

Home and Community Care (HACC) Program

# Northern Metropolitan Region 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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## **Section 1 – HACC Regional Plan 2003-06**

## **1.1. Context of the Regional Plan**

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

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

## **1.2. Purpose of the Regional Plan**

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

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

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

These are the subjects of the present Regional Plan.

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

## **1.3. Consultation with the sector**

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

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

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

## 1.4. What is the HACC Program?

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

## 1.5. Characteristics of HACC service users in Victoria

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

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

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

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

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

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

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

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

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

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

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

## **1.6. Better planning & funds allocation**

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

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

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

### **1. Focussed Ministerial Priorities for HACC growth funds**

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

### **2. Consistent three year planning**

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

### **3. More diverse means of funds allocation**

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

### **4. Automatic allocation of minor capital**

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

### **5. More focussed research and development program**

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

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

## 1.7. HACC budget

### 1.7.1. Service expansion - recurrent funding

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

#### 1.7.1.1. Joint Commonwealth/State commitment

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

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

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

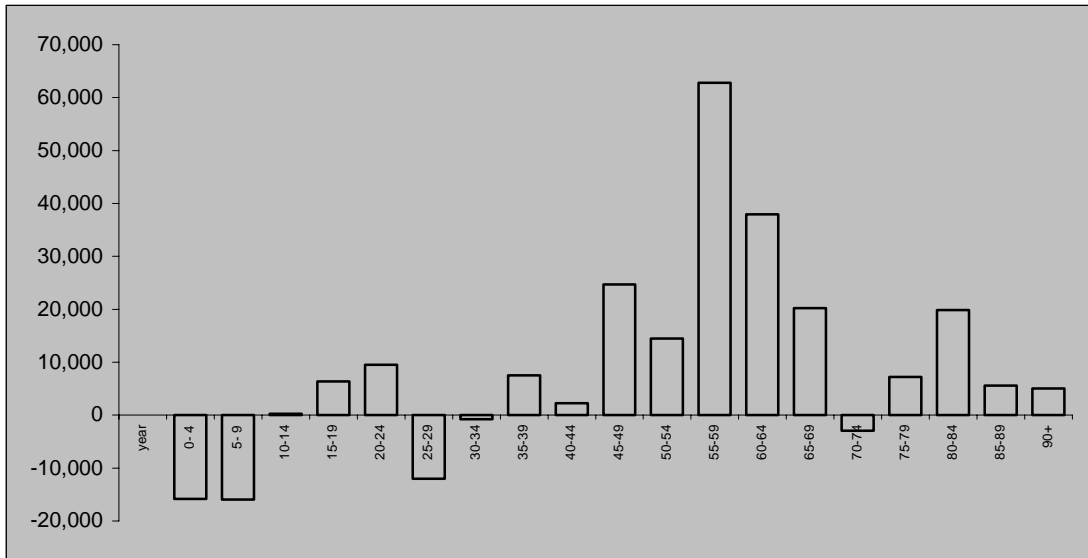
Projected changes in population and target groups indicate that growth in demand for HACC services will come predominantly from older age-groups. Not only does the rate of disability increase with age, but the rate of uptake of HACC services is also much higher among older persons, relative to the prevalence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

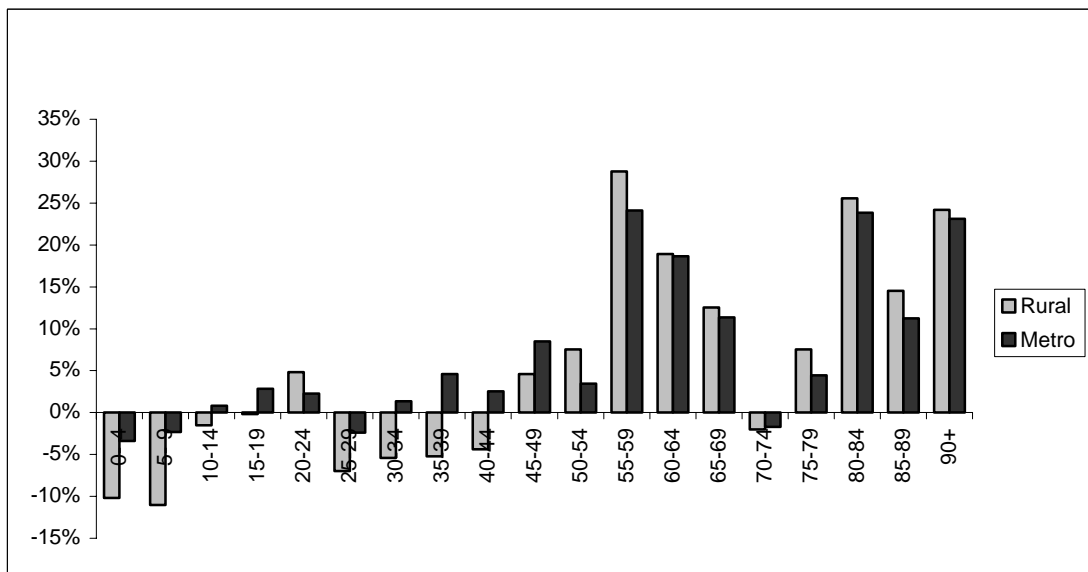
Figure 2.1 shows the projected change in age groups between 2001-06. There are:

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



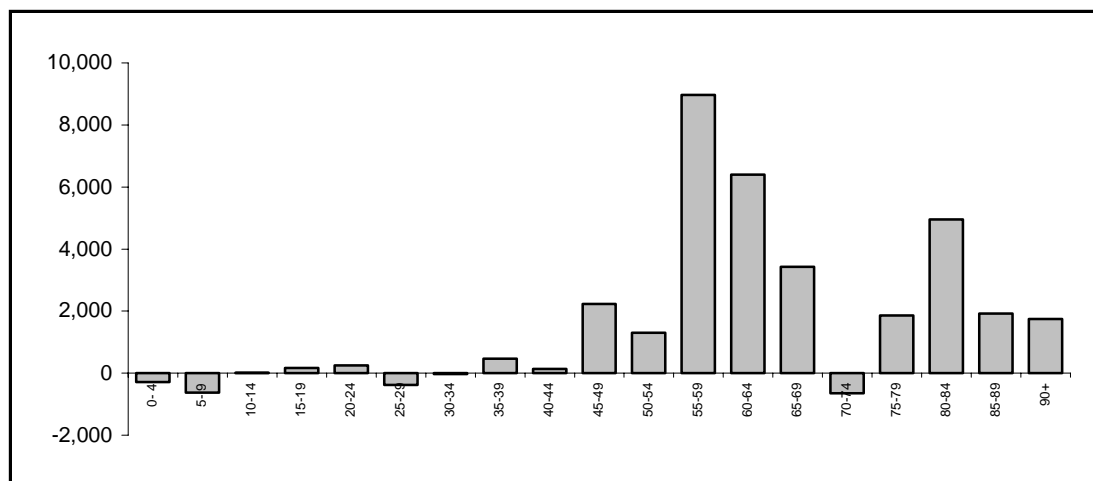
**Figure 2.1: Changes in population groups 2001-06 Victoria**  
 Source: Department of Infrastructure *Victoria In Future*

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.

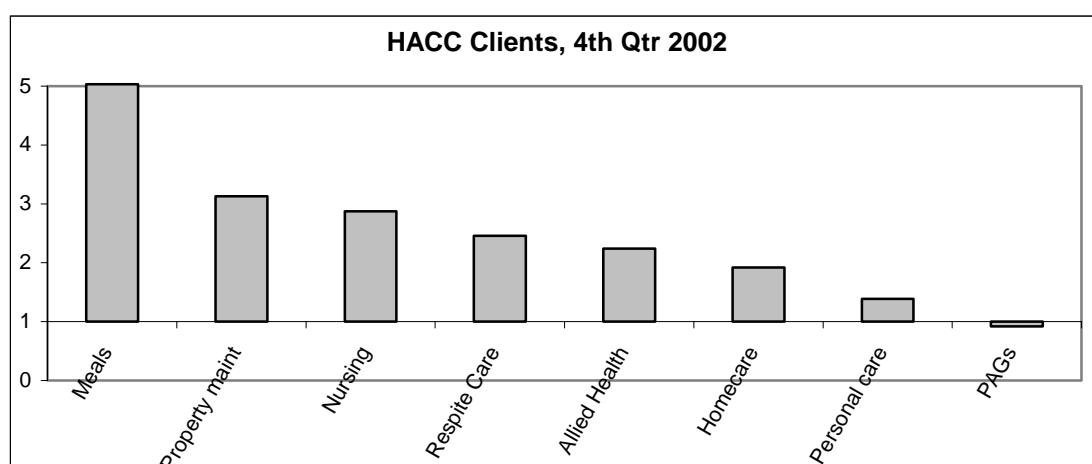
### 2.2.1.2. Priority 2

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 development of recommendations for allocation of growth funding outlined in Sections 5 and 6.

The data included a number of data sets used by all DHS Regional Offices to develop each Regional Plan, as well as additional data available locally. The primary data included:

- Regional HACC sector profile
- Local planning data
- Population statistics
- Service provision and usage (including HACC MDS data)
- Funding distribution.

In addition, the NMR plan has drawn information from a wide range of qualitative resources to gain a better appreciation of the NMR demographics, DHS program planning, service usage and need. This has included:

- Relevant policies and strategies from Aged Care, Disability, Hospital Admission Risk Program (HARP), Primary Care, Primary Care Partnerships and Community Health programs
- Qualitative information from the Regional HACC Advisory Committee, as well committees and meetings as listed in Section 3.3.

### 3.2. The Region's HACC sector

#### 3.2.1. The Region's local government areas

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

**Figure 3.1: Local government areas in Region**



### **3.2.2. The HACC sector**

Within the seven local government areas, DHS funds over 70 HACC providers. HACC providers are a diverse group and include:

- 7 local governments
- 10 community health centres
- 3 hospitals
- 34 non-government agencies
- 3 ATSI-specific agencies
- 13 CALD-specific agencies.

Of these 70 HACC agencies, 22 have a cross Regional service provision focus.

A large number of HACC providers are actively involved with three Primary Care Partnerships in the NMR.

85% of agencies have completed the National Service Standards Instrument (NSSI) training and are beginning an assessment against the NSSI.

### **3.3. Regional partnerships and networks**

In order to manage and support the HACC sector effectively, DHS engages a number of strategies to develop and sustain partnerships and to enhance sharing of local knowledge. These strategies enable DHS and HACC agencies to understand the needs of the HACC sector and to work together to develop services and implement changes that will better meet the needs of HACC clients.

The working groups detailed in Sections 3.3.1 and 3.3.2 have been established to address specific issues.

#### **3.3.1 Networks/Committees convened by DHS**

##### **3.3.1.1 The HACC Advisory Committee**

The HACC Advisory Committee meets bi-monthly and is the key point of consultation between DHS and the Regional HACC sector. The main function is to plan the growth and development of HACC services. Membership of the Committee consists of representatives from local councils, community health centres, community nursing, ATSI agencies, CALD agencies and the Community Connections Program. The membership has been developed to ensure that providers of all HACC activity types are represented.

##### **3.3.1.2 Smaller Community-Based Agency Reference Group**

This Reference Group is a sub-committee to the Regional HACC Advisory Committee and allows a wider forum for smaller HACC funded agencies to influence planning and development of HACC services. This Reference Group meets bi-monthly.

##### **3.3.1.3 Ethnic Service Providers Network**

The Ethnic Service Providers Network has been convened on an 'as needs' basis to assist in planning in the Region. It is currently being established by DHS in 2003 as a more permanent Network in order to contribute in an ongoing manner to HACC planning and service co-ordination for CALD communities.

#### **3.3.1.4 Linkages Providers Network**

The Linkages Providers Network was originally developed to facilitate the NMR's Linkages demand management service development project. This Network is to be established as a standing network in 2003 and will be convened by DHS.

#### **3.3.1.5 HACC Statewide Training Issues meeting (convened by DHS central office)**

DHS staff and HACC training co-ordinators from each Region meet to discuss training issues at a Regional and Statewide level and provide input and feedback. Meetings are held bi-monthly.

### **3.3.2 Networks/Committees convened by sector**

#### **3.3.2.1 Hume/Moreland Aged & Disability Service Providers Network**

The Hume/Moreland Aged & Disability Service Provider Network meets bi-monthly. A wide range of aged care providers and disability funded agencies attend this network to provide advice on localised planning, service co-ordination and service development for aged and disability clients living in the local government areas of Hume & Moreland.

#### **3.3.2.2 Yarra Aged & Disability Service (HACC) Forum**

This Forum is attended by HACC funded agencies in the City of Yarra. The Forum looks at planning and service delivery of HACC services for clients in the City of Yarra. The Yarra HACC Forum meets quarterly.

#### **3.3.2.3 Northern Region HACC Training Committee**

This Committee is responsible for representing HACC services providers in developing HACC training activities within the Region and overseeing the provision of DHS funded training to HACC funded agencies within the NMR. The Committee meets bi-monthly.

#### **3.3.2.4 Planned Activity Group Co-ordinators' meeting**

This meeting is attended by Planned Activity Group co-ordinators. It is an opportunity for co-ordinators to network, discuss issues and look at innovative service provision. The Planned Activity Group Co-ordinator's meeting is held bi-monthly.

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

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

### **3.4.1 Broad planning context**

The planning process for HACC has been broadly influenced by a number of Departmental and local government initiatives that are outlined below.

#### **3.4.1.1 Disability Services Policy and Funding Plan 2002-03**

The most important trend informing service planning is the fact that the Victorian population is ageing. The 'Disability Services Policy and Funding Plan 2002-03' states that the proportion of people with a disability increases as the population ages. The percentage of people with a disability in the 70 plus age group is 40-45%.

Within the NMR 15.6% of the population have a disability. It is predicted that the impact of the disability population ageing will cause demand for HACC (and other services) to increase significantly. As a significant proportion of older people with disabilities are currently cared for by parents, it is anticipated that this will place more pressure on carers who are also ageing.

Broadly, the Region proposes to expand basic in-home support, as well as increasing access to Nursing and Allied Health to support the needs of people with a disability who are ageing and living in the community.

#### **3.4.1.2 Primary Care Partnership (PCP) Community Health Plans**

The PCP Strategy is a key policy reform of the DHS Primary Health Branch. The three PCPs in the NMR develop annual Community Health Plans (CHP) for their catchment.

The 2002-03 North Central Metropolitan Community Health Plan identified the increased need for planned infrastructure to cope with population growth and general relative under availability of services within the local government area of Whittlesea. Other factors including distance and geography add costs to service provision in this area. Community transport has specifically been identified as a key issue. The CHP also stated that the catchment has higher levels of disadvantage compared to the rest of the NMR, Metropolitan Melbourne and Victoria.

The Hume and Moreland Community Health Plan identified chronic disease management in ageing populations, shortage of community allied health services and a lack of health promotion programs aimed at older people, as issues for this catchment. It also identified difficulties in diagnosing mental health and dementia in older people from CALD backgrounds who have little or no English language skills. The plan also identified that there is a shortage of bilingual/culturally aware workers across the service system when there are increasing numbers of older ethnic people with chronic health problems. These clients' health problems are exacerbated by inadequate access to health services due to limited English language skills.

The Banyule and Nillumbik Community Health Plan identified the demand for an increase in the availability of HACC services to resolve under resourcing issues. Current under-resourcing in the local government area has resulted in 1-2 week waiting periods for post acute hospital discharge. Community health issues include a lack of respite for carers, social isolation and lack of transport. People aged 65+ have the highest hospital admission rates for all Banyule and Nillumbik residents. It was also identified that there is a need for an aged services network for ongoing planning and effective co-ordination of aged services.

