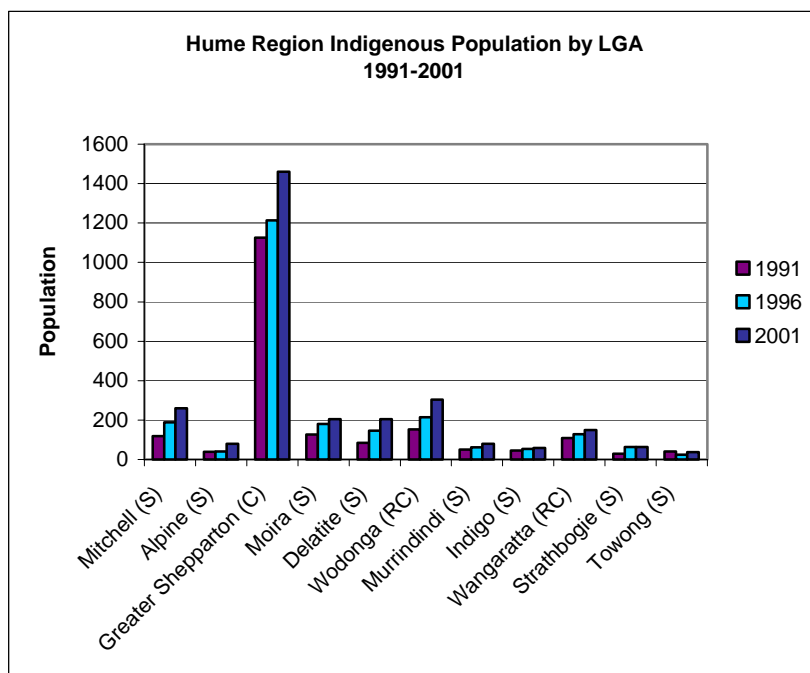


Figure 3.13 Indigenous population 1991-2001

***The change between 1996 and 2001***

Overall, the number of Indigenous people rose from approximately 2,314 in 1996 to 2,902 in 2001, which is an increase of 588 persons. Victoria’s Indigenous population also rose between 1996 and 2001, by 3,604 persons.

Indigenous people increased slightly as a proportion of the total population from 1.0% in 1996 to 1.2% in 2001. This compares to the Victorian population where the proportion of Indigenous people stayed at approximately 1% of the total population.

The largest increase between 1996 and 2001 was in the City of Greater Shepparton, where the number of Indigenous persons rose by 247 to a total of 1,460 in 2001. The next largest increase was in the Rural City of Wodonga, where the increase was 88 persons to a total of 303.

In proportionate terms, Alpine Shire showed a 100% increase as the Indigenous population doubled over the five years (from 40 to 80 persons). The Indigenous population rose 58.3% (from 24 to 38 persons) as a proportion of the total population in Towong Shire.

The smallest increase was in Strathbogie Shire, which showed a 1.6% increase in the proportion of Indigenous people. The population of Indigenous people in Indigo Shire showed an 11.3% increase in the proportion of the total population.

### ***Indigenous unemployment***

- Of the total Indigenous labour force, approximately 18.6% are unemployed (compared to the non-Indigenous population unemployment rate of approximately 5.9%)
- The highest levels of unemployment for Indigenous people are found in Indigo Shire (31.8%) and Strathbogie Shire (24.0%). The unemployment rates for the non-Indigenous population in these local government areas are 5.1% and 5.7% respectively
- Even where the levels of Indigenous unemployment are lowest, they are still approximately double that of the non-Indigenous population. Murrindindi Shire has an Indigenous unemployment rate of 12.0% and a non-Indigenous unemployment rate of 6.2%, while Moira Shire has 12.5% Indigenous unemployment and 5.8% non-Indigenous unemployment.

## **3.5.2. Demographic characteristics**

### **3.5.2.1. Socio-economic profile**

While Victoria as a whole reflects the general pattern of income distribution nationally, both regional Victoria and the Hume Region have lower than average income levels.

**Table 3.4: Income Distribution Victoria, 1996**

<b>Income Distribution</b>	<b>Hume Region</b>	<b>Regional Victoria</b>	<b>Metropolitan Melbourne</b>	<b>Victoria</b>
1 <sup>st</sup> quartile (lowest)	30.26%	31.06%	22.57%	26.82%
2 <sup>nd</sup> quartile	29.68%	29.22%	23.31%	26.27%
3 <sup>rd</sup> quartile	24.51%	23.57%	25.57%	24.57%
4 <sup>th</sup> quartile (highest)	15.56%	16.15%	28.54%	22.35%

Strathbogie Shire has the lowest income levels with almost 40% of the population in the lowest income bracket. Five other local government areas (Alpine, Moira, Murrindindi, Delatite and Towong) have more than 30% of their population in the lowest income distribution quartile as well as less than 15% in the highest income quartile. The Rural City of Wodonga and Mitchell Shire have the highest average income distributions, with close to 20% of their populations in the highest income range.

### 3.5.2.2. Income profile

Figure 3.14 shows the income profiles for the 65 years and over age group in Hume Region in comparison to the total population.

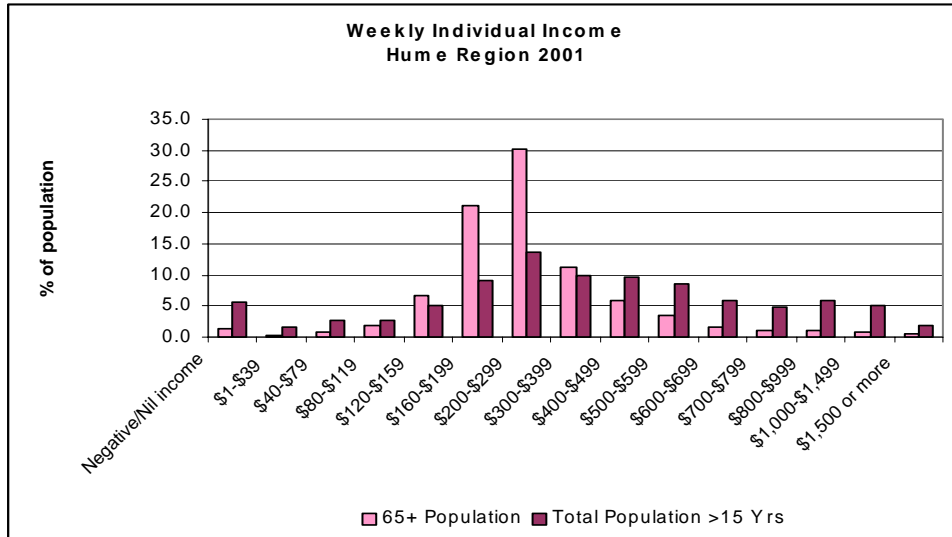


Figure 3.14. Income of 65+ population compared to income of total population 2001

- The large proportion of 65+ in the \$160-199 and \$200-299 income brackets will be mostly due to pension payments which are currently \$211 per week for a single person and \$176 per week per individual with a partner
- Approximately 1.2% of the 65+ group has a negative or nil income, and over 10% of this age group earn less than \$160 per week
- The highest proportion of people aged 65+ and earning less than \$160 per week were in Mitchell Shire (12.5%) and Towong Shire (12.4%).

### 3.5.2.3. Occupation

Figure 3.15 shows the percentage of older people currently in employment by occupation in 2001.

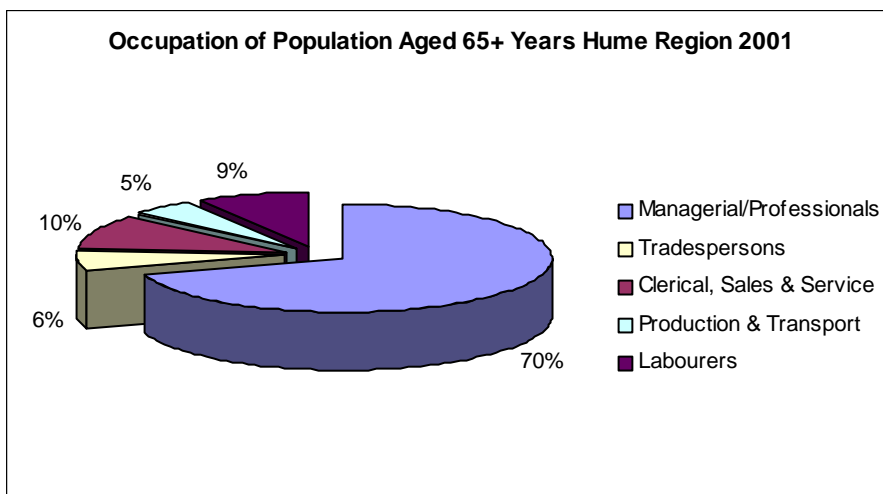


Figure 3.15. Occupation of the employed 65+ population

- 3,178 people aged 65 years and over are employed
- 70% of those in employment are employed as managers or professionals
- The highest proportion of persons aged 65+ who are employed are found in Towong Shire (18.3%), Murrindindi Shire (13.6%) and Indigo Shire (12.0%), compared to a regional average of 9.9%. This could be partly explained by the higher number of older people remaining working on farms.