HACC service providers have been mandated to implement the initial needs identification tool (now called the *Service Coordination Tools (ScOTT)* which is part of the PCP's *Service Co-ordination* initiative. This initiative will improve integrated care for all clients receiving primary care services including HACC, across PCPs by streamlining management of client information and referral.

#### **3.4.1.3 Hospital Admission Risk Program (HARP)**

Victorian Emergency Medical Data states that emergency department attendance in NMR 2002-03 peaks at ages 25–35 years of age and again (slightly lower) at 70 to 80 years of age. With regard to multi attendees (where a person has attended three or more times) the highest number of multi attendances are people aged 70 to 80.

The HARP aims to avoid unnecessary use of emergency departments and inpatient services in the hospitals participating in the Hospital Demand Management strategy. The integrated care for clients with complex needs working party report presents the importance of the integrated care system (involving hospital and the primary and community services sectors) as a way of managing this.

#### **3.4.1.4 Primary Health Program**

The Primary Health Program aims to maintain or improve the health of the Regional population through prevention and early intervention initiatives such as allied health, nursing and counselling services targeting high risk groups including chronic disease sufferers.

In 2002-03, \$393 000 was allocated to NMR community health agencies for allied health services with a view to achieving better integration with the acute program and contributing to the management of acute demand. Regional planning for HACC Allied Health will take into consideration this growth to existing primary health funded allied health services. The funds were directed to the following disciplines: occupational therapy; counselling; physiotherapy, podiatry and speech therapy.

#### **3.4.1.5 Victorian Homelessness Strategy**

The Victorian Homelessness Strategy found that while a large number of older people live in a state of "housing stress", many do not know how to, or do not wish to, access homelessness services. Clients' reasons include being fearful of the system, being unable to navigate through what they identify as a complex system without assistance, or fundamentally not identifying themselves as being homeless and therefore not needing homelessness services.

NMR has recently funded a HACC Equity and Access Project to address homelessness in the HACC target group working with agencies to improve access to people who are homeless. This strategy includes supporting people living in insecure and unsuitable housing, or residing in Supported Residential Services.

### **3.4.1.6 Local government plans**

The NMR Regional Plan has considered local government health plans, aged and disability strategic plans and community profiles. Most local government health plans have estimated significant growth in the 65 plus age group. It is anticipated that the growth of the older population will place an increased demand on community care and health services due to heightened care needs. Some of the issues identified in the local government health plans and profiles include the high use of public hospitals by older persons due to degenerative problems and chronic diseases; limited access to services by the CALD population and the low health status of the Indigenous community.

In particular the health plans identified people living in isolation as a major health issue and the need for the development of accommodation that is appropriate for the older population. The health plans of outer NMR local governments highlighted priority issues for people living in geographic isolation are lack of service infrastructure and transport. These issues impact on client access to HACC services, service delivery costs and increases the service demand on the smaller number of agencies located in the geographical area.

### **3.4.2. HACC planning context**

The Regional HACC planning process has been influenced by a number of key regional issues and factors that are outlined below.

#### **3.4.2.1. Ageing population**

As previously highlighted in the 2002-03 NMR HACC Plan and consistent with Victorian and Australian trends, the regional population of 65+ age group grew 11.6% between 1996-2001 (Australian Bureau of Statistics Census 2001). This significant population increase continues to place increasing pressure on the HACC service system in the NMR. Pressure on the service system is further compounded by factors including:

- A large segment of the community are socio-economically disadvantaged
- Higher than average levels of hospital admissions in some local government areas
- Large populations of special needs groups including CALD, people at risk of homelessness and people of ATSI background.

Darebin and Moreland local government areas continue to have the highest proportion of 65+ age group in the Region. 2001 Census data indicates significant changes in the population of 65+ age group since the 1996 Census in the outer growth corridors of Hume (40% change), Whittlesea (49% change) and to a lesser degree, Nillumbik (19% change). Department of Infrastructure projections also indicate significant growth in the 65+ cohort in these local government areas.

#### **3.4.2.2. Cultural diversity**

The NMR has one of the largest and most culturally diverse ethnic populations in Victoria. Comparisons between the 1996 and 2001 Census data indicate significant increases in the Italian, Greek, Croatian, Vietnamese, Chinese and Arabic language groups in the 65+ age cohort. NMR identifies the need to enhance the interface between mainstream and CALD providers with a view to improving access to, and quality of, 'HACC Basic' services to CALD communities.

According to Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) data, newly arrived immigrants tend to settle across the Region (excluding Nillumbik and Banyule). Many of these individuals are refugee/humanitarian entrants to Australia and have complex care needs due to the effects of torture and trauma.

#### **3.4.2.3. Regional health status**

Burden of Disease data suggests that a higher than State average demand for HACC and HACC-like services within NMR will continue to grow with the ageing of the population.

In particular, the local government areas of Darebin and Moreland currently rank the highest in the Region against negative health indicators including the 1996 Disability Adjusted Life Years lost (DALY) and the 1999-2000 Ambulatory Care Sensitive Conditions (ACSC) and the number of Public Hospital Admissions.

In general, the Region's health status remains below the Victorian average with the exception of the Banyule/Nillumbik catchment. Also indicated was the poor health status for the older Aboriginal population, in particular in the local government area of Darebin.

#### **3.4.2.4 Increasing complexity of client need**

Service provision data and indicators of demand suggest that HACC client needs are becoming increasingly complex. The Linkages Demand Management Project conducted by the Region has highlighted that complex medical, psychiatric, social and physical needs are now significant issues in the provision of responsive and appropriate services. HACC providers are being called upon to provide more flexible, and resource intensive, services to address the needs of these more complex clients. In particular, there is increasing demand for ongoing care management services to assist HACC clients with more complex issues to access appropriate services to meet their needs.

Given this pressure on basic services, it is important to enhance the HACC Basic service system to ensure that there are sufficient levels of service for both high and low needs HACC clients.

#### **3.4.2.5 Depreciation of high care packages**

The Regional Linkages demand management project has in particular highlighted the depreciation in value of high care packages such as Linkages and Community Aged Care Packages (CACP). The capacity of these programs has been significantly reduced over time, affecting the ability of providers to sufficiently address the care needs of increasing numbers of clients with very complex care needs. Consequently, pressure continues to increase on mainstream providers, particularly Councils, to increase the levels of HACC Basic services in order to maintain clients with high and complex needs at home. NMR, in partnership with local agencies, is currently conducting research into better service planning for people with complex care issues and service co-ordination.

#### **3.4.2.6 Regional HACC service system issues**

A very diverse range of providers comprises the Region's HACC service system. Twenty five percent of these providers are non-government organisations funded less than \$50,000 per annum to deliver a wide range of support services to mainstream and CALD populations. Services provided by these organisations with limited resources and organisational infrastructure, contribute significantly to the overall HACC service system within the Region. The ongoing viability of this part of the HACC sector needs to be closely monitored over the next three years to ensure the sustainability of the HACC service system and the effective management of demand.

#### **3.4.2.7 Service co-ordination and integration**

The NMR Regional survey, conducted as part of last year's planning process, indicated a strong call for improved service coordination and integration across the HACC and related service systems. Providers raised issues pertaining to improved coordination of services across local government areas, better integration of activities and programs across the Region and an emphasis on services with an early intervention/prevention focus. These directions are consistent with the DHS PCP Strategy Service Co-ordination initiative.

### 3.5. Data

#### 3.5.1. Population

The data in Section 3.5.1 builds a picture of the HACC population across the Region. This picture is important in helping to identify where the likely pressures will be on the service system over the 2003-06 period.

##### 3.5.1.1. Regional HACC population 2003-06

Table 3.1 and Figure 3.2 show the relative distribution across local government areas of the HACC target population in the Region.

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

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

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

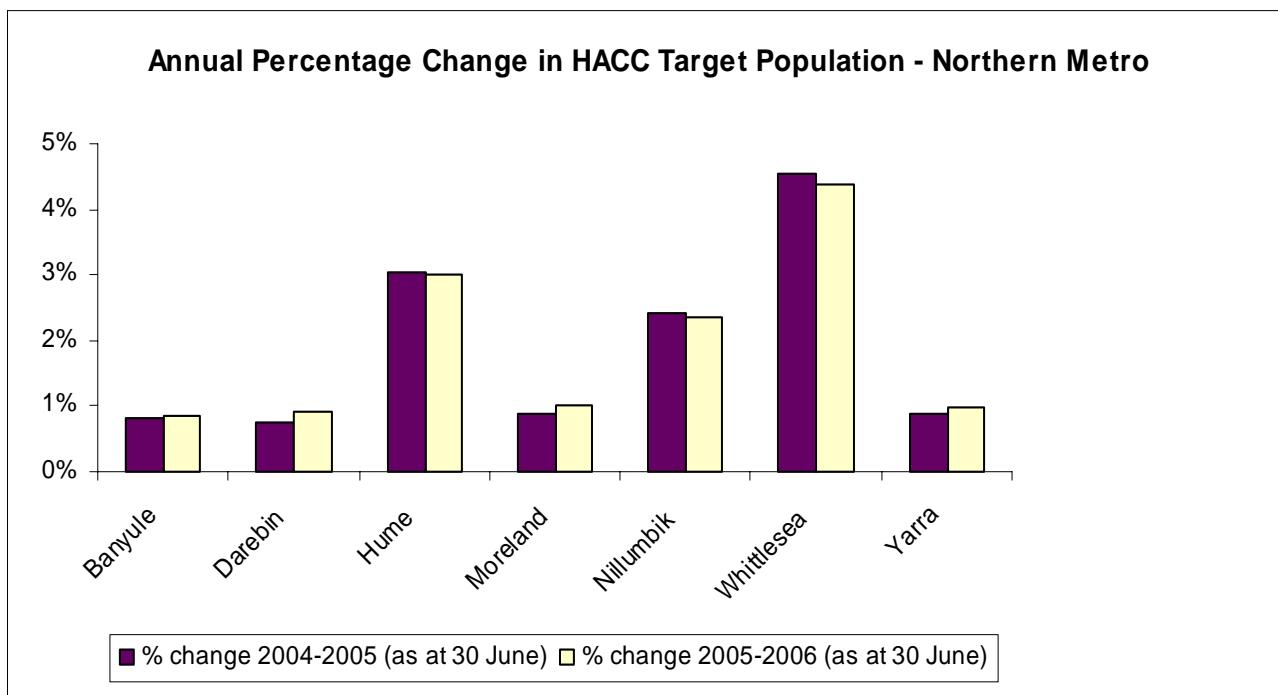
**Table 3.1: WREN population and percentage of WREN that is 70+ 2003-06**

Local government area	2003-04		2004-05		2005-06	
	WREN pop'n	% 70+	WREN pop'n	% 70+	WREN pop'n	% 70+
Banyule	15,240	59.5%	15,366	59.6%	15,495	59.6%
Darebin	24,446	63.2%	24,626	63.1%	24,852	63.1%
Hume	15,771	40.7%	16,249	41.1%	16,735	41.4%
Moreland	25,422	65.9%	25,650	66.0%	25,907	66.2%
Nillumbik	5,093	40.2%	5,215	40.6%	5,339	41.0%
Whittlesea	12,818	45.8%	13,399	46.8%	13,987	47.9%
Yarra	7,594	52.4%	7,660	52.4%	7,735	52.5%
<b>Total</b>	<b>106,384</b>	<b>56.0%</b>	<b>108,165</b>	<b>56.1%</b>	<b>110,050</b>	<b>56.3%</b>

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

These figures are graphically represented in Figure 3.2. This shows estimates of relative change in the HACC target population in each local government area on the 30 June each year. This is important in identifying where pressure on HACC services might be likely to ease or intensify over time.

It is clear from Figure 3.2 that overall the HACC target population is increasing over three years, but that the changes vary between local government areas. Where the second bar is higher than the first bar, the rate of HACC population growth is accelerating which indicates increasing service demand over time.



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

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

**Table 3.2: WREN population 70+ by age range across local government areas**

Local government area	70-79	%	80+	%	Total 70+
Banyule	5,950	65.62%	3,118	34.38%	9,068
Darebin	10,278	66.53%	5,172	33.47%	15,450
Hume	4,822	75.12%	1,597	24.88%	6,419
Moreland	11,622	69.37%	5,131	30.63%	16,753
Nillumbik	1,315	64.22%	733	35.78%	2,047
Whittlesea	4,323	73.63%	1,548	26.37%	5,871
Yarra	2,589	65.07%	1,390	34.93%	3,979
<b>Total</b>	<b>40,899</b>	<b>68.64%</b>	<b>18,688</b>	<b>31.36%</b>	<b>59,587</b>

Table 3.2 shows that the largest proportion of the HACC population are in the 70-79 age group. This is consistent across all local government areas in the Region. Yarra, Nillumbik, Banyule and Darebin have a slightly older WREN population, but this is not statistically significant.

### 3.5.1.2. Special needs populations

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

Data about people from CALD is provided in Section 3.5.1.3. Data about ATSI is provided in Section 3.5.1.4.

### 3.5.1.3 Regional profile of CALD HACC population

**Table 3.3: Population 65+ language other than English by local government area**

Local government area	65+ LOTE by local government area		
	1996	2001	Change 96-01
Banyule	3,037	3,962	30.46%
Darebin	7,585	9,914	30.71%
Hume	2,644	3,915	48.07%
Moreland	9,608	11,663	21.39%
Nillumbik	599	628	4.84%
Whittlesea	3,812	6,018	57.87%
Yarra	3,014	3,742	24.15%
<b>Total</b>	<b>30,299</b>	<b>39,842</b>	<b>31.50%</b>

*Source: ABS census 1996 & 2001-language other than english*

There has been significant growth in both general and CALD populations aged 65+ in the outer areas of the Region (mainly Whittlesea and Hume). This population movement is increasing the culturally and linguistically diverse nature of the community, consequently increasing demand for accessible and culturally appropriate HACC services.

Department of Immigration and Multicultural and Indigenous Affairs data shows that newly arrived immigrants tend to settle across the Region except in Nillumbik and Banyule. Darebin and Moreland have the highest settlement rates for the Region with significant communities from China, Sri Lanka, Lebanon, Iraq, Turkey and the Balkan countries.

Many of these individuals are refugee/humanitarian entrants to Australia and have a range of support needs due to the effects of torture and trauma. These communities, in addition to being unfamiliar with the Australian service system, also lack the resources and support systems that would enable them to access the services that are crucial to their recovery and well being.

MDS service provision data reflects that the Italian and Greek HACC populations across the Region are accessing HACC services, while other CALD groups appear to be under-represented. According to the data, the following language groups are under-represented across the Region: Macedonian, Lebanese, Croatian, Hungarian, Bosnian, Turkish, Ukrainian and Latvian.

Italian and Greek communities are relatively well serviced in terms of social support and respite programs provided by Italian and Greek agencies within the Region. The most immediate pressure for these communities is for the HACC Basic suite of services, particularly Home Care and Assessment and Care Management.

#### **Regional CALD population and languages spoken at home**

Please refer to Appendix C, *Supporting Evidence for HACC Priority 2-Appendix 3*, for a detailed breakdown of languages spoken home by local government area. Language spoken at home has been used as a proxy for cultural identification, as language is frequently identified as a significant barrier to access to services.

The Australian Bureau of Statistics Census data indicates that Italian and Greek communities are the largest and most established ethnic communities within the Region. Table 3.5 summarises these changes and shows that the Croatian and Arabic speaking communities are growing within NMR and that the Greek and Italian HACC populations are continuing to grow. Thus there is increasing demand for culturally appropriate services for these groups in particular.

**Tables: 3.4 a–g: Population changes in the top 10 language groups aged 65+ by local government area identified between 1996 and 2001.**

Please note that the percentage changes are large in some cases because the number of individuals is small, hence these figures should be used only as an indicator of movements of changes in CALD populations.

Source: ABS Census 1996 & 2001 language other than English spoken at home, by place of usual residence

<b>Banyule</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	835	1,037	24%
Greek	204	330	62%
German	185	177	-4%
Macedonian	72	101	40%
Polish	72	85	18%
Latvian	62	69	11%
Hungarian	60	48	-20%
Dutch	60	67	12%
Ukranian	58	53	-9%
Croatian	54	110	104%

<b>Darebin</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	3,567	4,583	28%
Greek	1,176	1,923	64%
Macedonian	438	565	29%
Arabic	158	221	40%
Maltese	148	158	7%
Cantonese	107	119	11%
German	99	71	-28%
Polish	79	69	-13%
Vietnamese	68	115	69%
Mandarin	66	153	132%

<b>Hume</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	689	1,002	45%
Greek	222	371	67%
Maltese	155	245	58%
Arabic	130	223	72%
Turkish	130	248	91%
German	129	106	-18%
Ukranian	79	86	9%
Polish	78	81	4%
Croatian	62	121	95%
Spanish	61	72	18%

<b>Moreland</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	4,939	6,062	23%
Greek	1,140	1,740	53%
Maltese	435	531	22%
Polish	365	308	-16%
Arabic	243	331	36%
German	227	168	-26%
Ukranian	208	179	-14%
Croatian	100	157	57%
Latvian	71	64	-10%
Turkish	68	106	56%

<b>Nillumbik</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	105	138	31%
German	47	49	4%
Dutch	42	40	-5%
Greek	15	24	60%
Polish	13	11	-15%
Hungarian	12	12	0%
Latvian	12	3	-75%
Macedonian	10	20	100%
Croatian	9	18	100%
Maltese	8	12	50%

<b>Yarra</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	765	797	4%
Greek	615	833	35%
Vietnamese	247	278	13%
Cantonese	195	209	7%
Hakka	103	89	-14%
Polish	50	41	-18%
German	48	32	-33%
Macedonian	48	50	4%
Arabic	41	37	-10%
Croatian	40	58	45%

<b>Whittlesea</b>			
<b>Language</b>	<b>1996</b>	<b>2001</b>	<b>Change 96-01</b>
Italian	1,444	2,276	58%
Macedonian	682	1,076	58%
Greek	526	946	80%
Maltese	124	209	69%
German	67	73	9%
Arabic	62	124	100%
Cantonese	56	66	18%
Vietnamese	53	94	77%
Turkish	47	72	53%
Tagalog (Filipino)	43	39	-9%

Note: 'Dutch' includes Flemish

**Table 3.5: Summary of language groups by local government area**

Local Gov't Area	% Pop'n LOTE 65+yrs	5 largest communities aged 65+ 2001 Census	Changes in CALD populations 1996 – 2001 Census	New & emerging communities
Banyule	17%	Italian Greek German Croatian Macedonian	Increasing language groups: Croatian, Greek, Macedonian, Italian, Polish Decreasing language groups: Hungarian	Croatian Arabic Somali Chinese
Darebin	44%	Italian Greek Macedonian Arabic Maltese	Increasing language groups: Mandarin, Vietnamese, Greek, Arabic, Macedonian, Italian. Decreasing language groups: German, Polish	Vietnamese Chinese Iraqi, Indian, Turkish, Somali, Balkan communities
Hume	36%	Italian Greek Maltese Turkish Arabic	Increasing language groups: Croatian, Turkish, Arabic, Greek, Maltese, Italian, Spanish. Decreasing language groups: German	Spanish Hmong Iraqi & Afghani communities Balkan communities
Moreland	48%	Italian Greek Maltese Arabic Polish	Increasing language groups: Croatian, Turkish, Greek, Arabic, Italian, Maltese. Decreasing language groups: German, Polish	Croatian, Bosnian, Iraqi, Chinese, Sri Lankan, Turkish, Somalian, Filipino.
Nillumbik	12%	Italian German Dutch Greek Croatian	Increasing language groups: Greek, Croatian, Macedonian, Italian. Decreasing language groups: Polish, Hungarian, German, Dutch	Croatian Macedonian
Whittlesea	61%	Italian Macedonian Greek Maltese Arabic	Increasing language groups: Arabic, Greek, Vietnamese, Maltese, Macedonian, Italian, Turkish, Cantonese, German. Decreasing language groups: Tagalog (Filipino)	Arabic Vietnamese
Yarra	43%	Greek Italian Vietnamese Cantonese/Mandarin Croatian	Increasing language groups: Croatian, Greek, Vietnamese, Chinese. Decreasing language groups: Arabic, German, Polish	Hakka (East Timorese) Vietnamese Horn of Africa Iranian Afghani Croatian

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

Table 3.6 shows the distribution of the ATSI population in the Region.

**Table 3.6: Experimental estimates of total Indigenous population**

Local government area	0-49	50-69	70+	Total
Banyule	481	38	12	531
Darebin	1,080	99	23	1,202
Hume	694	56	10	760
Moreland	467	43	16	526
Nillumbik	123	15	1	139
Whittlesea	714	44	5	763
Yarra	317	38	7	362
<b>Total</b>	<b>3,876</b>	<b>333</b>	<b>74</b>	<b>4,283</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 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.

Burden of Disease data demonstrates that Aboriginal people generally have lower health status compared with the non-Indigenous population. An Aboriginal persons life expectancy is 8–18 years shorter than that of non-Aboriginal people<sup>1</sup>. Due to the significantly reduced life expectancy of the Aboriginal population, it is generally agreed that the threshold for measuring the older HACC target population be reduced to 50+ years, 20 years lower than the non-Indigenous population.

It is generally agreed that available Koori population data is not accurate enough to undertake reliable analysis. The Australian Bureau of Statistics 2001 Census Indigenous population estimates show that the NMR Indigenous community is concentrated in specific localities within the Region. These population estimates indicate the largest population of Aboriginal people aged 50+ years reside in the local government area of Darebin, with smaller communities residing in Hume, Whittlesea, Moreland and Banyule. See Section 5.6 for a specific description and analysis of Regional ATSI issues and priorities.

#### **Key issues for the Regional ATSI community**

The key issues for the Regional ATSI community are outlined below:

**Access to mainstream services:** The majority of Aboriginal HACC clients presenting at mainstream agencies are referred on to Aboriginal service providers. This creates additional pressure on the three Regional Aboriginal agencies and reinforces the access and equity issues for the Aboriginal community.

<sup>1</sup> Reiterated in Department of Human Services Disability Services Policy and Funding Plan 02-03

**Health issues:** Nearly one-third of deaths among Indigenous people are from circulatory diseases and another one-third from injury, respiratory diseases, and cancer. In addition, the death rate from diabetes for Indigenous people is about eight times the national rate. This means that Indigenous people are dying more often and at younger ages, from largely preventable conditions.<sup>2</sup>

**Complexity of need:** Many Aboriginal HACC clients have a wide range of needs that cover multiple and inter-related issues such as physical and mental health, social support, welfare support, accommodation in addition to in-home service requirement. These multiple and complex requirements often go beyond both the DHS funding and programmatic capacity of the service provider to address. Both DHS Programs and HACC service responses for this sector need to become more integrated and flexible to allow Aboriginal service providers to more adequately respond to the needs within their communities.

**Transport and community connectedness:** Aboriginal service providers report that clients will travel extremely long distances in order to access a service provided by people who are familiar to them or have connections with their own extended family. This cultural preference can place additional pressure on agency transport services, particularly if the client resides outside the Region where the agency is located.

**Allied Health/Nursing:** During a Regional planning consultation ATSI providers identified that demand for Nursing and Allied Health are a top priority for the Aboriginal community in the Region. One agency has been funded specifically to provide these health services and has experienced significant difficulty in the employment of appropriate staff to deliver these services. This is an issue that is being worked through, however in light of this, it is recommended that growth funds be targeted to these activities, but that allocation should be deferred until the existing service delivery issues have been resolved.

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<sup>2</sup> Office of Aboriginal and Torres Strait Islander Affairs, Indigenous Health Fact Sheet, DIMIA August 2002

### 3.5.2. Data analysis - Regional HACCC service provision

The focus of analysis of the service provision data is on identifying the relative levels of resourcing of each HACCC activity in the Region. This has provided an indicator for the development of recommendation for expansion Priority 1 HACCC Basic activities.

Figures 3.3-3.9 below show the per capita service provision of Priority 1 activities by local government area. The per capita data is derived from the HACCC MDS service usage data divided by the HACCC target population (WREN) for each local government area. However, it was found that this data did not provide an accurate picture of relative service levels due to low Regional response rates and data errors.

As NMR had access to a full year of Quarterly Output Collection returns for 2001-02, it was felt that this data was more reliable and could provide a more accurate picture of HACCC service provision in the Region. Figures 3.10-3.16 below show per capita Priority 1 service levels per head of HACCC target population (WREN) by local government area. The Region recognises the need to improve quality of MDS data for planning purposes and will concentrate efforts over the next three years to support MDS reporting through the "Data quality improvement initiative" outlined in Section 6.2.

Figures 3.3-3.9 HACCC MDS service usage data for Priority 1 activities divided by the HACCC target population (WREN) in each local government area. The line across the bars represents the Regional average.