### **3.5.3. Service provision**

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

In the first instance graphs showing per capita hours for each HACC activity per local government area were derived from the HACC MDS. Because of wide variations in the quality of regional MDS returns, these figures did not provide an accurate picture of HACC services across the Region. For example, Mitchell Shire appears to be significantly under resourced in Home Care, Personal Care, Property Maintenance and Delivered Meals. In reality, the Shire is well resourced for these services but has never lodged a MDS return.

Another example of how this data may paint an incorrect picture is the recent discovery of an MDS software error that has led to Wodonga Rural City significantly over reporting.

The Region enhanced the data analysis by comparing funding, quarterly output collection data with the MDS data (figures 3.16 to 3.22). Considerable variance was found between the three data sets; the funding data (target hours/capita) was considered the most reliable. A comparative analysis of the activity levels in each local government area was then made and conclusions drawn. From these conclusions proposals for service expansion for 2003-06 are presented.

### Home Care Hours Per Capita By LGA

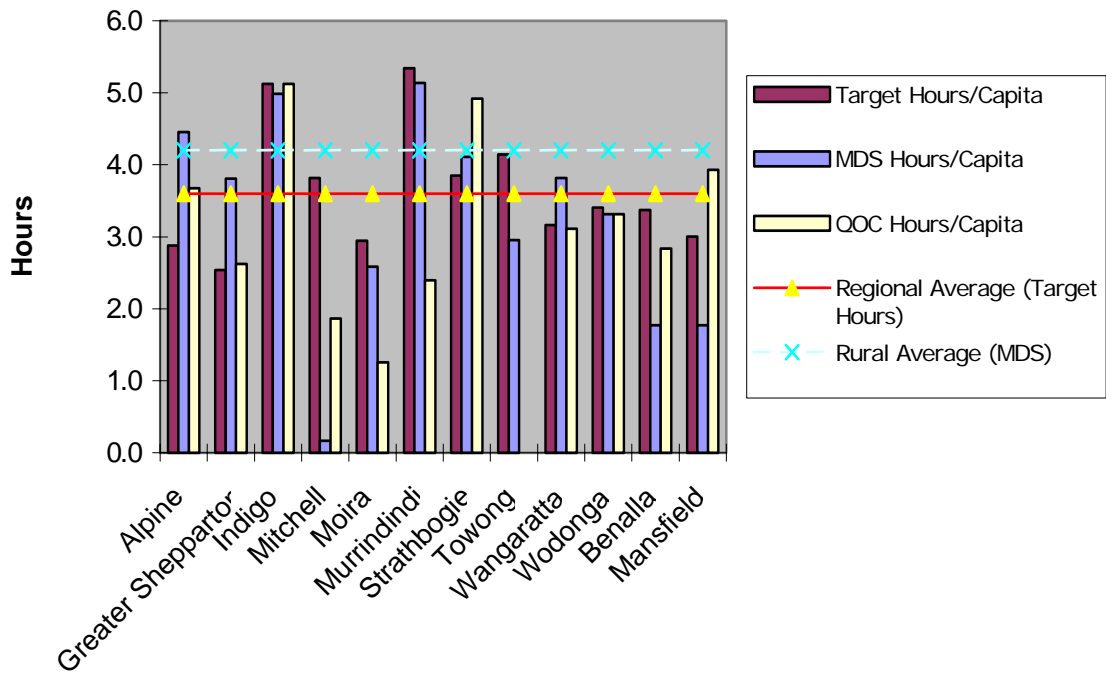


Figure 3.16 Home Care hours per capita

### Personal Care Hours Per Capita By LGA

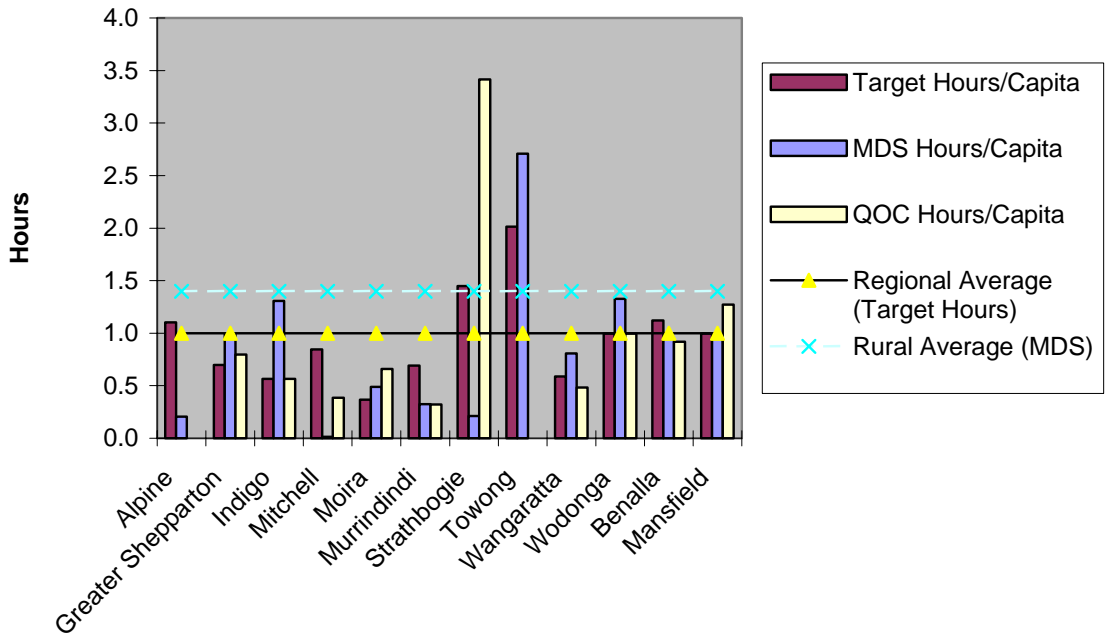
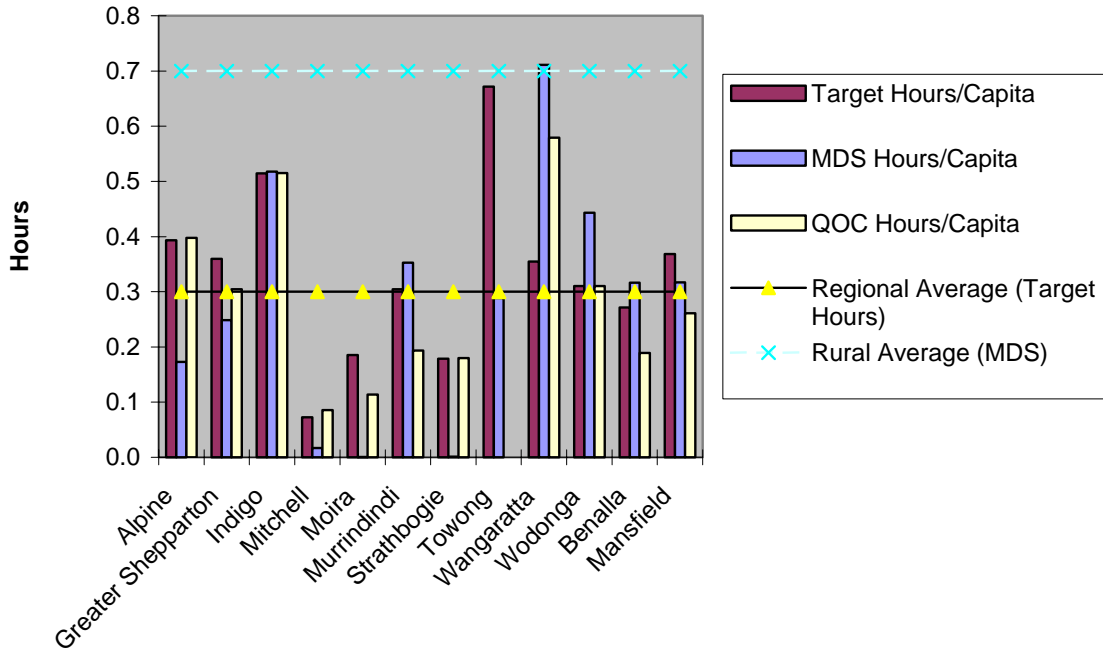