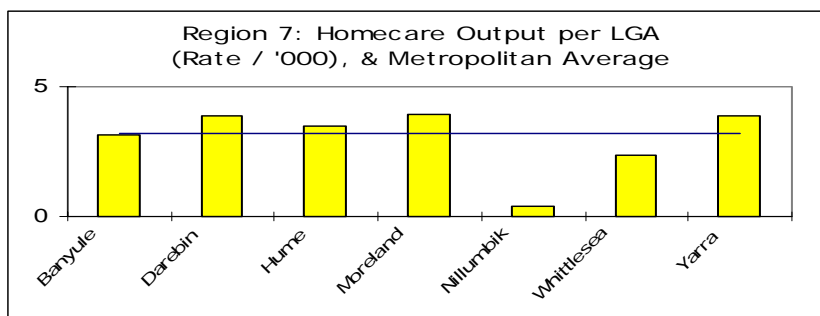


Figure 3.3: Hours of Home Care per 1,000 target population

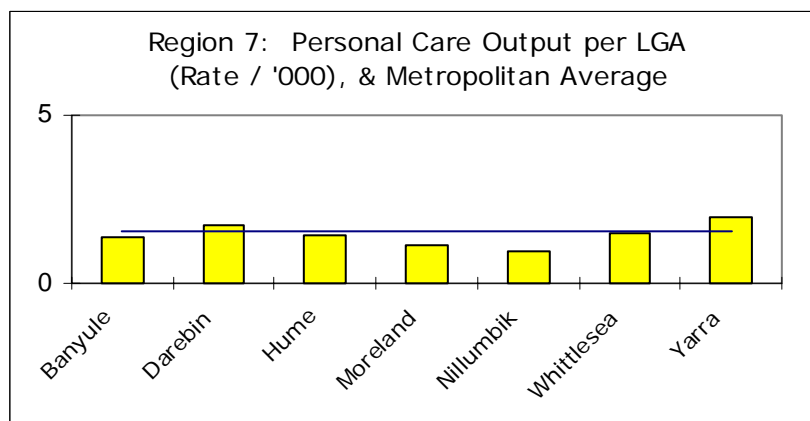


Figure 3.4: Hours of Personal Care per 1,000 target population

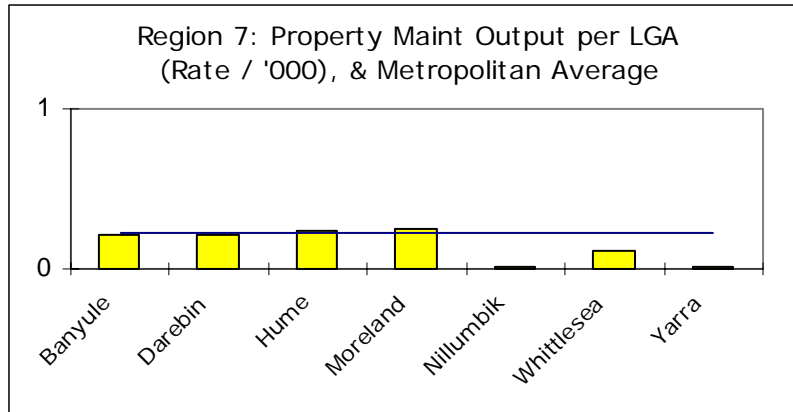


Figure 3.5: Hours of Property Maintenance per 1,000 target population

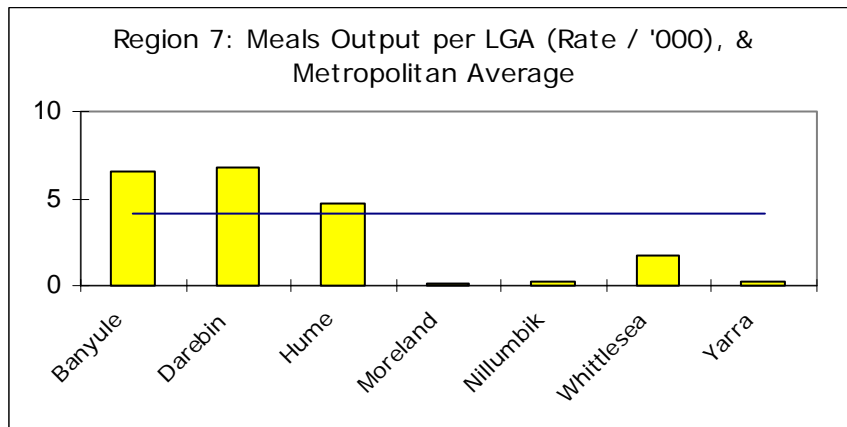


Figure 3.6: Meals per 1,000 target population

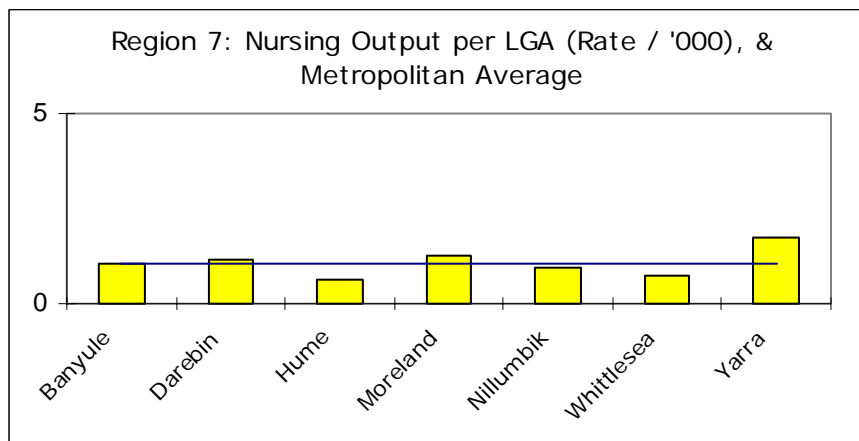


Figure 3.7: Hours of Nursing per 1,000 target population

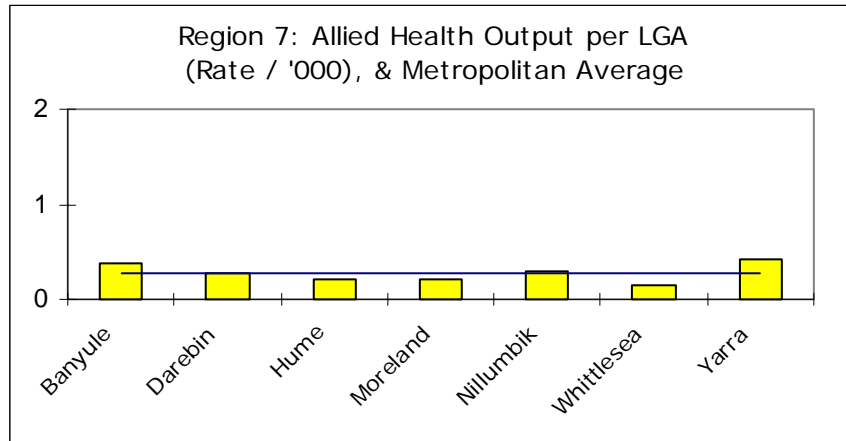


Figure 3.8: Hours of Allied Health per 1,000 target population

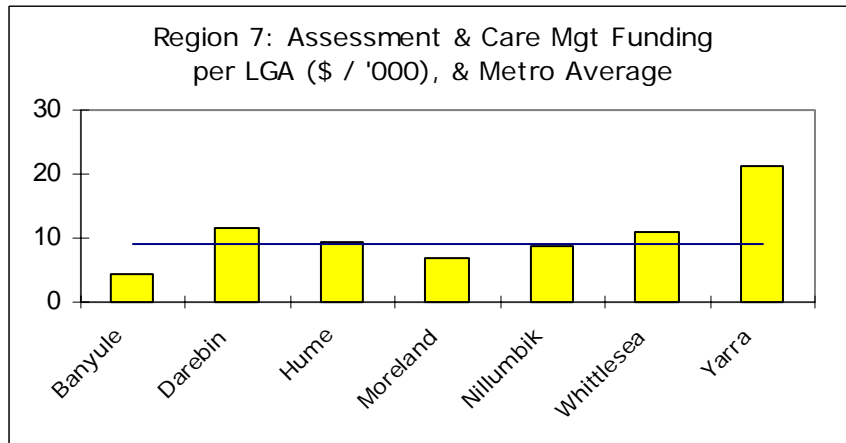
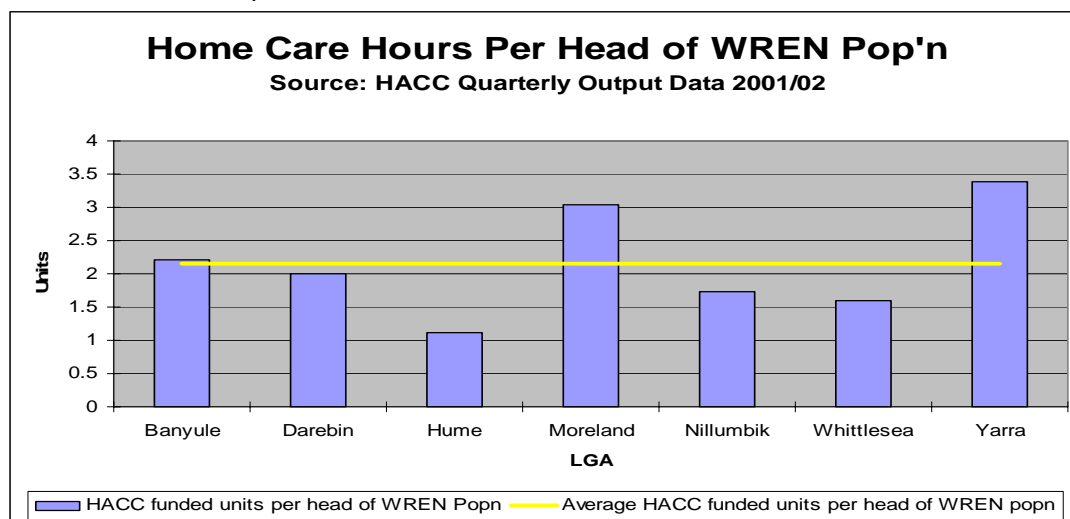


Figure 3.9: Dollars of Assessment and Care Management per 1,000 target population

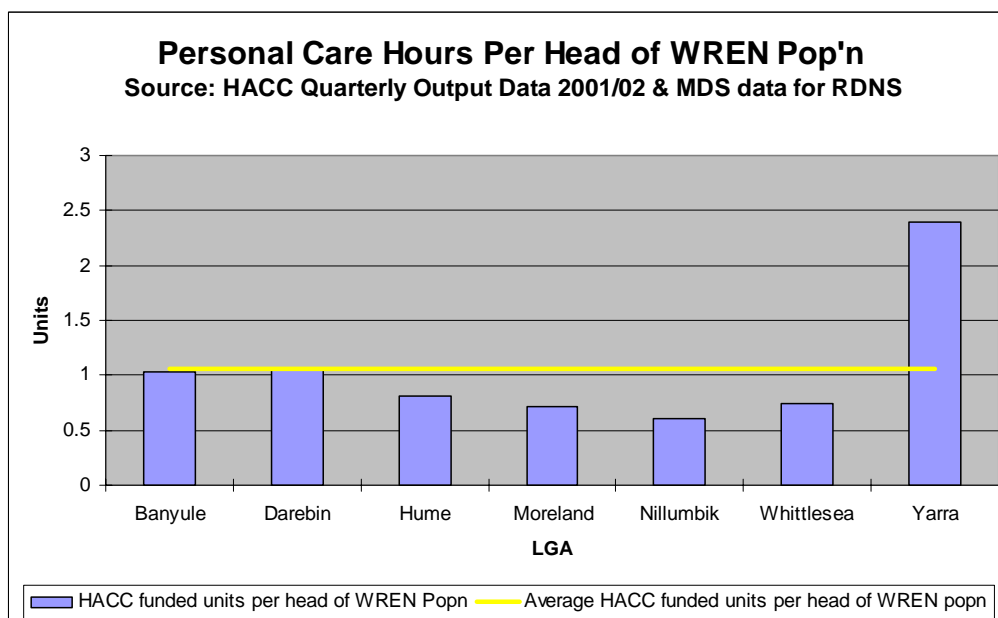
Figures 3.10 to 3.16 HACC Quarterly Output Collection service usage for Priority 1 activities divided by the HACC target population (WREN) in each local government area.<sup>3</sup>

It should be noted that the average line in the graphs below relate to the HACC funded units per head of WREN population in each local government area, not total HACC units reported.



**Figure 3.10 Home Care Hours per head of WREN population**

In the figure above Moreland and Yarra appear to have a higher proportion of Home Care relative to their WREN populations. Hume appears to be well under for Home Care hours followed by Whittlesea, and by a lesser extent Nillumbik and Darebin.

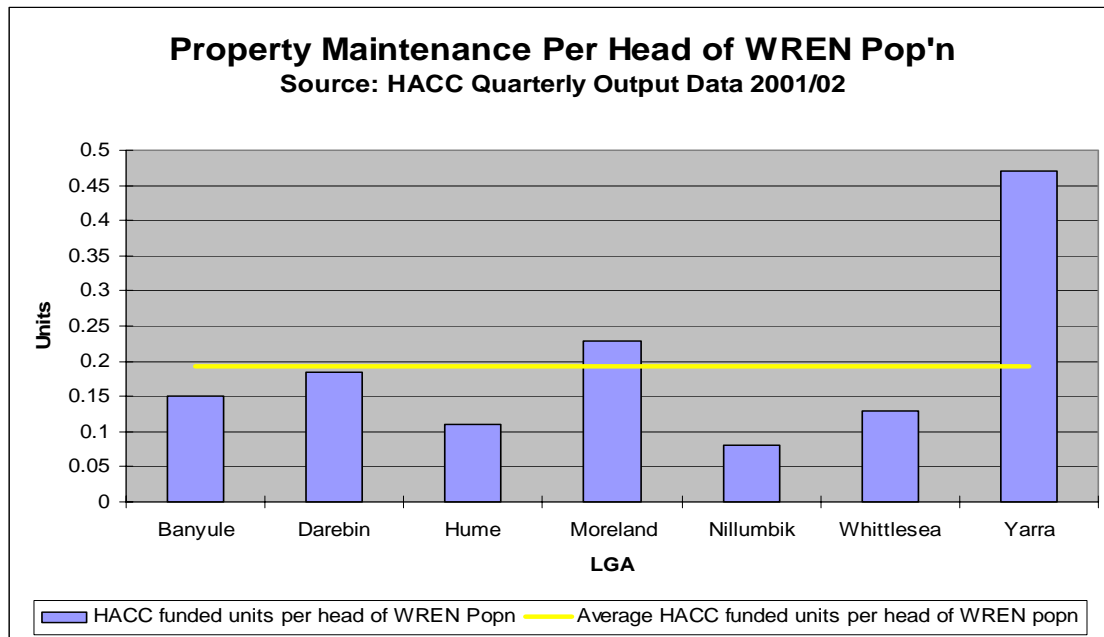


**Figure 3.11: Personal Care Hours per head of WREN population**

<sup>3</sup> As RDNS data is reported on a metropolitan wide level, estimates of service by local government area have been calculated by applying MDS local government area service provision percentages to the RDNS Quarterly Output Collection information.

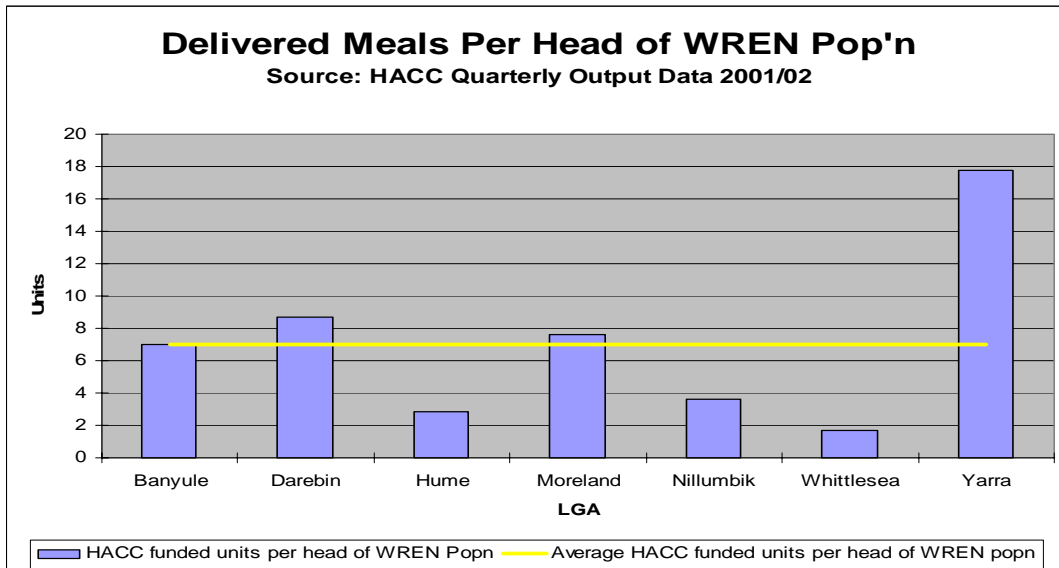
<sup>4</sup> It should also be noted that data does not include Priority 1 services provided by CALD or Koori agencies as this data is separately analysed for Priorities 2 & 3 in Section 5.4 and 5.5.

In the figure above all local government areas apart from Yarra are below or at the average for Personal Care service provision. The NMR recommends significant increases to funding to Personal Care in Hume, Nillumbik, Moreland and Whittlesea as they fall below the average. Banyule and Darebin are currently funded approximately to the Regional average, so have been recommended for moderate increases to Personal Care to keep pace with increasing demand. However, additional agency feedback has highlighted a significant increase in unmet demand in Darebin for Personal Care in the last 12 months, consequently a larger increase for Personal Care has been deemed appropriate for this local government area.



**Figure 3.12: Property Maintenance per head of WREN population**

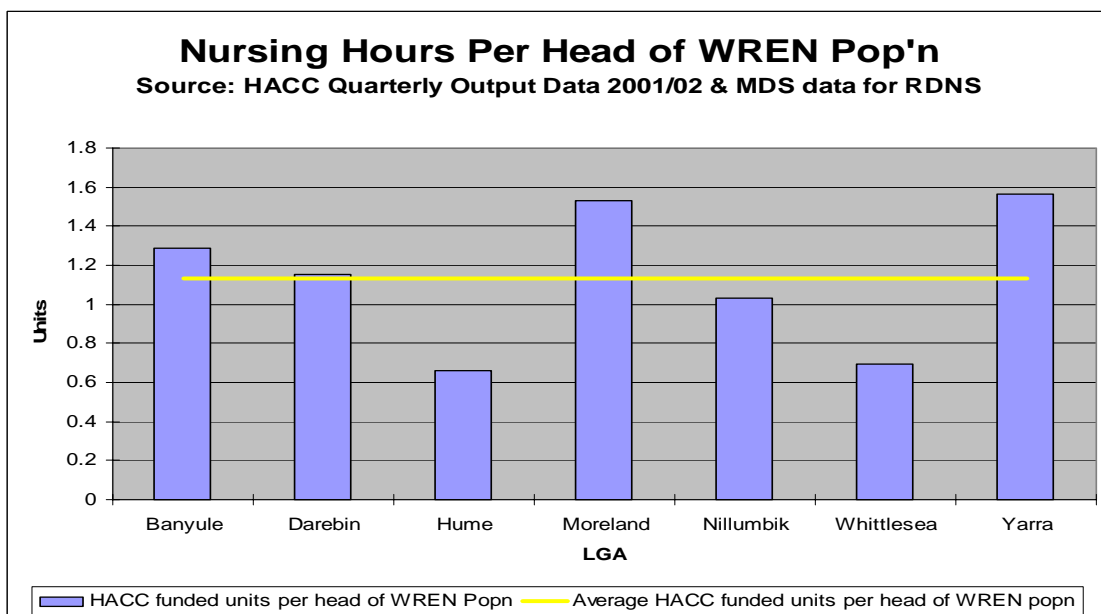
The above figure shows that Yarra seems relatively well resourced in Property Maintenance. Nillumbik is relatively under resourced in comparison to other local government areas. Hume, Whittlesea and Banyule are also under the average, while Darebin falls just short of the average. It is recommended that significant increases in Property Maintenance be directed to Nillumbik, Hume and Whittlesea local government areas within the capacity of the local government area allocation. Moderate increase is recommended for Banyule local government area.