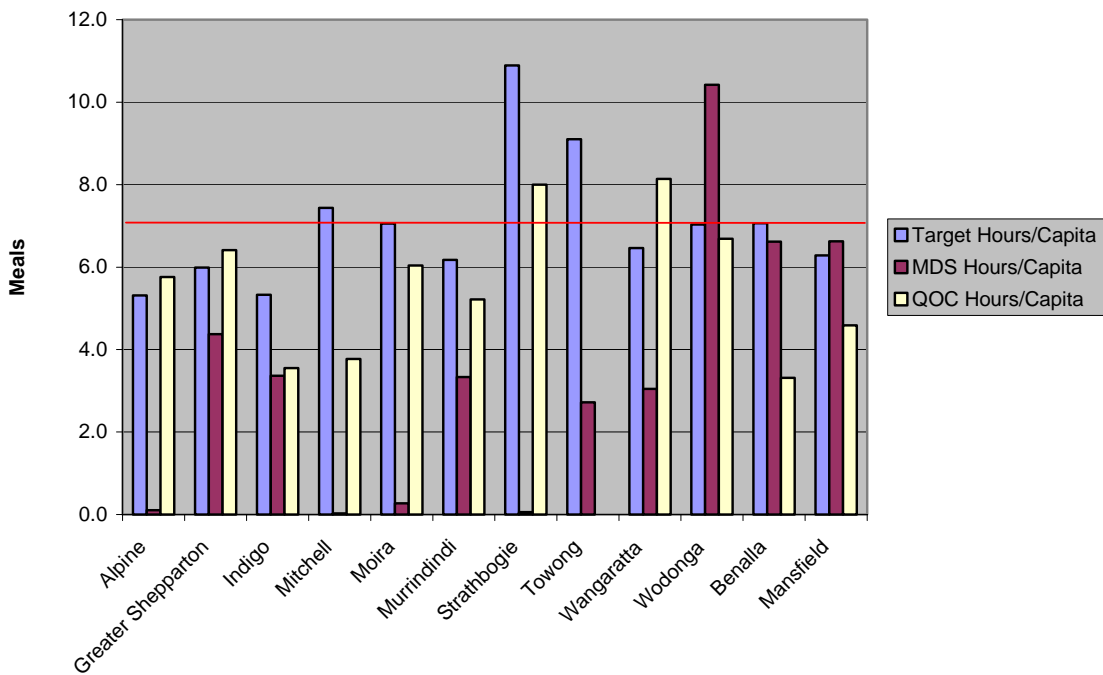
Figure 3.17 Hours of Personal Care per capita

**Property Maintenance Hours Per Capita By LGA**



**Figure 3.18 Hours of Property Maintenance per capita**

**Delivered Meals per capita by LGA**



**Figure 3.19 Meals per capita**

### Nursing Hours Per Capita By LGA

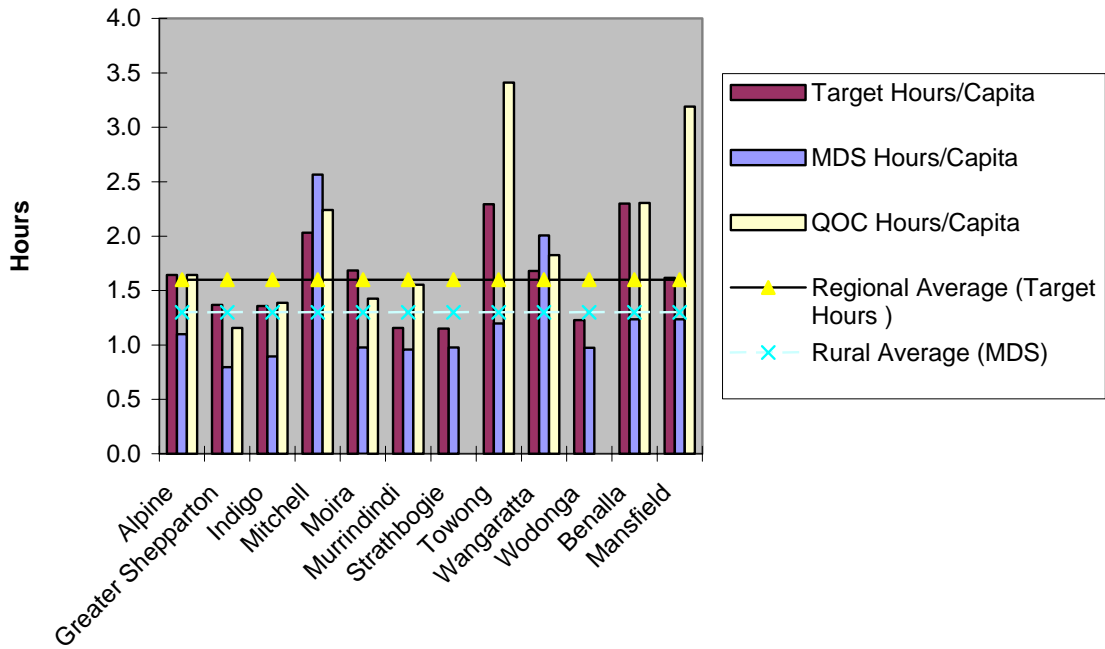


Figure 3.20. Hours of Nursing per capita

### Allied Health Hours Per Capita By LGA

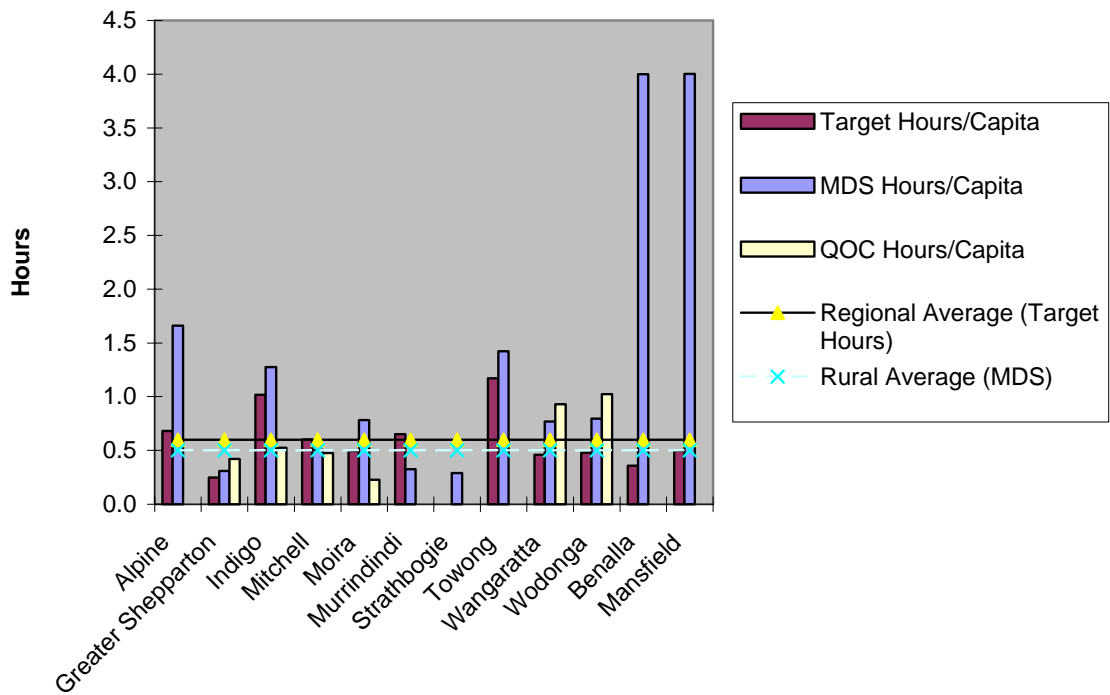
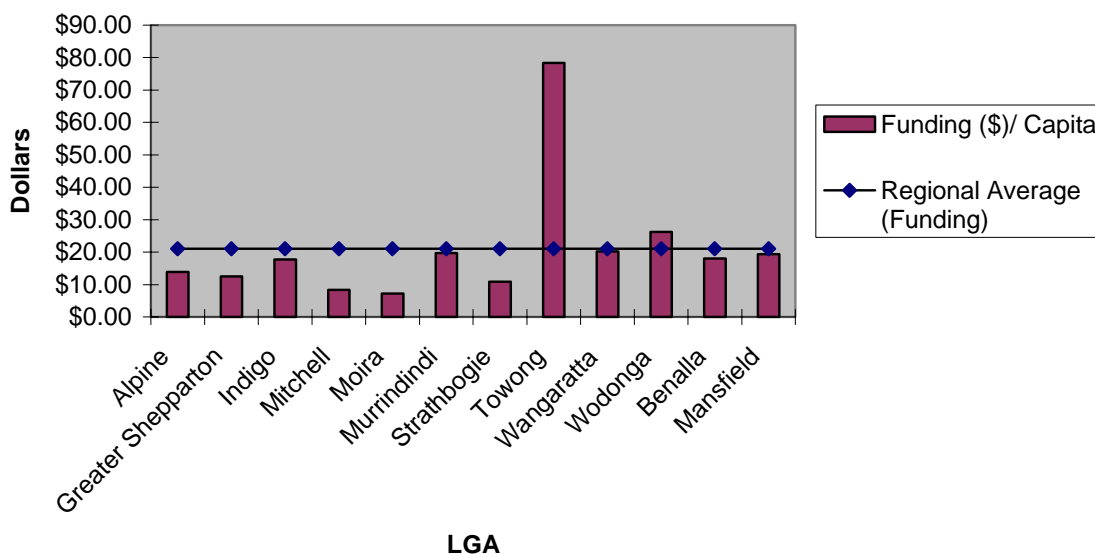