**Figure 3.13: Delivered Meals per head of WREN population**

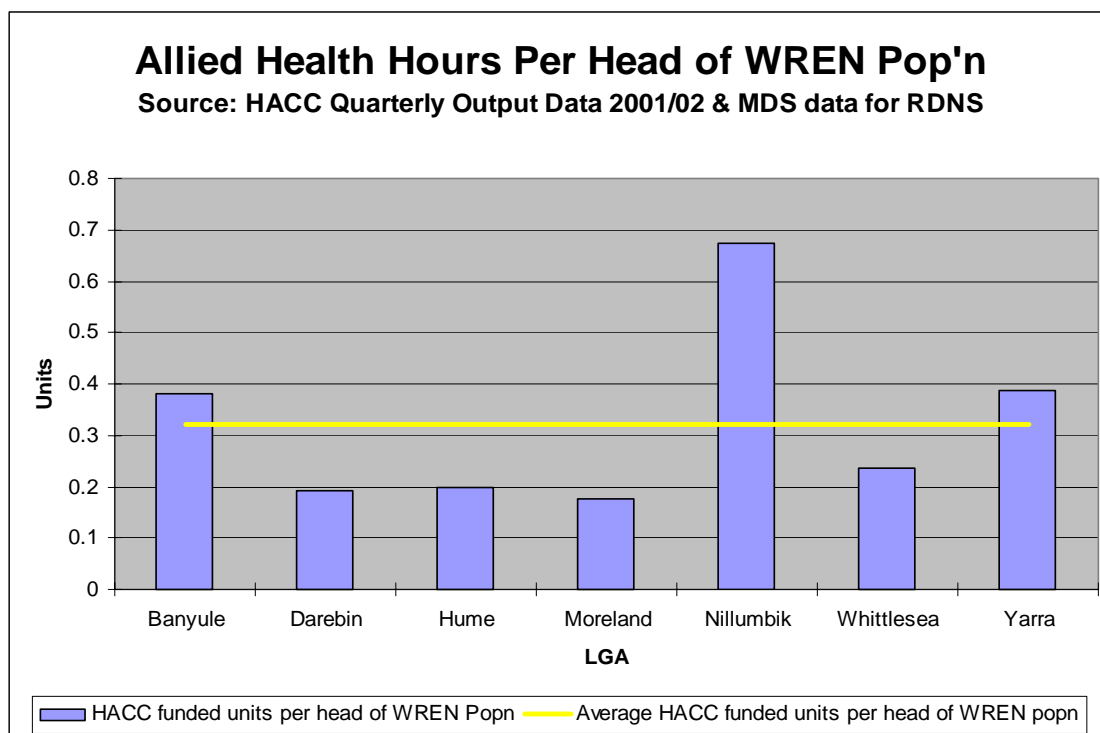
The previous chart shows Yarra to be relatively well resourced in comparison to other local government areas. Whittlesea seems to be considerably under resourced in the area of Delivered Meals followed by Hume and Nillumbik. Allocation of growth to Delivered Meals is dependent upon actual demand and the capacity of the service provider to expand this service. Consequently the NMR is recommending moderate increases to funding for this activity in Hume, Nillumbik and Banyule within the capacity of the local government area allocation. Whittlesea City Council has advised that there is currently insufficient demand for current meals services and that funding that was targeted to expand this activity could be better directed towards higher priority HACC Basic services such as Home Care and Personal Care.

Increases to Delivered Meals will be reviewed in subsequent years subject to the outcomes of the Food Services review to be conducted by DHS in 2003-04.



**Figure 3.14: Nursing Hours per head of WREN population**

Figure 3.14 shows that Moreland and Yarra are very well resourced for Nursing in comparison to other local government areas. Hume and Whittlesea local government areas are significantly under resourced, while Nillumbik is moderately under resourced. For these reasons NMR is recommending a significant increase to Nursing in Hume and Whittlesea and a moderate increase in Nillumbik. NMR is also recommending a small increase be made to funding for Nursing in Darebin to keep pace with increasing demand. Further supporting the need to significantly increase nursing services particularly in Whittlesea, RDNS waiting periods in that local government area can be up to 15 days whilst the maximum wait in other local government areas in the NMR is three days.



**Figure 3.15: Allied Health Hours per head of WREN population**

The figure above shows that Nillumbik is relatively well resourced in comparison to other local government areas for Allied Health. Banyule and Yarra are also above average for this activity. Moreland, Darebin, Hume and Whittlesea are clearly the priority areas to receive growth funds for Allied Health within the capacity of the local government area allocation.

Feedback from service providers has highlighted the need for a moderate increase in funding in Yarra and Banyule for Allied Health. Consequently the Region has recommended moderate increases to Allied Health in Banyule and Yarra to support agencies to meet increasing demand.

To further refine priorities by discipline in each local government area, Community Health Program service provision data was reviewed for 2001-02. Additionally, HACC Allied Health service providers were asked for feedback on high demand disciplines by local government area.

**Table 3.7 Summary of NMR allied health discipline priorities by local government area**

<b>Local government area + Number of HACC Allied Health providers</b>  <b>Source: DHS Service Agreement Mngt Data Base</b>	<b>Relative priority of Allied Health by local government area according to HACC MDS/QOD</b>  <b>Source: HACC QOD &amp; MDS 2001-02</b>	<b>HACC - Disciplines in demand by local government area highlighted by allied health service providers</b>  <b>Source: NMR Service Provider survey June 2003.</b>	<b>Community health - disciplines highlighted by service provision data for clients aged 70+ yrs in 2001-02</b>  <b>Source: Community Health Program – client contacts aged 70+ by discipline by local government area 2001-02</b>
Banyule 4 Providers	Medium Priority	Occupational Therapy Speech Pathology Dietetics	Physiotherapy Podiatry Occupational Therapy
Darebin 2 Providers	High Priority	Dietetics Occupational Therapy Podiatry	Podiatry Physiotherapy Occupational Therapy
Hume 2 Providers	High Priority	Podiatry Physiotherapy Occupational Therapy	Podiatry Physiotherapy
Moreland 3 Providers	High Priority	Podiatry – Home Visits Podiatry Occupational Therapy Physiotherapy Allied Health Assistant	Podiatry Counselling/Casework
Nillumbik 4 Providers	Low Priority	Dietetics Physiotherapy	Physiotherapy Occupational Therapy
Whittlesea 3 Providers	High Priority	Physiotherapy Occupational Therapy Podiatry	Podiatry Physiotherapy
Yarra 3 Providers	Medium Priority	Occupational Therapy – Home assessment Dietetics Podiatry Physiotherapy Allied Health Assistant	Podiatry Physiotherapy

Review of Table 3.8 provided some information as to priority disciplines within some local government areas, however the evidence is insufficient to build a clear picture of priorities or a justifiable case for direct allocation according to DHS funds allocation policy. Consequently the Region intends to invite submissions for growth funding to HACC Allied Health.

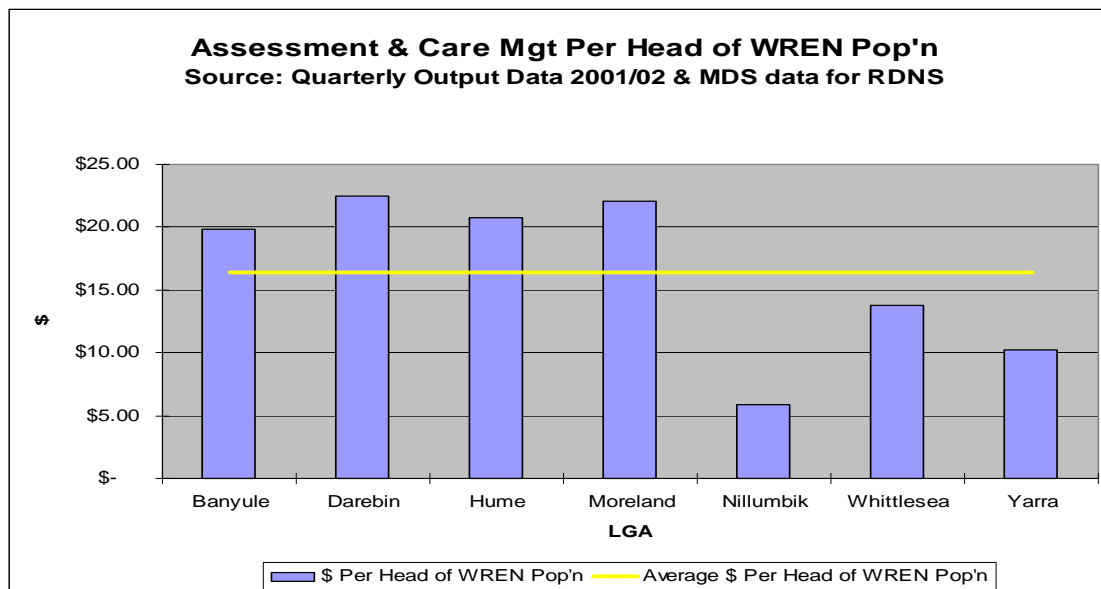


Figure 3.16: Assessment & Care Management funding per head of WREN population<sup>5</sup>

Analysis of HACC Assessment and Care Management is inherently difficult as the activity is not undertaken in a consistent way across service providers. As service provision targets are not consistent between agencies, the Region elected to review activity funding by local government area as an indicator of funding equity across the Region.

Figure 3.16 shows that Nillumbik is significantly under resourced for Assessment and Care Management in comparison to other local government areas. Yarra and Whittlesea are also under the Regional average per head of WREN Population. Additionally, the Region acknowledges that significant growth to core HACC activities will require additional Assessment & Care Management funding to support the implementation of the new services.

Hence, NMR is recommending increases in funding for Assessment and Care Management for Nillumbik, Yarra and Whittlesea within the capacity of the local government area allocation, as well as increases in line with growth to HACC Basic services within each local government area as appropriate. In support of the significant increases to HACC Basic activities resulting from the application of intra-Regional equity funds, the Region has recommended significant increases to Assessment and Care Management in Hume and Whittlesea.

### 3.5.3. Equity of distribution of Regional funding

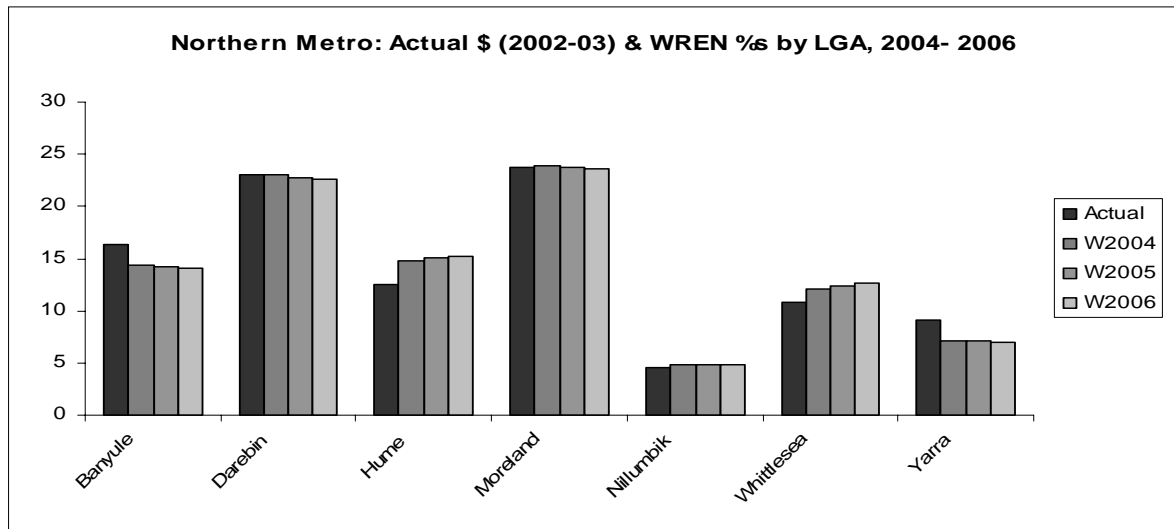
To complete the picture of the Region, the proportion of the existing HACC recurrent funding has been compared to the proportion of the WREN population by local government area (see columns 4 and 5 in Table 3.9). The comparison provides a picture of relative HACC funds equity between local government areas. This information is critical in determining how well the local government areas are resourced for HACC in relation to their relative share of the WREN population.

<sup>5</sup> Due to differences in Assessment & Care Management service models and funding distribution across agencies, the Region has excluded data from smaller non-government agencies in this calculation.

**Table 3.8: Comparison of HACC recurrent funding with proportions indicated by WREN populations**

Local government area	Recurrent \$ 2002-03	Current \$ per capita	% share of recurrent budget (2002-03)	WREN Population 2003-04	Difference between % share recurrent budget & WREN population
Banyule	\$7,538,497	\$495	16.3%	14.3%	+2.0%
Darebin	\$10,613,269	\$434	23.0%	23.0%	0.0%
Hume	\$5,744,532	\$364	12.5%	14.8%	-2.3%
Moreland	\$10,919,252	\$430	23.7%	23.9%	-0.2%
Nillumbik	\$2,114,590	\$415	4.6%	4.8%	-0.2%
Whittlesea	\$4,970,872	\$388	10.8%	12.0%	-1.2%
Yarra	\$4,220,153	\$556	9.2%	7.1%	+2.1%
<b>Total</b>	<b>\$46,121,163</b>	<b>\$434</b>	<b>100.0%</b>	<b>100.0%</b>	<b>-</b>

Column 6 above shows the differences between percentage share of recurrent budget in each local government area and the WREN population. This demonstrates that the local government areas of Hume and Whittlesea are relatively under funded whilst the local government areas of Banyule and Yarra are relatively over funded. This is further supported by Figure 3.17, which shows the relative gap between the distribution of recurrent funding and the distribution of the HACC target population (WREN) 2003-06. This information has guided proposals about the application of growth funds for equalisation across local government areas.



**Figure 3.17: Proportion of actual recurrent budget (30 June 2003) and WREN population proportions 2003-06 by local government area**

## **Section 4 - What do the data tell us?**

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

### **4.1 Summary of primary data analysis**

Consistent with Victorian and Australian Trends, the Regional population of 65+ age group grew 11.9% (Australian Bureau of Statistics Census 2001) between 1996-2001. The local government areas of Darebin and Moreland have the highest number and proportion of people in the 65+ age group. The largest increase in this population was in Hume and Whittlesea. In the 2003-06, it is estimated that the ageing population will continue to grow in the local government areas of Whittlesea and Hume, followed by the local government area of Nillumbik.

The Indigenous population make up 0.5 per cent of the NMR population (2001 census), with the majority of the Region's Indigenous community residing in Darebin.

Compared with the Statewide average, NMR has a considerably higher proportion of people who are born overseas, and people who speak a language other than English (2001 Census).

### **4.2 Additional information to supplement the primary data**

A number of provider networks within the Region have provided feedback to DHS on HACC service priorities within specific local government areas. These priorities continue to build on planning undertaken by the Region in previous years and focus on improving the flexibility, responsiveness and capacity of the service system to meet growing demand.

This feedback has highlighted that Allied Health and Nursing require significant investment over the next three years particularly to the special needs groups. Additionally, there is a growing awareness within the sector of the need to build partnerships between mainstream and specialist agencies to ensure that special needs groups are accessing HACC Basic services.

Through sector consultations the Region revised a number of preliminary proposals to better reflect need within the Region. Further details regarding the changes made to the plan through the consultations can be found in Appendix B.

### **4.3. Conclusion**

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

#### **4.3.1 Priority 1: HACC Basic**

As demand continues to increase for HACC Basic services across the Region, it is proposed that some funding is directed to essential support services such as Home Care, Personal Care, Property Maintenance and Assessment and Care Management in line with growth to HACC Basic services to meet demand in each local government area.

Additionally, data analysis indicated which HACC Basic activities are relatively under-funded in each local government area. These activities have been highlighted as a higher priority for additional funding over the next three years. Further to this, funded projects aimed at increasing access to HACC services for Priority 2 and 3 special needs groups necessitates commensurate growth to HACC Basic services to meet expected increases in demand.

Data analysis indicates a significant need for expansion to HACC Allied Health and Nursing in certain parts of the Region. As the unit prices for these activities are high, they require significant amounts of funding to ensure sufficient hours for a viable service. The Region proposes to stage growth to these two activities over the triennium so as to spread the impact of this activity on funding growth.

It should also be noted that the Region intends to further refine priority disciplines under Allied Health expansion for each local government area. Additionally, it is the intention of the Region to direct Nursing funds to expansion of general community nursing. While the Region has planned for Nursing expansion at the HACC hospital nursing rate, this expansion does not exclude agencies who provide Nursing at the HACC community nursing rate.

Additionally, the strategy recommended by the Region for out years 2004-05 and 2005-06, is that growth be directed to all HACC Basic activities. The Region has also recommended nominal growth for Delivered Meals over the next three years. This will be reviewed for the out years pending the outcomes of the DHS Food Services Review and advice from councils regarding their capacity for expansion.