Figure 3.21. Hours of Allied Health per capita

### Assessment & Care Management Funding Per Capita By LGA



#### 3.22. Dollars of Assessment and Care Management per capita

Analysis of the above figures 3.16 to 3.22 show that for:

- Home Care – the local government areas of Alpine, Benalla, Greater Shepparton, Mansfield, Moira, Wangaratta and Wodonga are funded at a level below both the regional and rural averages. Of these, Greater Shepparton, Mansfield, Moira, Wangaratta and Wodonga are also under funded when compared to their WREN share of the population.
- Personal Care – the local government areas of Greater Shepparton, Indigo, Mitchell, Moira, Murrindindi and Wangaratta are funded at a level below both the regional and rural averages. Of these, Greater Shepparton, Moira, Murrindindi, and Wangaratta are also under funded when compared to their WREN share of the population.
- Property Maintenance – the local government areas of Mitchell, Moira, Strathbogie, and Benalla are funded at a level below both the regional and rural averages. Of these, Moira and Strathbogie are under funded when compared to their WREN share of the population.
- Delivered Meals – the local government areas of Alpine, Greater Shepparton, Indigo, Murrindindi, Wangaratta and Mansfield are funded at a level below both the regional and rural averages. Of these, Greater Shepparton, Murrindindi, Wangaratta and Mansfield are under funded when compared to their WREN share of the population.
- Nursing – the local government areas of Murrindindi, Strathbogie and Wodonga are funded at a level below both the regional and rural averages. All three municipalities are under funded when compared to their WREN share of the population.

- Allied Health – the local government areas of Greater Shepparton, Strathbogie, Wangaratta, Wodonga and Benalla are funded at a level below both the regional and rural averages. Of these, Greater Shepparton, Strathbogie, Wangaratta and Wodonga are under funded when compared to their WREN share of the population.
- Assessment & Care Management – the local government areas of Alpine, Greater Shepparton, Indigo, Mitchell, Moira, Murrindindi, Strathbogie, Wangaratta, Benalla and Mansfield are funded at a level below both the regional and rural averages. Of these, Greater Shepparton, Mansfield, Moira, Murrindindi, Strathbogie, and Wangaratta are under funded when compared to their WREN share of the population.

#### **3.5.3.2. HACC CALD service utilization**

From MDS returns for 2001-02, there were 1,077 overseas born people that received HACC services (10.8% of all HACC clients). Of these:

- 23.1% of the overseas born HACC clients were Italian, while 21.5% were English
- 22.1% of the overseas born HACC clients live in Rural City of Wangaratta, 16.6% live in Moira Shire and 11.5% live in Alpine Shire
- 25% of the MDS records did not record or adequately describe the client's country of birth.

#### **3.5.3.3. HACC ATSI Service Utilization**

Analysis of the HACC MDS for 2001-02 shows that:

- There were 329 Indigenous people that accessed HACC services
- Of these, 30.2% were aged less than 50 years old. In comparison, only 11.9% of non-Indigenous HACC clients were aged less than 50 years old.
- 42.7% of Indigenous HACC clients were aged 65 years and over. In comparison, 78.9% of non-Indigenous HACC clients were aged 65 years and over
- 58.8% of the Indigenous HACC clients live in City of Greater Shepparton, 14.3% live in Delatite Shire and 10.7% live in Moira Shire.

The table below compares Census data for the 50+ population with 2001-02 HACC service utilization data (MDS).

**Table 3.5 ATSI population compared to ATSI HACC service usage 2001-02**

LGA	ATSI Pop. 50+	LGA Pop. 50+	ATSI % Of Total 50+ Pop.	HACC Pop. 50+	ATSI HACC Pop. 50+	HACC ATSI % of Total HACC Pop.
Alpine	12	4,777	0.3	638	0	0.0
Delatite	17	6,955	0.2	764	45	5.9
Gr. Shepparton	154	14,883	1.0	1,897	119	6.3
Indigo	11	4,367	0.3	555	0	0.0
Mitchell	20	6,483	0.3	331	4	1.2
Moira	43	8,860	0.5	961	29	3.0
Murrindindi	12	4,162	0.3	657	4	0.6
Strathbogie	15	3,740	0.4	464	5	1.1
Towong	8	2,264	0.4	156	0	0.0
Wangaratta	13	8,505	0.2	1,290	6	0.5
Wodonga	24	7,075	0.3	857	12	1.4
Other LGA	-	-	-	220	5	2.3
<b>Total</b>	<b>329</b>	<b>72,071</b>	<b>0.5</b>	<b>8,790</b>	<b>229</b>	<b>2.6</b>

- The local government areas of Delatite, Shepparton, Mitchell, Moira, Murrindindi, Strathbogie, Wangaratta and Wodonga exhibit a greater proportion of Indigenous HACC clients than their proportion in the total population
- Alpine, Indigo and Towong exhibit a lower proportion of Indigenous HACC clients
- ATSI people comprise 2.6% of all HACC clients.

In her draft report of the *Victorian Aboriginal And Torres Strait Islander (ATSI) Communities HACC Needs Analysis Project – Hume Region*, Juliet Frizzell estimates that the ATSI population in Hume Region may be as much as twice the number identified in the census. The report estimates the Region's ATSI HACC population as 1,190 people.

#### **3.5.4. Funding**

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

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

**Table 3.6 Current funding and equity calculations for 2003-04**

LGA	WREN	Recurrent \$ (000)	Current \$ per capita	% of Recurrent Budget (Actual)	WREN %	Recurrent Funding WRENeD (000)	Amount Over/(Under) WREN (000) \$
Alpine	2,521	1,131	449	6.0%	6.8%	1,267	(136)
Benalla	2,441	1,206	494	6.5%	6.6%	1,227	(21)
Gr. Shepparton	7,191	3,443	479	18.4%	19.3%	3,615	(172)
Indigo	2,108	1,114	528	6.0%	5.7%	1,060	54
Mansfield	1,175	585	498	3.1%	3.2%	591	(6)
Mitchell	3,443	1,883	547	10.1%	9.3%	1,731	152
Moira	5,240	2,470	471	13.2%	14.1%	2,634	(64)
Murrindindi	2,071	1,088	525	5.8%	5.6%	1,041	47
Strathbogie	1,979	937	473	5.0%	5.3%	995	(58)
Towong	1,151	852	740	4.6%	3.1%	579	273
Wangaratta	4,250	2,062	485	11.0%	11.4%	2,136	(74)
Wodonga	3,622	1,924	531	10.3%	9.7%	1,821	103
<b>Total</b>	<b>37,19</b>	<b>18,695</b>	<b>503</b>	<b>100.0%</b>	<b>100%</b>	<b>18,695</b>	

Seven municipalities are under resourced when current funding is examined against the equity formula. These municipalities are Alpine, Benalla, Greater Shepparton, Mansfield, Moira, Strathbogie and Wangaratta.

The combined under resourcing for these seven municipalities equals \$630,506.

The 1 July 2003 transfer of \$2,896,900 of Aged Care funding to the HACC program has compounded the existing HACC funding inequalities identified in Table 4.

The Table 3.7 below highlights this impact.

**Table 3.7. Hume Region – Equity Calculations Including Consolidation**

LGA	WREN	Recurrent (\$'000)	% of Recurrent Budget (Actual)	WREN %	Consolidation Funding '000	Recurrent Funding Plus Consolidation (000)	Revised WREN Amount (000)	Amount Over/ Under WREN (000)
Alpine	2,521	1,131	6.0%	6.8%	539	1,670	1,464	\$206
Benalla	2,441	1,206	6.5%	6.6%	253	1,459	1,417	\$42
Gr. Shepparton	7,191	3,443	18.4%	19.3%	228	3,671	4,175	-\$504
Indigo	2,108	1,114	6.0%	5.7%	530	1,644	1,224	\$420
Mansfield	1,175	585	3.1%	3.2%	90	675	682	-\$7
Mitchell	3,443	1,883	10.1%	9.3%	212	2,095	1,999	\$96
Moira	5,240	2,470	13.2%	14.1%	365	2,835	3,042	-\$208
Murrindindi	2,071	1,088	5.8%	5.6%	87	1,175	1,202	-\$27
Strathbogie	1,979	937	5.0%	5.3%		937	1,149	-\$212
Towong	1,151	852	4.6%	3.1%	294	1,146	668	\$478
Wangaratta	4,250	2,062	11.0%	11.4%	150	2,212	2,467	-\$256
Wodonga	3,622	1,924	10.3%	9.7%	150	2,074	2,103	-\$29
<b>Total</b>	<b>37,192</b>	<b>18,695</b>	<b>100%</b>	<b>100%</b>	<b>2,898</b>	<b>21,592</b>	<b>21,592</b>	

Seven municipalities are under-resourced when Consolidation funds are factored into the equity calculation. These municipalities are Greater Shepparton, Mansfield, Moira, Murrindindi, Strathbogie, Wangaratta and Wodonga.

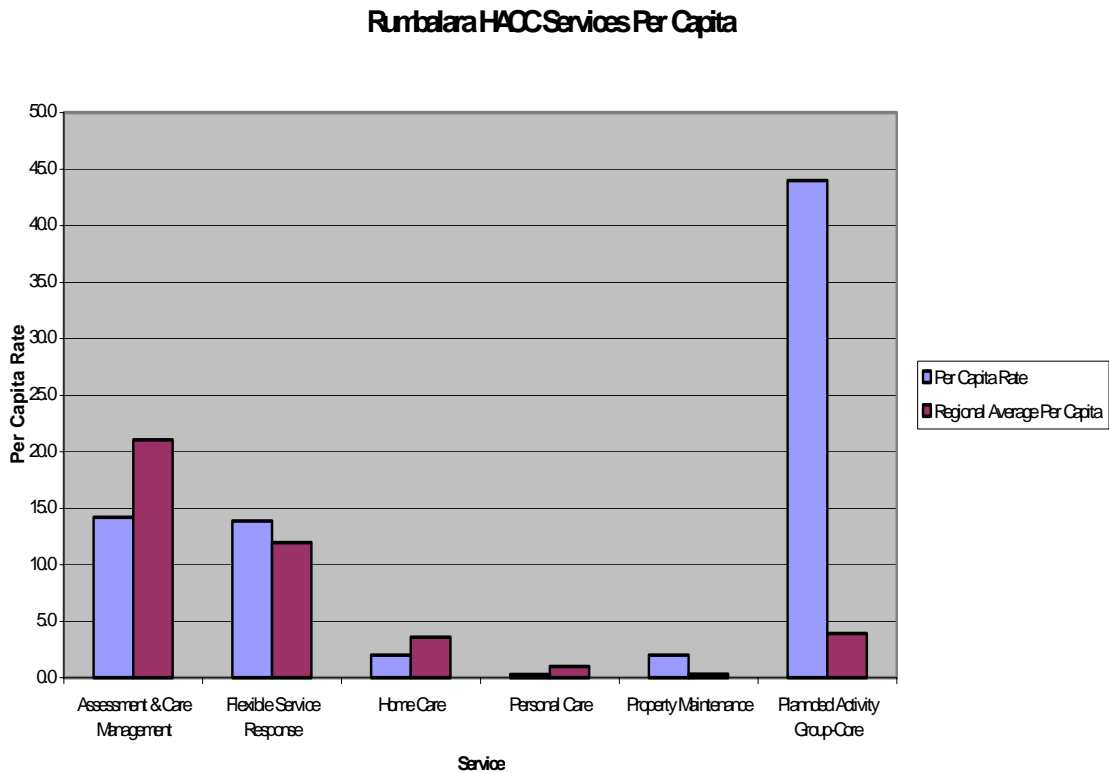
The combined under resourcing of these seven municipalities equals \$1,243,000.

### 3.5.4.2. ATSI funding

Using the population estimates contained in the report *Victorian Aboriginal And Torres Strait Islander (ATSI) Communities HACC Needs Analysis Project – Hume Region* 62.5% of the ATSI HACC population live in the municipalities of Greater Shepparton, Moira and Strathbogie.

Rumbalara Aboriginal Co-operative is the main provider of HACC services to the ATSI population in these local government areas.

The chart below shows Rumbalara’s per capita HACC funding for the three local government areas compared to the Regional average per capita funding.



**Figure 3.23. Rumbalara activities per capita compared to regional per capita activity averages**

When Rumbalara’s funding is compared to Regional average funding levels it is evident that the agency is under funded in the HACC activities of Assessment and Care Management, Home Care and Personal Care.

The agency’s Planned Activity Group funding is nearly nine times the Regional average.

## 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. Conclusion

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

Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
1	Increase HACC Basic in those municipalities that are under funded when compared to their WREN share of the population.	2003-06	<ul style="list-style-type: none"> <li>Increase is targeted to equity considerations and existing regional commitments</li> </ul>	<ul style="list-style-type: none"> <li>Increased client numbers across Region</li> <li>More service provided in areas of high need and increased demand</li> </ul>
1	Increase HACC Response Service across Region	2003-06	<ul style="list-style-type: none"> <li>Increase is proportional to reallocation of Personal Alert Victoria (PAV) units (funded by Aged Care)</li> </ul>	<ul style="list-style-type: none"> <li>Increased client numbers across Region</li> <li>More service provided</li> </ul>
2	Strategies will be developed pending the outcome of current projects	2004-06	<ul style="list-style-type: none"> <li>Enhance access to services for CALD clients</li> </ul>	<ul style="list-style-type: none"> <li>Increased proportion of CALD people accessing services across Region</li> <li>More service provided in areas of high need and increased demand</li> </ul>
3	Enhance access to services for ATSI people. Particularly those in emerging communities	2003-06	<ul style="list-style-type: none"> <li>Enhance access to and redress current service imbalance</li> </ul>	<ul style="list-style-type: none"> <li>Increased proportion of ATSI people accessing services across Region</li> <li>More service provided in areas of high need and increased demand</li> </ul>

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

### **5.1. Introduction**

Drawing on the data analyses and conclusions documented in Sections 3 and 4, this section details DHS' 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 identify the recommended recurrent growth allocations to the Region and local government areas for Priorities 1–3, subject to consultation, yearly reviews and budget confirmation. The recommendations reflect the overall planning goals for the Region, and were discussed with the sector. It is important to note that the recommendations for 2003-04 are detailed, while those for the out-years are subject to change when the Regional Plan is adjusted for 2004-05 and 2005-06.

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

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

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

<b>2003-04</b>	<b>Priority 1 Total (incl Training and HACC Response Service)</b>	<b>Priority 2 CALD</b>	<b>Priority 3 ATSI</b>
Alpine	\$ 14,205	\$ -	\$ -
Benalla	\$ 9,832	\$ -	\$ -
Greater Shepparton	\$ 112,963	\$ -	\$ 37,855
Indigo	\$ 12,680	\$ -	\$ -
Mansfield	\$ 13,298	\$ -	\$ -
Mitchell	\$ 15,328	\$ -	\$ -
Moira	\$ 93,062	\$ -	\$ 8,064
Murrindindi	\$ 34,516	\$ -	\$ -
Strathbogie	\$ 31,014	\$ -	\$ 2,554
Towong	\$ 13,538	\$ -	\$ -
Wangaratta	\$ 66,576	\$ -	\$ -
Wodonga	\$ 56,879	\$ -	\$ 7,150
Region Wide	\$ 29,300	\$ -	\$ 25,000
<b>Grand Total</b>	<b>\$ 503,193</b>	<b>\$ -</b>	<b>\$ 80,622</b>

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

<b>2004-05</b>	<b>Priority 1 Total (incl Training and HACC Response Service)</b>	<b>Priority 2 CALD</b>	<b>Priority 3 ATSI</b>
Alpine	\$ 4,317	\$ -	\$ -
Benalla	\$ -	\$ -	\$ -
Greater Shepparton	\$ 131,579	\$ -	\$ -
Indigo	\$ 4,381	\$ -	\$ -
Mansfield	\$ 1,675	\$ -	\$ -
Mitchell	\$ 15,251	\$ -	\$ -
Moira	\$ 109,030	\$ -	\$ -
Murrindindi	\$ 1,289	\$ -	\$ -
Strathbogie	\$ 36,316	\$ -	\$ -
Towong	\$ 9,342	\$ -	\$ -
Wangaratta	\$ 77,550	\$ -	\$ -
Wodonga	\$ -	\$ -	\$ -
Region Wide	\$ 107,660	\$ 50,000	\$ 50,000
<b>Grand Total</b>	<b>\$ 498,390</b>	<b>\$ 50,000</b>	<b>\$ 50,000</b>

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

2005-06	Priority 1 Total (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Alpine	\$ 4,425	\$ -	\$ -
Benalla	\$ -	\$ -	\$ -
Greater Shepparton	\$ 165,806	\$ -	\$ -
Indigo	\$ 4,624	\$ -	\$ -
Mansfield	\$ 1,783	\$ -	\$ -
Mitchell	\$ 15,841	\$ -	\$ -
Moira	\$ 28,417	\$ -	\$ -
Murrindindi	\$ 1,321	\$ -	\$ -
Strathbogie	\$ 20,013	\$ -	\$ -
Towong	\$ 9,709	\$ -	\$ -
Wangaratta	\$ 88,556	\$ -	\$ -
Wodonga	\$ -	\$ -	\$ -
Region Wide	\$ 205,484	\$ 50,000	\$ 50,000
<b>Grand Total</b>	<b>\$ 545,978</b>	<b>\$ 50,000</b>	<b>\$ 50,000</b>

### 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 proposed in order to best meet the needs of the HACC target population?