#### **4.3.2 Summary Priority 2: CALD needs in NMR**

NMR has one of the largest and most culturally diverse ethnic populations in Victoria. Consequently many HACC service providers within the Region are aware of and actively try to respond to the needs of the culturally diverse populations residing in their municipalities.

In order to address the very complex issues associated with this high degree of diversity, more sophisticated approaches to service planning and delivery need to be developed to ensure continued improvement in cultural appropriateness and access to HACC services. It is proposed that this developmental work will continue to build on existing initiatives and planning addressing these issues within the Region.

DHS MDS service provision data shows that the Italian and Greek HACC populations across the Region are accessing HACC services at a higher rate than other CALD groups. The most immediate pressure for these communities is the need for HACC Basic suite of services, particularly Home Care and Assessment and Care Management.

HACC MDS data also indicates an under representation of a range of growing language groups across the Region. It is recommended that these groups become the focus of culturally specific service modelling projects to improve cultural responsive practice of mainstream services to these communities. These need to be developed in co-ordination with Statewide Priority 2 initiatives. (Refer Section 1.7.1.2)

The Region is proposing that Regional growth funds be allocated to a range of CALD service development projects and initiatives that will further support and enhance the implementation of the Cultural Gateways Strategy in the NMR.

These projects include:

- Expansion of existing part time cultural planning positions recurrently funded to multi-cultural agencies in the 2002-03 HACC Growth Funding Round
- Development of an Ethno-specific Planning and Resource position with formal links to the Regional Ethno-specific Service Providers Network to address Regional planning issues for ethno-specific service provision in the Region and provide support to the Ethno-Specific providers network and associated projects
- Additional funding to allow the Network to undertake Regional forums and training initiatives
- Service modelling and practice projects specifically targeting emerging CALD communities in each local government area to be initiated in the context of the Statewide Culturally Equitable Gateways Strategy.

Table 4.1 below summarises the specific communities identified through data analysis by local government area as being in greatest need for targeted access to HACC Basic services as defined by Priority 1.

**Table 4.1 Summary of communities in need of Priority 1 HACC services by local government area**

<b>Community</b>	<b>Locality</b>	<b>HACC Basic need</b>
Italian	Entire Region	Home Care, Personal Care, Allied Health, Nursing
Greek	Entire Region	Home Care, Personal Care, Allied Health, Nursing
Croatian & other Balkan communities (except Macedonian)	Entire Region except Whittlesea	Improve access and uptake of HACC services
Macedonian	Whittlesea, Banyule, Darebin	Improve access and uptake of HACC services
Arabic speaking	Whittlesea, Banyule, Darebin, Hume, Moreland	Improve access and uptake of HACC services
Vietnamese	Yarra, Whittlesea	Home Care, Personal Care, Allied Health, Nursing
Chinese	Yarra, Whittlesea	Home Care, Personal Care, Allied Health, Nursing

#### **4.3.3. Priority 3: ATSI**

Australian Bureau of Statistics 2001 Census Indigenous population estimates show that the largest population of Aboriginal people aged 50+ years reside in the local government area of Darebin, with smaller communities residing in Hume, Whittlesea, Moreland and Banyule. It is understood, however, that these estimates are much lower than actual population numbers and should be used as a guide only.

Quarterly Output Collection data indicates the following HACC activities should be considered higher priority for growth funding over the next three years:

- Home Care
- Personal Care
- Volunteer Co-ordination
- Planned Activity Group Core
- Flexible Service Response.

Previous regional planning consultations for the ATSI client group identified Nursing and Allied Health as the top priorities for the Aboriginal community. It is crucial that these services are further developed and the Region has provided for specific Aboriginal HACC projects to be undertaken to contribute to these HACC needs.

Flexible Service Response is identified as a high priority as this activity allows for innovative and flexible service responses to the complex needs of Indigenous clients.

Consequently, the Region has recommended strategic expansion of Nursing, Allied Health, Home Care, Personal Care, Planned Activity Group Core, Flexible Service Response and Service System Resourcing to Aboriginal HACC clients.

Culturally specific HACC services to Aboriginal people are provided by three Aboriginal agencies in NMR plus a small number of mainstream agencies. Each agency is funded to provide a specific set of HACC service types. Consequently, the Region recommends direct allocation as the preferred method of funding for planned Aboriginal services.

#### **4.3.4 Equity of funds distribution**

Regional service provision data provided in figures 3.10 to 3.16 show that levels of HACC Basic services per head of WREN population tend to be significantly lower in the Whittlesea and Hume local government areas, and to a lesser degree Nillumbik.

Comparison of HACC populations (via WREN) and distribution of HACC funding in each local government area also indicates that Hume and Whittlesea, and to a lesser degree Nillumbik and Moreland local government areas, would benefit from additional growth funds to address intra-Regional equity.

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

### **5.1. Introduction**

Drawing on the data analyses and conclusions documented in Sections 3 and 4, this Section details DHS NMR's recommendations to address the Ministerial Priorities 2003-06 and to implement the *Better Planning and Funds Allocation* processes.

### **5.2. Distribution of recurrent funds and regional Equity**

Before determining growth allocations to each local government area and Ministerial Priority, the Region recommends addressing the issue of equity of funds distribution within the Region through the creation of an equalisation pool.

#### **5.2.1. Case for funds equalisation**

Based on data in Section 3.5.3, there is sufficient evidence to support the decision to top slice a portion of funding from the regional growth allocation to redress HACC funds inequity.

In Section 3, Table 3.7 and Figure 3.6 identify that HACC funding is not equitably distributed throughout the NMR. In particular the local government areas of Hume and Whittlesea, and to a lesser degree Nillumbik and Moreland, are relatively under-funded whilst the local government areas of Banyule and Yarra are relatively over funded. There are a number of historical factors that have created this inequity, largely to do with recent shifts in demographics of each Region. This inequity is expected to continue unless a regional equalisation formula is applied to the distribution of recurrent HACC growth funding.

Historically, inequities in the distribution of funding across local government areas have been identified through application of the RREF formula. Although it was acknowledged that the RREF was not robust enough to apply at local government area level, it was the best measure of equity available. The Region attempted to address these inequities in previous funding rounds through the development of equalisation formulas based on RREF populations and estimates of total HACC funding by local government area. However, these attempts at equalisation have had minimal impact on regional equity to date.

Funds equalisation across local government areas has been recommended for the following reasons:

- Access to more accurate data on regional funds distribution (see Table 3.7) and the development of the WREN as a measure of HACC population at the local government area level, now allows the Region to develop a more robust approach to equalisation that will address existing regional inequities
- Allocation based solely on the newly developed WREN does not have the capacity to adequately address the equity issues arising from significant population growth in the local government areas of Hume and Whittlesea.

The local government areas that will benefit from funds equalisation are:

- Hume
- Whittlesea
- Nillumbik
- Moreland

The need for an equalisation formula to be applied to Hume, Whittlesea and Nillumbik is also supported by regional service provision data provided in figures 3.9 to 3.15 which show that levels of HACC Basic services per head of WREN population tend to be significantly lower in these local government areas.

Local Council data on service usage and demand in Hume, Whittlesea and Nillumbik demonstrates a need for a greater increase in HACC services. Moreland local government area has the highest regional population of the 70+ age group, hence it is important that this local government area is sufficiently resourced in the coming years to meet increasing demand from these service users as they age.

It is important also to note that Statewide funding decisions made outside the regional planning process will impact on regional funds distribution and equity in the 2004-05 and 2005-06 years, therefore decisions regarding the application of equalisation formulae must be reviewed each year in the light of updated funding and population data.

## 5.2.2. Recommended approach to equalisation

### Creation of equity funding pool

Whilst the percentage differences in equity appear small (Table 3.7, Column 6), the funding amounts in real terms are quite significant. In order for the Region to make a real difference to intra-regional equity, a significant injection of funds is required.

The Region recommends addressing regional inequities over the next three years through the creation of an equity funding pool. In 2003-04 the pool will consist of two components:

- a. Quarantine 30% from the total growth allocation less local government area specific commitments
- b. Contribution of State only equity funds allocated to NMR through the Labor Financial Statement (LFS).

**Table 5.1 Budget breakdown**

<b>2003-04 Funding Component</b>	<b>Amount</b>
30% equalisation on \$1,633,048	\$489,914
LFS contribution to equity	\$235,252
LFS Ministerial commitment	\$100,448
LGA specific Aboriginal liaison funding	\$65,000
<b>Total Equity Pool 2003-04</b>	<b>\$725,166</b>

In subsequent years, the Region is proposing to continue to quarantine 30% of total growth allocation to the Region for equity purposes. The Region recommends a review of this decision annually in light of variations within the WREN estimates, population projections and base funding in each local government area including the impact of the Statewide Culturally Equitable Gateways Strategy.

## Distribution of equalisation pool

The recommended distribution ratio for equalisation pool funds to each local government area is calculated based on relative ratios of inequity between nominated local government areas.

**Table 5.2 Formula for distribution of equity funding pool**

Local government areas identified as relatively under funded	% relative under funding	% equity share to be applied
Hume	-2.37%	58.30%
Moreland	-0.22%	5.45%
Nillumbik	-0.20%	4.98%
Whittlesea	-1.27%	31.27%
<b>Total</b>	<b>-4.06%</b>	<b>100.00%</b>

**Table 5.3 Outcome of application of regional equalisation formula, 2003-04 HACC growth funding allocations by local government area**

LGA	Growth \$ WREN applied (Less equalisation pool & local government area specifics)	30% Equalisation Pool	LFS contribution to equalisation	LFS Ministerial Commitment	LGA specific (Koori Liaison)	Total growth distribution after equalisation
Banyule	\$154,446	-	-	-	-	\$154,446
Darebin	\$247,743	-	-	\$100,448	\$28,000	\$376,191
Hume	\$159,831	\$285,607	\$137,145	-	\$18,500	\$601,083
Moreland	\$257,639	\$26,711	\$12,826	-	-	\$297,176
Nillumbik	\$51,612	\$24,390	\$11,712	-	-	\$87,714
Whittlesea	\$129,903	\$153,207	\$73,568	-	\$18,500	\$375,179
Yarra	\$76,959	-	-	-	-	\$76,959
<b>Total</b>	<b>\$1,078,134</b>	<b>\$489,914</b>	<b>\$235,252</b>	<b>\$100,448</b>	<b>\$65,000</b>	<b>\$1,968,748</b>

## Impact of 30% Equalisation Pool over 3 years to 2006

The Region has modeled the impact of applying 30% equalisation funding as per the above formula over the next three years. It should be noted that all figures are indicative only and will need to be reviewed annually in order to account for changes to variables such as population projections, local government area demographics and base funding within each local government area.

Table 5.4: YEAR 1: 2003-04 reference point for equity distribution

Local government area	Within-Region Estimate of Need (WREN) %	Actual share of 2002-03 BUDGET	% Difference between actual share and WREN share	2003-04 Growth \$ according to WREN (no equity adjustment - guide only)	2003-04 Actual growth following equity adjustments 30%– P1, P2, P3 (inc State only \$)
Banyule	14.33%	16.34%	+2.01	\$ 233,940	\$ 130,960
Darebin	22.98%	23.01%	+0.03	\$ 375,257	\$ 252,623
Hume	14.82%	12.46%	-2.36	\$ 242,095	\$ 729,997
Moreland	23.90%	23.68%	-0.22	\$ 390,245	\$ 244,010
Nillumbik	4.79%	4.58%	-0.21	\$ 78,177	\$ 47,652
Whittlesea	12.05%	10.78%	-1.27	\$ 196,764	\$ 472,177
Yarra	7.14%	9.15%	+2.01	\$ 116,569	\$ 91,329
<b>Total</b>	<b>100.00%</b>	<b>100.00%</b>		<b>\$ 1,633,048</b>	<b>\$ 1,968,748</b>

Table 5.5 YEAR 2: 2004-05 indicative HACC growth allocation by local government area

Local government area	Growth \$ WREN applied (Less equalisation pool & local government area specifics)	30% Equalisation	Total growth distribution after equalisation
Banyule	\$171,594	-	\$171,594
Darebin	\$275,003	-	\$275,003
Hume	\$181,455	\$253,581	\$435,037
Moreland	\$286,438	\$54,083	\$340,521
Nillumbik	\$58,242	\$33,611	\$91,853
Whittlesea	\$149,632	\$176,401	\$326,033
Yarra	\$85,547	-	\$85,547
<b>Total</b>	<b>\$1,207,912</b>	<b>\$517,676</b>	<b>\$1,725,588</b>

Table 5.6 YEAR 3: 2005-06 indicative HACC growth allocation by local government area

Local government area	Growth \$ WREN applied (Less equalisation pool & local government area specifics)	30% Equalisation	Total growth distribution after equalisation
Banyule	\$177,129	-	\$177,129
Darebin	\$284,097	-	\$284,097
Hume	\$191,306	\$245,334	\$436,640
Moreland	\$296,148	\$52,486	\$348,634
Nillumbik	\$61,029	\$37,812	\$98,841
Whittlesea	\$159,890	\$203,520	\$363,411
Yarra	\$88,421	-	\$88,421
<b>Total</b>	<b>\$1,258,021</b>	<b>\$539,152</b>	<b>\$1,797,173</b>

Table 5.7 Intra-regional equity picture after three years application of 30% equalisation pool

Local government area	Total Recurrent 2006/07 Base	% of recurrent budget (actual)	2005-06 WREN %	WREN \$ distribution on base	Difference % of budget & WREN %
Banyule	\$8,041,667	15.58%	14.08%	\$7,267,065	1.50%
Darebin	\$11,548,560	22.38%	22.58%	\$11,655,617	-0.21%
Hume	\$7,217,291	13.98%	15.21%	\$7,848,691	-1.22%
Moreland	\$11,905,583	23.07%	23.54%	\$12,150,042	-0.47%
Nillumbik	\$2,392,997	4.64%	4.85%	\$2,503,829	-0.21%
Whittlesea	\$6,035,494	11.69%	12.71%	\$6,559,791	-1.02%
Yarra	\$4,471,080	8.66%	7.03%	\$3,627,636	1.63%
<b>Total</b>	<b>\$51,612,672</b>	<b>100.00%</b>	<b>100.00%</b>	<b>\$51,612,672</b>	<b>0.00%</b>

After three years of equalisation, Banyule and Yarra equity share has reduced by 0.51%, while the local government areas of Hume and Whittlesea equity has improved by 1.14% and 0.25% respectively. Equity share for Nillumbik remains static and the local government areas of Moreland and Darebin has marginally reduced equity share. The reduction is relatively insignificant when considered in the context of the total base budget for Darebin and Moreland local government areas, which are the largest in the Region (ie: approximately \$30,000 in \$12 million budget in Moreland).

### 5.3. Recurrent growth allocations

Tables 5.8 a, b & c identify the recommended recurrent growth allocations to the Region and local government areas for Priorities 1–3, subject to yearly reviews and budget confirmation. It is important to note that the recommendations for 2003-04 are more detailed, while those for the out-years are subject to change when the Regional Plan is reviewed and adjusted for 2004-05 and 2005-06.