#### 5.3.1. Funds equalisation or not?

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

As noted in Section 3.5.4 Table 3.7 the local government areas under resourced when current funding is examined against the equity formula are Alpine, Benalla, Greater Shepparton, Mansfield, Moira, Strathbogie and Wangaratta. The combined under-resourcing for these seven municipalities equals \$630,506. However, the 1 July 2003 transfer of \$2,896,900 of Aged Care Consolidation funding to the HACC program compounds this inequality.

Seven municipalities are under-resourced when Consolidation funds are factored into the equity calculation. These municipalities are Greater Shepparton, Mansfield, Moira, Murrindindi, Strathbogie, Wangaratta and Wodonga.

The combined under-resourcing of these seven municipalities equals \$1,243,000.

Allocating HACC growth funds over the next three years, using the WREN only local government area percentages, will maintain the inequalities.

Options for redressing this inequality require the Regional Office to either allocate significant funds (top slice) from each year's growth or move to redistribute existing HACC funds between municipalities.

Hume Region recommends that HACC growth funds be used to redress the funding inequity.

Scenarios for using growth funds involve the following amounts each year for:

- Three years - \$414,212 (approx 72% of growth pa)
- Four years - \$310,660 (approx 54% of growth pa)
- Five years - \$248,528 (approx 43% of growth pa)
- Six years - \$207,106 (approx 36% of growth pa)
- Eight years - \$155,330 (approx 27% of growth pa).

The three-year scenario means that only local government areas that are under-resourced will receive growth funds over the next three years. The advantage of this scenario is that the equalization process will be quick. The disadvantage is that this scenario reduces the Regional Office ability to:

- Complete an existing three-year commitment to bring the Lower and Upper Hume Rural Allied Health Teams up to a full complement of professional disciplines. This requires \$150,000 in 2003-04
- Provide additional funds under the small rural health agency requirement, which amounts to \$48,000 pa for the next three years
- Adequately resource services to ATSI and CALD communities at \$100,000 pa over the next three years, (see pages 53 & 56 for further details)
- Expand the HACC Regional Training function at \$20,000 pa over the next three years.

The five, six and eight year scenarios will take too long to achieve. In addition, any growth funds going into over resourced municipalities, during this period, will continue the inequality.

The Region recommends allocating a significant portion of the growth to redress funds inequity between local government areas over the next four years. This equates to a minimum of 54% of growth each year for four years.

The Region believes that it is important to implement an accelerated approach to equalisation for the following reasons:

- Any growth going to over funded municipalities, over this time, will compound the existing inequality
- Due to the lack of one main population centre within the Region, it is important that services be distributed as equitably as possible to ensure best possible coverage
- The seven under resourced local government areas have the largest aged populations and/or will experience significant growth in this cohort over the next nine years
- Approximately 70% of the Region's HACC population live in these local government areas
- Shepparton and Wodonga have the largest ATSI populations in the Region
- Shepparton, Wodonga and Wangaratta have the Region's largest CALD populations.

The Region will allocate the remainder of each year's growth to specific service priorities that are independent of funds equity considerations. These are:

- Complete an existing three-year commitment to bring the Lower and Upper Hume Rural Allied Health Teams up to a full complement of professional disciplines. This requires \$150,000 in 2003-04
- Provide additional funds under the small rural health agency requirement. This amounts to \$48,000 for 2003-04
- Adequately resource services to ATSI and CALD communities at \$100,000 pa over the next three years
- Expand the HACC Regional training function at \$20,000 pa over the next three years.

In targeting the majority of growth funds over the next three years to equalization the following municipalities will benefit:

- 2003-04 - Shepparton, Mansfield, Moira, Murrindindi, Strathbogie, Wangaratta and Wodonga
- 2004-05 – Shepparton, Moira, Strathbogie and Wangaratta.
- 2005-06 – Shepparton, Strathbogie and Wangaratta.

Other municipalities will receive some growth through the Small Rural Agencies project or through allocations to expand services provision to CALD and ATSI populations.

### **5.3.2. Proposed expansion of activities – Priority 1**

The Region believes that the primary objective of service expansion through Priority 1 is to achieve funds equity between municipalities rather than ensure adequate funding for all activities in each local government area. This also means that to achieve funds equity in some municipalities' activities that are adequately resourced, when compared to the WREN, will receive growth funding. Within this framework the Region recommends the following service expansion drawing on the data analysis described in Section 3.5.3.

#### **5.3.2.1. Expansion of HACC Basic**

- Home Care funding is recommended for Greater Shepparton, Mansfield, Moira, Wangaratta and Wodonga between 2003-06
- Personal Care funding is recommended for-Greater Shepparton, Moira, Murrindindi and Wangaratta between 2003-06
- Property Maintenance funding is recommended for Moira and Strathbogie in 2003-05
- Delivered Meals funding is recommended for Greater Shepparton in 2004-05
- Nursing is recommended for Greater Shepparton, Murrindindi, Strathbogie, Wangaratta and Wodonga, 2003-06
- Allied Health is recommended for speech pathology services to rural/remote communities across the Region in 2003-04. The Region will set aside an indicative amount of \$230,000 between 2004-05 and 2005-06 for the purpose of implementing the Rural Allied Health Team review. This is described in further detail below
  - Assessment & Care Management is recommended for-Greater Shepparton, Moira, Murrindindi, Strathbogie and Wangaratta, between 2003-06.

### **Continued expansion of Allied Health**

Over the past ten years, the Region has developed a model for the provision of allied health services to HACC clients living in rural/remote communities. The model is based upon four multi-discipline allied health teams, each covering a designated Primary Care Partnership catchment. The teams are based in agencies within the larger towns/cities and travel out to visit clients in rural/remote areas. The teams do not see clients in the larger towns/cities.

Except for Lower Hume and Upper Hume, each team has the following disciplines: podiatry, physiotherapy, occupational therapy, dietician, speech pathology and continence nurse. It is recommended to allocate growth funds in 2003-04 for speech pathologist positions in the Upper Hume and Lower Hume teams.

Currently, speech pathologists from the Central Hume and Goulburn Valley teams service the Upper and Lower Hume catchments. Funding new positions in the Lower and Upper Hume catchments will have the effect of doubling HACC speech pathology services across the Region.

Expansion and consolidation of rural allied health services has been a Regional priority for the past two years. The Region recommends that this expansion and consolidation of rural allied health service delivery remain a priority for 2003-06.

With the success of the Rural Allied Health Team model, there is growing anecdotal evidence that HACC clients living in the Region's larger towns have less access to Allied Health than people living in rural remote areas. Consequently, Hume Region is currently undertaking a review of its Rural Allied Health Team model. This review will be completed in 2003-04. The Region will use the review's findings to inform allied health planning for 2004-06.

#### **5.3.2.2. Expansion of funding to small rural communities**

There are 16 agencies in Hume Region that are included under the Small Rural Health Services project. These agencies comprise:

- Eleven D & E hospitals
- Two Multi Purpose Services
- Two community health services
- One non-government organization.

In the first year, through direct allocation, these agencies will receive 1.5% of their HACC budget as growth. This amounts to:

- 2003-04 - \$46,577.64.

In 2004-05 and 2005-06 the Region will consider proposals to support small rural communities. The anticipated small rural community budget is

- 2004-05 - \$48,458.21
- 2005-06 - \$50,414.71.

### 5.3.2.3. Expansion of the HACC Regional Training Co-ordination function

The Regional Information & Advocacy Council currently receives \$15,000 pa to coordinate HACC training.