**Table 5.8a: Recommended growth allocations by priority and local government area, 2003-04**

2003-04	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Banyule	\$96,764	-	-
Darebin	\$255,664	-	\$28,000
Hume	\$522,889	-	\$18,500
Moreland	\$200,953	-	-
Nillumbik	\$68,438	-	-
Whittlesea	\$308,162	-	\$18,500
Yarra	\$48,216	-	-
Region wide	\$35,565	\$245,000	\$153,297
<b>Total</b>	<b>\$1,536,651</b>	<b>\$245,000</b>	<b>\$218,297</b>

**Table 5.8.b: Recommended growth allocations by priority and local government area, 2004-05**

2004-05	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Banyule	\$131,552	-	-
Darebin	\$210,829	-	-
Hume	\$392,693	-	-
Moreland	\$273,679	-	-
Nillumbik	\$78,262	-	-
Whittlesea	\$291,116	-	-
Yarra	\$65,584	-	-
Region wide	\$40,367	\$100,000	\$172,706
<b>Total</b>	<b>\$1,484,082</b>	<b>\$100,000</b>	<b>\$172,706</b>

**Table 5.8.c: Recommended growth allocations by priority and local government area, 2005-06**

2005-06	Priority 1 (including Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Banyule	\$139,036	-	-
Darebin	\$223,000	-	-
Hume	\$395,499	-	-
Moreland	\$284,945	-	-
Nillumbik	\$85,716	-	-
Whittlesea	\$329,025	-	-
Yarra	\$69,405	-	-
Region wide	\$41,284	\$100,000	\$160,463
<b>Total</b>	<b>\$1,567,910</b>	<b>\$100,000</b>	<b>\$160,463</b>

#### 5.4.2. Expansion of the HACC regional training co-ordination function

NMR is committed to expanding the HACC Regional Training Co-ordination Function. Training is a vital part of workforce development and should be seen as an important function in the ongoing delivery of a high quality HACC service system.

The expansion will assist the Regional Training Co-ordinator to develop and implement a regional training strategy to address training priorities of HACC staff in the NMR. This strategy will also provide support to HACC agencies in accessing traineeships and other training and learning opportunities that are funded from other sources, such as the Vocational Education Training system, that address HACC specific training needs.

In the first year, 2003-04, it is recommended to increase the training co-ordination function budget by 5%. In 2004-05 NMR is proposing a minimum increase of 10% and in 2005-06 it is also proposing a further minimum increase of 10%.

**Table 5.9: Training budget 2003-06**

	<b>2003-04</b>	<b>2004-05</b>	<b>2005-06</b>
Base	\$87,304.28	\$91,669.49	\$100,836.44
Increase	\$4,365.21	\$9,166.95	\$10,083.64
<b>Total</b>	<b>\$91,669.49</b>	<b>\$100,836.44</b>	<b>\$110,920.09</b>

## **5.4. Recommended expansion of activities – 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.

### **5.4.1 Expansion of the HACC Basic services**

Available planning data has highlighted growth in the 70+ age group in each local government area over the next three years. Due to this anticipated growth of the older population there will be increased demand on community care and health services. Some allowance has also been made in the first year to address service viability issues for some services within the Region.

Following the data analysis and conclusions described in Sections 3 and 4, Table 5.10 summarises the service activities highlighted for expansion in each local government area in 2003-04. Further details are available in Appendix B.

**Table 5.10: Service activities identified for greater expansion by local government area**

<b>Local government area</b>	<b>Activity</b>
Banyule	Property Maintenance Delivered Meals Home Care Personal Care Allied Health
Darebin	Home Care Nursing Allied Health Personal Care Property Maintenance Flexible Service Response Service System Resourcing
Hume	Home Care Personal Care Property Maintenance Delivered Meals Nursing Allied Health Service System Resourcing
Moreland	Personal Care Allied Health Home Care Property Maintenance Nursing
Nillumbik	Home Care Personal Care Property Maintenance Delivered Meals Nursing Assessment & Care Mgt
Whittlesea	Home Care Personal Care Property Maintenance Nursing Allied Health Assessment & Care Mgt
Yarra	Assessment & Care Mgt Home Care Property Maintenance Flexible Service Response Allied Health

The recommended expansion of activities over the 2003-06 period is summarised in the tables below. Nursing and Allied Health will be allocated through an invited submission process due to a number of providers operating within the Region. It should be noted that although Nursing public unit prices have been used for calculation purposes, Nursing non public providers will not be excluded from applying for nursing growth funds. Priority 1 expansion targets the whole HACC population.

**Table 5.11.a: 2003-04 Recommended expansion of activities – Priority 1**

<b>Activities</b>	<b>Units</b>	<b>\$</b>
Home Care	6,448	\$157,589
Personal Care	5,655	\$158,001
Property Maintenance	5,334	\$189,624
Allied Health	5,814	\$417,271
Nursing	4,885	\$307,071
Delivered Meals	17,008	\$20,920
ACM	-	\$110,046
Flexible Service Response	-	\$15,013
Service System Resourcing	-	\$107,461
SSR Training	-	\$4,365
PAG High	1,292	\$18,088
SSR HACC Response Service	-	\$31,200

Table 5.11a includes an allocation for Planned Activity Groups. This allocation has been included to meet a prior Ministerial commitment for the PANCH health service and has been allocated from State only funds provided through the Labor Financial Statement as identified in Table 5.3.

**Table 5.11.b: 2004-05 Recommended expansion of activities – Priority 1**

<b>Activities</b>	<b>Units</b>	<b>\$</b>
Home Care	6,220	\$155,792
Personal Care	5,700	\$163,248
Property Maintenance	4,927	\$179,519
Allied Health	6,539	\$481,040
Nursing	5,237	\$337,445
Delivered Meals	10,000	\$12,608
ACM	-	\$76,064
Flexible Service Response	-	\$28,000
Service System Resourcing	-	\$10,000
SSR Training	-	\$9,167
SSR HACC Response Service	-	\$31,200

**Table 5.11.c: 2005-06 Recommended expansion of activities – Priority 1**

<b>Activities</b>	<b>Units</b>	<b>\$</b>
Home Care	6,849	\$175,835
Personal Care	5,533	\$162,427
Property Maintenance	5,235	\$195,509
Allied Health	6,718	\$506,563
Nursing	5,716	\$377,517
Delivered Meals	16,000	\$20,676
ACM	-	\$73,098
Flexible Service Response	-	\$5,000
Service System Resourcing	-	\$10,000
SSR Training	-	\$10,084
SSR HACC Response Service	-	\$31,200

#### 5.4.4. Recommended allocation process, 2003-04

The funding allocations recommended below are in accordance with the DHS *Purchasing and Funding e-guide*. Stakeholders generally agreed with the Region's proposals to expand HACC services.

**Table 5.12 Recommended funds allocation processes for 2003-04 proposals for Priority 1 growth**

Allocation Method	Catchment	Name of Agency	Home Care	Personal Care	Prop. Maint.	Allied Health	Nursing (Blair)	Del. Meals	ACM	FSR	SSR	SSR Training	PAG High
Direct Allocation	Banyule	Banyule City Council	\$12,220.00	\$13,970.00	\$53,360.55			\$ 6,159.84					
Direct Allocation	Darebin	Darebin City Council	\$31,429.84	\$33,555.94	\$10,665.00								
Direct Allocation	Hume	Hume City Council	\$61,026.68	\$41,910.00	\$53,325.00			\$12,300	\$65,004.31				
Direct Allocation	Moreland	Moreland City Council	\$10,020.40	\$28,051.76	\$10,665.00								
Direct Allocation	Nillumbik	Nillumbik Shire Council	\$ 4,888.00	\$12,573.00	\$16,033.05			\$ 2,460	\$ 1,996.77				
Direct Allocation	Whittlesea	Whittlesea City Council	\$30,672.20	\$27,940.00	\$28,440.00				\$35,024.14				
Direct Allocation	Yarra	Yarra City Council	\$ 7,332.00		\$ 7,145.55				\$ 8,020.90				
Direct Allocation	Yarra	Yarra City Council								\$ 10,000.00			
Direct Allocation	Whittlesea	LINC			\$ 9,989.55								
Direct Allocation	Darebin	BECC									\$82,360.73		
Direct Allocation	Darebin	Darebin Community Health											\$ 18,088
Direct Allocation	Darebin	Bethlehem Community Services							\$ 5,012.81				
Direct Allocation	Region wide	Northern Care & Share									\$25,100.00		
Direct Allocation	Region-wide	Training										\$4,365.21	
Invited Submission	Region wide	Nursing provider					\$307,071.10						
Invited Submission	Banyule	Allied health provider				\$ 11,052.58							
Invited Submission	Darebin	Allied health provider				\$ 55,693.52							
Invited Submission	Hume	Allied health provider				\$150,717.00							
Invited Submission	Moreland	Allied health provider				\$ 89,353.65							
Invited Submission	Whittlesea	Allied health provider				\$ 94,736.40							
Invited Submission	Yarra	Allied health provider				\$ 15,717.63							

## **5.5. Recommended expansion of activities – 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.

### **5.5.1. Introduction**

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

- Developed with reference to the Statewide Cultural Gateways Strategy coordinated by DHS Central Office and outlined in Section 1.7.1.2
- Based on an analysis of the data and information about the CALD communities documented in Section 3.5.1.2.

### **5.5.2 Regional planning context of the NMR CALD sector**

The Region has very high rates of diversity in each local government area except Nillumbik. However MDS data demonstrates a relatively low take up rate of HACC services by the CALD community. Data analysis indicates that the potential demand for HACC Basic services by the CALD target group is increasing significantly (ABS 2001 Census), yet these client groups tend to be under-represented in MDS reports for mainstream agencies. DHS expects mainstream agencies to proactively engage with this target group to ensure these groups are more appropriately reflected in the HACC data collections.

In recent years a number of projects have been undertaken to support mainstream, ethno-specific and multi-cultural agencies to enhance the quality of and access to HACC services for the CALD communities within the Region. These initiatives include:

- Two recurrently funded part time positions located within multi-cultural agencies in the Region. The positions are designed to work with both mainstream agencies and CALD communities to improve equity of access to HACC services through the development and maintenance of sustainable and culturally responsive service models within the existing service system. One position located at Action on Disability within Ethnic Communities (ADEC) continues the work undertaken through DHS' Equity and Access Program, which requires all HACC funded agencies to submit an annual cultural action plan. The primary focus of this position is to continue to improve the quality of planning within organisations to ensure that responsiveness to cultural diversity becomes embedded into normal business practice. The other regional position located at Migrant Resource Centre North East (MRCNE), focuses on empowering smaller and emerging communities to engage in the HACC service system through training of community leaders and support to smaller community groups
- In 2002-03 the Region funded an Assessment and Care Management project at CoAsIt on a Fixed Term Recurrent basis for 18 months. This focus of this project is to investigate and clarify the specific requirements of older Italian HACC clients in the development of culturally appropriate assessments and care plans. The outcomes of this project are expected to feed into the partnership enhancement projects proposed through the Culturally Equitable Gateways Strategy and regional projects recommended in this Regional Plan
- The Region is also in the initial stages of establishing an Ethno-Specific HACC Service Providers Network (the Network), a priority that arose out of HACC

Planning processes in 2002. The purpose and function of this Network is still under development, but it is envisaged that this Network will contribute to the planning of HACC services in the NMR. The secretariat and executive support for the Network will be managed by the agency auspicing the Network resourcing position. The Network is a formal subcommittee of the NMR HACC Advisory Committee.

#### **5.5.4 Regional CALD strategy**

The Region is proposing that regional growth funds be allocated via direct allocation and invited submission (as per table 5.12) to the following CALD projects and initiatives that will further support and enhance the implementation of the Cultural Gateways Strategy in the NMR. The structure of these projects will be further developed through detailed project briefs to be developed by the Region in consultation with regional CALD agencies and include:

- **Expansion of existing cultural planning positions to full time**  
Expansion of existing part time cultural planning positions recurrently funded to multi-cultural agencies in 2002-03 HACC Growth Funding round. It is intended that these two positions will focus on developing strategies to address growing levels of diversity within HACC target population within the Region.
- **Ethno-specific planning and network resource position**  
Creation of an Ethno-specific HACC Planning and Resource position to be funded through invited submission to an NMR agency. The responsibilities of this position will be to resource the CALD community to assist with HACC planning and service development in the NMR. This position will have formal links to the regional Ethno-specific Service Providers Network and will have secretariat and “follow up” responsibilities for the Network. It is expected that this position will provide a formal link to other planning networks operating with the Region such as the HACC Advisory Committee. The ethno-specific service providers network is chaired by the NMR DHS.
- **Ethno-specific service providers network resourcing**  
It is anticipated that with the establishment of the regional Ethno-specific Service Providers Network there will be requirement for additional funding to meet the needs of enhancing CALD service development in the NMR. Additional funding has been recommended to allow the network to initiate regional forums on good practice in cultural planning and address workforce development issues such as the recruitment and retention of bilingual workers in mainstream agencies. This funding will be held with the agency that is the successful auspice of the Ethno-specific planning and network resource position to be spent in accordance with the directions of the regional Ethno-specific Service Providers Network.
- **CALD service provision models**  
This plan provides some scope to develop a range of initiatives to enhance the interface between mainstream and CALD providers with an aim of improving access to and quality of “HACC Basic” services for people from CALD communities. NMR will quarantine some funds specifically for service modelling and practice projects targeted to emerging CALD communities in each local government area. It is intended these projects will be developed in the context of the development and impact of the

Statewide Cultural Gateways strategy. Project funds will be allocated (subject to Ministerial endorsement) based on advice from the Ethno-specific providers network and projects to be developed and initiated will aim to ensure communities with highest need are targeted specifically.

### 5.5.5. Recommended allocation process, 2003-04

The funding allocations recommended below are in accordance with DHS' *Purchasing and Funding e-guide*. Stakeholders generally agreed with the Region's proposals to expand HACC services.

**Table 5.13 Recommended funds allocation processes for Priority 2 Growth**

<b>Allocation Method</b>	<b>Agency (if known)</b>	<b>Project</b>	<b>Activity</b>	<b>FUNDS</b>
Invited submission	ADEC and NEMRC	Ethno-specific Planning and Network resource position & Ethno-specific Network resourcing	Service System Resourcing	\$80,000
Direct Allocation	ADEC	Mainstream CALD planning support project	Service System Resourcing	\$30,000
Direct Allocation	NEMRC	Smaller, emerging community access project	Service System Resourcing	\$35,000
Quarantined to DHS pending specific project proposals and Ministerial endorsement	DHS Northern	Flexible & culturally responsive service delivery. Developed through Ethno-specific Network and building on Gateways strategy better service needs of emerging CALD communities in Region.	SSR, FSR	\$100,000
				<b>\$245,000</b>

## **5.6. Recommended expansion of activities – Priority 3**

Priority 3 is to increase the quantity and quality of HACC services for Aboriginal and Torres Strait Islander (ATSI) communities.

### **5.6.1. Introduction**

A brief outline of ATSI distribution in the Region is provided in Section 3.5.1.4. It should be noted that the ATSI proposals have been developed via a two-stage 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.

### **5.6.2. 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 ATSI 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 ATSI 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 recommended was:

- Implementing workforce development strategies
- Improving understanding, 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.

### **5.6.3. ATSI sector**

#### **5.6.3.1. Regional planning context of NMR ATSI HACC sector**

Culturally specific services to ATSI clients are provided by three ATSI agencies in NMR plus a small number of mainstream agencies. ATSI agencies are funded to provide the full suite of HACC services, except for Linkages and Delivered Meals.

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<sup>6</sup> Reiterated in Department of Human Services Disability Services Policy and Funding Plan 02-03

In recent years the three primary ATSI providers in the Region reached an agreement to specialise in provision of specific HACC services to maximise service delivery and minimise competition for growth funds. Consequently, Aborigines Advancement League focus on Home and Personal Care, Property Maintenance and respite services; Victorian Aboriginal Health Service focuses on Allied Health and Nursing services; and Aboriginal Community Elders Service focuses on Planned Activity Group and podiatry. In addition all agencies receive Flexible Service Response funding for specialist programs that respond to the complex needs of ATSI clients.