Following discussion with the Regional HACC Training Advisory Committee, Hume Region intends to increase the hours of the Regional Training Coordinator to full time over the next three years. This will enable the coordinator to develop and implement a regional training strategy to address the training needs of HACC staff as well as to initiate training activities that are not available through the Vocational Education Training sector.

It is recommended that the Region increase the Regional Training Coordinator position incrementally over the next three years:

- 2003-04 - \$17,000 (\$12,000 to make the position 0.5 EFT and \$5,000 program funds)
- 2004-05 - \$21,800 (\$16,800 to increase the position to 0.8 EFT and an additional \$5,000 program funds)
- 2005-06 - \$17,200 (\$12,200 to increase the position to 1.0 EFT and \$5,000 program funds).

The funds will be allocated directly to the existing fund holder for a fixed term of three years, commencing January 2004 and ending December 2006. Continuation of the funding will be subject to a review undertaken in conjunction with the Region's HACC Training Advisory Committee.

### 5.3.2.4 Summary of service expansion

The service expansion recommended for each local government area is depicted in Appendix F.

The Region-wide picture is summarised in the tables below, that is, recommended expansion in activities during 2003-06. It should be noted that Priority 1 targets the whole HACC population.

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

<b>ACTIVITIES</b>	<b>Units</b>	<b>\$</b>
Home Care	5,077	\$124,082
Personal Care	567	\$ 15,842
Property Maintenance	66	\$ 2,346
Allied Health	2,037	\$ 146,195
Nursing	933	\$ 58,648
Assessment & Care Management	-	\$126,779
SSR HACC Response Service	-	\$ 12,300
SSR Training	-	\$ 17,000

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

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

<b>ACTIVITIES</b>	<b>Units</b>	<b>\$</b>
Home Care	3,387	\$ 84,844
Personal Care	2,948	\$ 84,431
Property Maintenance	656	\$ 23,905
Allied Health	1,132	\$ 83,270
Nursing	2,510	\$161,719
Delivered Meals	7,191	\$ 9,061
Assessment & Care Management	-	\$ 17,060
SSR HACC Response Service	-	\$ 12,300
SSR Training	-	\$ 21,800

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

<b>ACTIVITIES</b>	<b>Units</b>	<b>\$</b>
Home Care	2787	\$ 71,542
Personal Care	994	\$ 29,184
Allied Health	2467	\$186,012
Nursing	2063	\$136,261
Assessment & Care Management	-	\$ 93,479
SSR HACC Response Service	-	\$ 12,300
SSR Training	-	\$ 17,200

### 5.3.4. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Personal Care (hours)	Property Maintenance (hours)	Allied Health (hours)	Nursing Blair (hours)	Assessment & Care (\$)	Service System Resourcing /Training \$
Upper Hume	Wodonga Regional Health Service	Direct				1,019	483		
Lower Hume	Mitchell Community Health Service	Direct				1,018			
Goulburn Valley	City of Greater Shepparton	Direct	2,637					\$19,304	
Central Hume	Alpine Health	Direct					65		
Upper Hume	Beechworth Health Service	Direct					49		
Upper Hume	Glenview Community Care	Direct					18		
Lower Hume	Alexandra District Hospital	Direct					9		
Lower Hume	Murrindindi Community Health Service	Direct					11		
Lower Hume	Yea & District Memorial Hospital	Direct					15		
Lower Hume	Shire of Murrindindi	Direct						\$23,991	
Goulburn Valley	Shire of Strathbogie	Direct			66			\$20,701	
Upper Hume	Upper Murray Health & Community Services	Direct	198						
Upper Hume	Tallangatta Health Service	Direct	168						
Central Hume	Rural City of Wangaratta	Direct	1,043	567				\$8,162	
Regional	Regional Information & Advocacy Council	Direct							\$17,000
Central Hume	Mansfield District Hospital	Direct					25		
Central Hume	Mansfield Shire	Direct	286						
Lower Hume	Kilmore District Hospital	Direct					16		
Lower Hume	Seymour District Memorial Hospital	Direct					68		
Goulburn Valley	Moira Healthcare Alliance	Direct	262					\$54,621	
Goulburn Valley	Cobram District Hospital	Direct					52		
Goulburn Valley	Nathalia District Hospital	Direct					26		
Goulburn Valley	Numurkah District Health Service	Direct					46		
Goulburn Valley	Yarrawonga District Health Service	Direct					50		
Upper Hume	Wodonga Rural City	Direct	483						
Regional	Villa Maria Society (HACC Response Service)	Direct							\$12,300
<b>Total</b>			<b>5,077</b>	<b>567</b>	<b>66</b>	<b>2,037</b>	<b>933</b>	<b>\$126,779</b>	<b>\$29,300</b>

## 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 – Current projects

Hume Region is currently undertaking two projects that aim to improve access to HACC services for people from CALD backgrounds. These projects are:

- **Special Dietary Requirements** – This project concludes in 2004. Dieticians from the four Rural Allied Health Teams are working with the Region's fifteen Food Service providers to increase awareness about the needs of people who require therapeutic or culturally appropriate meals. Apart from working with individual providers and kitchens, the dieticians will also conduct forums and seminars for the Food Services sector.
- **Diversity Plus** – This project is being undertaken by the Region's HACC Equity and Access workers. The project concludes in 2004 and aims to improve access to HACC services, for CALD groups, by developing and supporting networks, disseminating information, supporting greater service system flexibility and responsiveness by:
  - Establishing links with CALD communities
  - Identifying service provision gaps
  - Improving agency cultural planning capabilities
  - Providing cultural awareness training and other staff development activities
  - Developing appropriate models for (CALD) consumer participation
  - Assisting agencies to implement HACC Cultural Plans.

In addition, Goulburn Valley Primary Care Partnership (PCP) has recently completed a Best Practice project that aimed to increase the use of language services across the Goulburn Valley catchment. As an outcome of the project, the Primary Care Partnership is finalising a Language Services Information and Training Kit designed specifically for agencies in rural areas.

Hume Region believes that the outcomes of this project could have wider application across rural Victoria.

### 5.4.2. Project recommendations

Hume Region recommends continuing and finalising the above-mentioned CALD initiatives during 2003-04. The findings will inform new CALD initiatives for 2004-05 and 2005-06. The Region has allocated an indicative amount of \$100,000 over two years for Priority 2.

## **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.

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

### **5.5.3. ATSI sector**

#### **5.5.3.1. HACC ATSI services in Hume**

Historically, Rumbalara has been funded to provide a limited range of HACC services across the Region. Over the last few years, the agency has found it difficult to continue providing services to ATSI people residing some distance from Shepparton.

Providing HACC services to ATSI communities outside the Goulburn Valley presents a challenge. These communities are small and apart from Wodonga do not have a local aboriginal agency to provide HACC services.

Hume Region funds the Mungabareena Aboriginal Corporation in Wodonga for:

- 720 hours (\$6,976.80) Planned Activity Group Core. Mungabareena is currently developing this service in partnership with the Wodonga Rural City
- \$72,240 for a HACC Aboriginal Liaison Officer covering the local government areas of Alpine, Benalla, Indigo, Mansfield, Towong, Wangaratta and Wodonga. This funding is fixed term and ceases on 31 December 2003.

Key recommendations of the draft report of the *Victorian Aboriginal And Torres Strait Islander (ATSI) Communities HACC Needs Analysis Project – Hume Region* are related to:

- Funding a project to build sustainable relationships between local Koori communities and mainstream agencies
- Developing a viable and adequately funded model to support the delivery of culturally appropriate and high quality HACC services to ATSI people
- Developing a strategy for addressing the concerns and barriers Koori people have accessing mainstream agencies across the Region.

#### **5.5.4. Expansion of services**

##### **5.5.4.1. 2003-04**

In 2003-04 Hume Region will:

- Increase Rumbalara's HACC funding for the activities: Assessment & Care Management, Home Care and Personal Care commensurate to the Regional average per capita level for each activity
- Work with Rumbalara to re-direct some of the Planned Activity Group funding to its other HACC services
- Increase Mungabareena's Planned Activity Group Core funding to 1,440 hours
- Evaluate the Aboriginal Liaison Officer positions servicing the eastern and western sides of the Region
- Fund a Fixed Term Recurrent project that will develop strategies to address the key recommendations from the draft report of the *Victorian Aboriginal And Torres Strait Islander (ATSI) Communities HACC Needs Analysis Project – Hume Region*

##### **5.5.4.2. 2004-06**

In 2004-05 and 2005-06, Hume Region will implement strategies to address the recommendations of the above-mentioned needs analyses.

The Region has allocated an indicative amount of \$100,000 to be used for this purpose in 2004-05 and 2005-06.

### 5.5.6. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Personal Care (hours)	Assessment & Care Management (\$)	Service System Resourcing (\$)	PAG Core (hours)
Goulburn Valley	Rumbalara Aboriginal Cooperative	Direct	1,190	521	\$4,832		
Upper Hume	Mungabareena Aboriginal Corporation	Direct					720
Regional	DHS Hume Region	Direct				\$25,000	
<b>Total</b>			<b>1,190</b>	<b>521</b>	<b>\$4,832</b>	<b>\$25,000</b>	<b>720</b>

## 5.6. Impact of Priorities 1-3 proposals

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

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

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

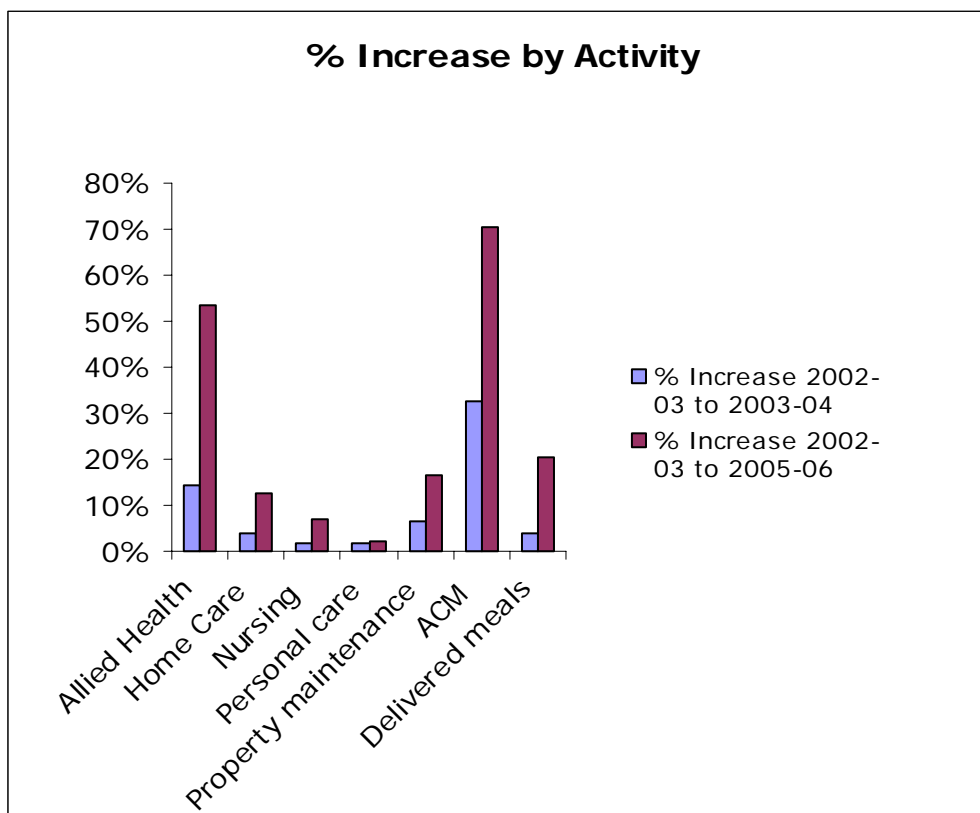
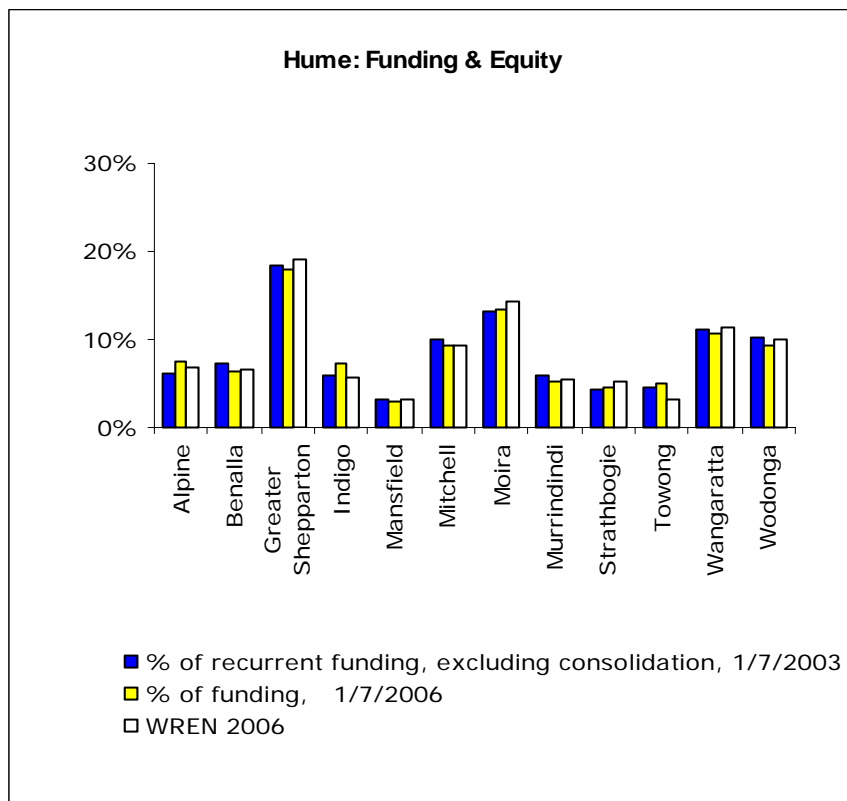


Figure 5.1 Percentage increase of Priority 1 activities, 2003-04 and 2003-06

The table and the graph below provide a summary of the impact of the distribution of growth funding for 2003-06 in each local government area. The first bar shows the recurrent base budget 1 July 2003 (excluding consolidation funds). The second bar shows the 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 consolidati on, 1/7/2003	WREN 2003-04	Recurrent \$ + growth, including consolidation, 1/7/2006	% of funding, 1/7/2006	WREN 2006
Alpine	\$ 1,130,910	6.0%	6.8%	\$ 1,731,118	7.4%	6.8%
Benalla	\$ 1,345,719	7.2%	6.6%	\$ 1,506,540	6.4%	6.6%
Gr. Shepparton	\$ 3,442,947	18.4%	19.3%	\$ 4,228,351	18.1%	19.2%
Indigo	\$ 1,114,006	6.0%	5.7%	\$ 1,697,645	7.2%	5.7%
Mansfield	\$ 584,711	3.1%	3.2%	\$ 709,239	3.0%	3.2%
Mitchell	\$ 1,882,944	10.1%	9.3%	\$ 2,194,043	9.4%	9.3%
Moira	\$ 2,469,802	13.2%	14.1%	\$ 3,153,362	13.5%	14.2%
Murrindindi	\$ 1,088,176	5.8%	5.6%	\$ 1,243,522	5.3%	5.5%
Strathbogie	\$ 797,326	4.3%	5.3%	\$ 1,057,009	4.5%	5.3%
Towong	\$ 851,818	4.6%	3.1%	\$ 1,196,289	5.1%	3.1%
Wangaratta	\$ 2,061,638	11.0%	11.4%	\$ 2,507,973	10.7%	11.3%
Wodonga	\$ 1,924,414	10.3%	9.7%	\$ 2,194,362	9.4%	9.9%
<b>Total</b>	<b>\$ 18,694,411</b>	<b>100.00%</b>	<b>100.0%</b>	<b>\$23,419,451</b>	<b>100.0%</b>	<b>100.0%</b>



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

Progress towards redressing HACC funds inequity between local government areas will be achieved over the three years of this plan. However, as the Regional equalisation strategy is to be implemented over four years there will still be some local government areas that remain under-funded according to the WREN at the end of the three years. This is also affected by the fact that 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, beyond the four-year equalisation strategy, may be 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.

Furthermore, the Regional Office proposes to work with agencies in the over WREN municipalities to explore opportunities to re-distribute the Consolidation Project funds within these local government areas. This will change the existing HACC service mix and ensure a more effective response to changing community needs.

## **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 project is recommended in 2003-04:

The HACC Care Planning, Care Coordination and Case Management project has identified the need to undertake further work to assist HACC services operate effectively within an enhanced service coordination environment. In particular, the work needs to focus on defining the roles, responsibilities, expectations, and relationships with other services/agencies, protocol development and client participation for HACC services working as or with:

- Lead agencies
- Assessment services
- Case management services.

This project will cost up to \$30,000, and will be administered via direct allocation negotiated through a partnership process.

Service development initiatives for 2004-05 and 2005-06 will be considered as the Regional Plan is adjusted for those years.

### **6.3. Minor capital discretionary funding**

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

The Region will put 80% of the minor capital budget through the formula. It is proposed that the discretionary allocation be used to:

- Assist with the establishment of the two speech pathology positions that will be funded recurrently. Likely establishment costs are for two vehicles, office equipment, computers and mobile phones
- If possible, assist agencies during the transition to a new allocation process for minor capital.