These agencies work closely together to ensure that clients are referred to other agencies as necessary and services are responsive to client need. A partnership has been developed between Darebin Community Health and ATSI service providers to provide Allied Health to ATSI HACC clients in Darebin.

#### **5.6.4. Priority HACC activities identified for expansion**

Based on the information in Sections 3 and 4 the following priorities have been identified:

##### **2003-04**

- Allied Health
- Home Care
- Personal Care
- Planned Activity Group Core
- Flexible Service Response
- Service System Resourcing
- Property Maintenance

##### **2004-05**

- Nursing
- Home Care
- Personal Care
- Property Maintenance
- Planned Activity Group Core
- Flexible Service Response
- Service System Resourcing

##### **2005-06**

- Allied Health
- Nursing
- Home Care
- Personal Care
- Property Maintenance
- Planned Activity Group Core
- Flexible Service Response
- Service System Resourcing

#### **5.6.4.1 ATSI service development project proposals**

In keeping with Commonwealth strategies for addressing ATSI health issues, the Region will focus on expanding access to HACC services for ATSI clients through developing the responsiveness of mainstream service providers and facilitating complementary initiatives through ATSI agencies.

The Region is prioritising projects that address the overall health status of the ATSI HACC population. Initiatives could include HACC services that contribute to addressing the primary health issues affecting ATSI HACC clients in NMR, specifically diabetes, obesity and cardiovascular disease. Primary partnerships in this instance would be with Community Health Centres in the local government areas of Darebin, Hume and Whittlesea.

### **Flexible Service Response and Service System Resourcing initiatives**

The objective of these projects is to increase the uptake of HACC services by Indigenous HACC population (which will be measured through the MDS) and address ongoing ATSI health and service access issues. The following initiatives are recommended to be undertaken systematically over the next three years:

#### **2003-04**

- Aboriginal Liaison Officer position focused on developing partnerships between mainstream and ATSI service providers in the local government areas of Darebin, Hume and Whittlesea
- Through a mix of regional and cross regional funding, a project to develop an Aboriginal Services and Resource Directory will be supported. It will be linked to the PCP Services Directory. It will assist both ATSI and mainstream service providers in referring ATSI HACC clients to local and culturally relevant services in the inner areas of Metropolitan Melbourne. The project will be funded as a Fixed-Term Recurrent project directly allocated to Northern Division of General Practice
- Flexible Service Response ATSI HACC project to build on holistic services for older ATSI HACC clients

#### **2004-05 to 2005-06**

- Transport Co-ordination project to focus on developing a collaborative transport service model with ATSI agencies working through the issues of transport and identifying strategies to improve the use of ATSI transport resources within the Region
- ATSI HACC project to develop holistic service to address health issues affecting older ATSI HACC clients including diabetes, cardiovascular disease and obesity. This project provides a link between Flexible Service Response funds and Allied Health funds to facilitate holistic and responsive service for older ATSI clients
- Further projects will be developed as a consequence of the Region's ATSI HACC Strategic Needs Analysis and Planning Service Development project, which will identify ATSI HACC populations residing in Hume, Whittlesea, as well as Banyule and Moreland. Projects might foster partnerships between local community health centres, local government and ATSI agencies with an aim of improving access to the full suite of HACC services for ATSI HACC clients.

### 5.6.6. Recommended allocation process, 2003-04

The funding allocations recommended below are in accordance with DHS' *Purchasing and Funding e-guide*. Stakeholders generally agreed with the Region's proposals to expand HACC services.

**Table 5.14 Recommended funds allocation processes for Priority 3 growth**

Catchment	Allocation method	Agency (if known)	Project	Activity	Funds
Darebin, Hume & Whittlesea	Invited submission	VAHS, AAL, ACES, City of Darebin, Hume City, Whittlesea City Council	Aboriginal Liaison Officer - D'bin, W'sea & Hume	SSR	\$65,000
Region Wide	Direct	Victorian Aboriginal Health Service	Allied Health		\$46,435
Region Wide	Direct	Aborigines Advancement League	Home Care		\$13,173
Region Wide	Direct	Aborigines Advancement League	Personal Care		\$3,437
Region Wide	Direct	Aborigines Advancement League	Property Maintenance		\$7,110
Region Wide	Direct	North Western Division of General Practice	NMR Pilot Koori Service Directory	SSR FTR to 31/12/04	\$20,000
Region Wide	Direct	ACES/Darebin CH	Social Support programs	PAG Core	\$34,755
Region Wide	Invited submission	ACES, VAHS, AAL	ATSI HACC project - holistic service response to older ATSI clients (link to Allied Health)	FSR/SSR	\$28,387
<b>Total</b>					<b>\$218,297</b>

## 5.7. 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.

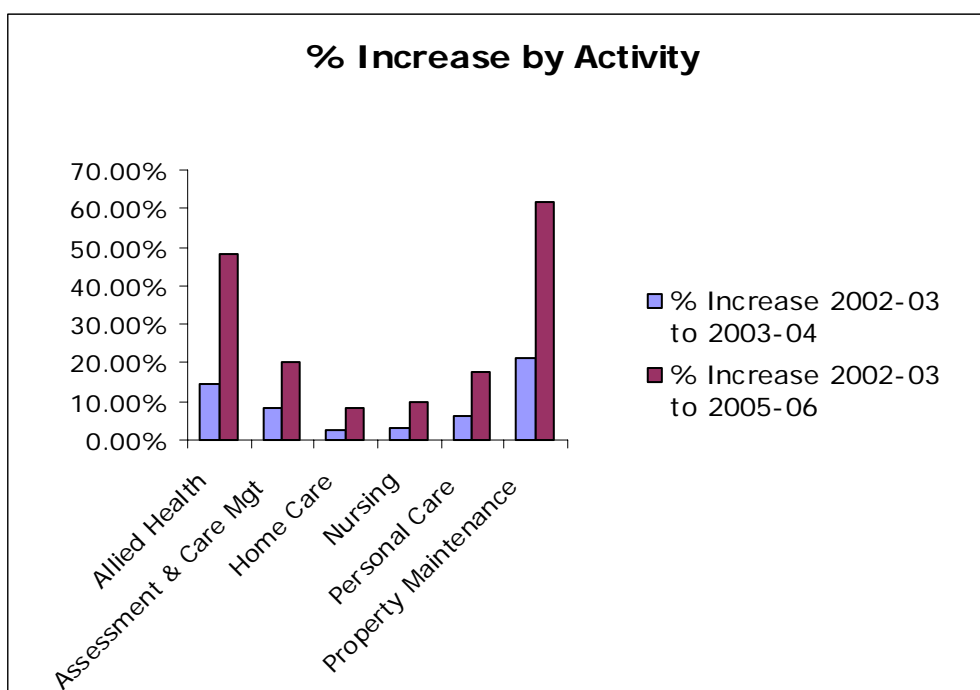


Figure 5.14 Percentage increase of Priority 1 activities, 2003-04 and 2005-06

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. The second bar shows the proposed recurrent base budget at 1 July 2006 and reflects funding allocations as recommended in this 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 5.15: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

Local government area	Recurrent \$ 1/7/2003	% of recurrent budget, 1/7/2003	WREN 2003-04	Recurrent \$ + growth, 1/7/2006	% of budget, 1/7/2006	WREN 2006
Banyule	\$7,538,497	16.3%	14.3%	\$8,125,432	15.5%	14.1%
Darebin	\$10,613,269	23.0%	23.0%	\$11,717,856	22.4%	22.6%
Hume	\$5,744,532	12.5%	14.8%	\$7,569,567	14.5%	15.2%
Moreland	\$10,919,252	23.7%	23.9%	\$11,905,204	22.7%	23.5%
Nillumbik	\$2,114,590	4.6%	4.8%	\$2,307,822	4.4%	4.9%
Whittlesea	\$4,970,872	10.8%	12.0%	\$6,182,712	11.8%	12.7%
Yarra	\$4,220,153	9.2%	7.1%	\$4,538,029	8.7%	7.0%
<b>Total</b>	<b>\$46,121,163</b>	<b>100.0%</b>	<b>100.0%</b>	<b>\$52,346,622</b>	<b>100.00%</b>	<b>100.00%</b>

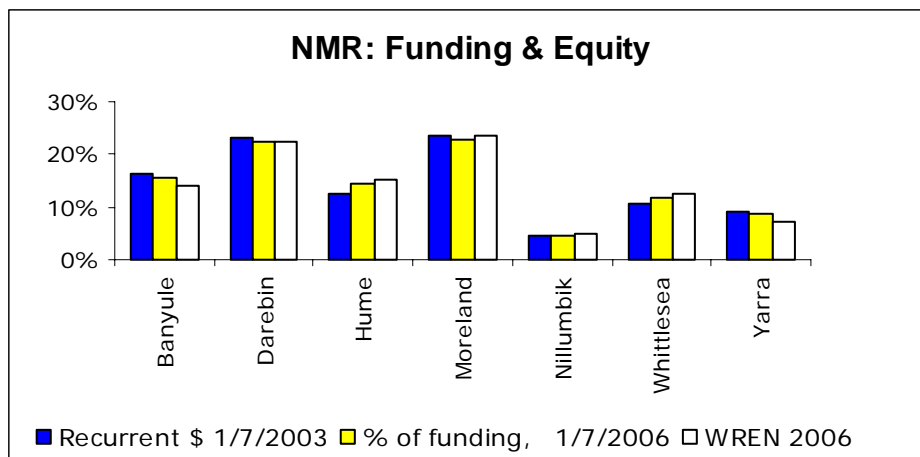


Figure 5.14: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

## **Section 6 – Non-recurrent funding**

### **6.1. Introduction**

This section outlines regional 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. As significant developmental work is being undertaken with respect to Priority 2 and 3, the Region is recommending two service development projects for 2003-04, with a view to identifying additional projects for subsequent years through regional planning over the next 12 months.

The following projects are recommended for 2003-04:

#### **6.2.1. Recommended funded projects**

##### **ATSI strategic needs analysis project (\$20,000)**

The Region has identified that there is a need for an ATSI Strategic HACC Needs Analysis project. This needs analysis is to be part of a statewide project building on recent work undertaken in various regions. The project will improve NMR's knowledge and understanding of ATSI HACC needs and deliver a strategic plan identifying better targeting of accessible and quality services for ATSI clients. NMR funds are to be quarantined to the Region for the purpose of implementing the strategic plan.

##### **IT (information technology/information management)–Data quality improvement initiative (\$10,000)**

Section 3.2.2 of this plan identifies that the majority of HACC providers in the NMR are small non-government agencies where HACC services are their major service response. Many agencies have inadequate MDS IT/IM systems/processes that inhibit efficient service delivery and compromise quality HACC reporting. This plan identifies in section 3.5.2 that regional planning has been inhibited because the MDS was corrupted by low regional response rates and data errors. Discrepancies found in the Quarterly Output Collection and the MDS reporting requirements together with low or poor quality reporting could be due to either a lack of adequate MDS IT/IM infrastructure/processes or staff untrained in the use of MDS IT systems/processes. In particular, a number of agencies continue to use paper based reporting formats for Quarterly Output Collection and MDS reports.

The purpose of this project will be to identify HACC funded agencies that are ineffectively reporting MDS data and work with them to identify solutions to remedy this situation. Priority of planning for the initiative will be to identify the agencies having the largest difficulties reporting HACC MDS. It is intended that this initiative will complement rather than supplement expenditure under the revised HACC Minor Capital allocations.

The outcome of the project is to significantly improve the quality of the MDS data to enable an accurate picture of use of HACC services in the Region; improve HACC regional planning processes and make the HACC reporting requirements less onerous for HACC funded agencies.

### 6.2.2. Recommended unfunded projects

The following unfunded projects are recommended to be undertaken and developed by regional staff. Unfunded projects will be scheduled over the next three years and awarded equivalent importance in service development as funded projects within the Region.

**Linkages service providers network** one of the outcomes of the regional Linkages Demand Management Project was to establish a Linkages Service Providers Network supported and convened by DHS. The Region will resource this network independently with a view to implementing project recommendations, providing a forum for service planning and development and improving consistency in the management of the Linkages program throughout the Region.

**Smaller HACC agency viability project** one of the issues highlighted in the Region is the preservation of the diversity and integrity of the existing HACC service system. A fundamental component of the regional HACC service system are the many smaller, non-government agencies that have developed localised service responses that cater for the diverse needs of HACC clients and their carers with the minimal infrastructure available to them.

In order to better understand the issues and needs of this component of the service sector, the Region recommends to undertake a review of the ongoing viability of such smaller agencies, looking at issues concerning financial viability over the longer term, agency infrastructure, the role of these agencies within the HACC service system and consumer impacts and satisfaction.

**Monitoring of no-growth HACC services** the Region recommends a project to work with the regional Planned Activity Group Co-ordinators Network and Respite providers to develop a strategy to monitor the impact of the changes to the HACC Planning and funds allocation process on these services. Outcomes of this project will be utilised to provide feedback and evidence to support future planning processes.

### 6.2.3 Recommended allocation process - service development initiatives

Stakeholders generally agreed with the Region's proposals to expand HACC services.

Project	Funding Allocation Method	Agency
ATSI Strategic Needs Analysis project	Direct Allocation	Effective Change
IT Capacity Audit	Invited submission	Unknown

### 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, allowing the Region to reserve up to 20% one-off funds for discretionary purposes.

The Region recommends an allocation of 80% of the minor capital budget through the formula<sup>7</sup> and retain 20% as discretionary minor capital funds to manage any unexpected impacts of the application of the new minor capital formula. It is intended that these funds will be allocated to agencies according to the priorities listed below to assist them in the transition to the new Minor Capital funding formula. In particular, the Region is concerned about the ongoing viability of HACC community transport initiatives that will not be sufficiently funded through the application of the formula.

In addition, some discretionary minor capital funds may be required in 2003-04 to support projects recommended under Priorities 2 and 3.

### **6.3.1. One off discretionary funding priorities 2003-04**

The following priorities are recommended for 2003-04 to support agencies to make the transition to the new minor capital formula. This approach will be reviewed in 2004-05 and 2005-06 once the outcomes of the new Minor Capital formula are known.

<b>Priority</b>	<b>Rationale</b>
Vehicle changeover - HACC transport provider	Under the revised minor capital allocation method, the HACC transport provider in the Region will not attract sufficient minor capital funds for vehicle changeover, as its infrastructure requirements are disproportionate to other HACC providers.
Support to ensure service viability	The Region has identified some agencies that may require additional support in the transition to the minor capital allocation formula.
Support to CALD access projects	These projects may require additional minor capital support to purchase computer and office equipment for project workers.
Support to IT audit project/improved IT capacity	The Region will use discretionary funds as an adjunct to the IT audit project (refer to Section 6.2.1) to ensure that all HACC funded agencies within the Region have sufficient IT capacity to maximize the efficient use of HACC resources.
Koori Agency equipment/vehicle changeover	To ensure sufficient funds to continue service provision to ATSI HACC clients, subject to outcomes of Minor Capital formula application

### **6.3.2 One-off discretionary funding priorities for consideration in 2004-05 and 2005-06**

Discretionary minor capital funds may be required to support a range of Priority 2 and 3 projects emerging from work done in 2003-04. This may include items such as a car to support the recommended Aboriginal Liaison position and potentially computer and office equipment to support other CALD and ATSI projects. In addition, some provisions may need to be made for allied health equipment in support of the recommended CALD community and ATSI HACC projects.

<sup>7</sup> Better Planning and Funds Allocation for the HACC Program in Victoria – Final Report March 2003