

Better Planning and Funds  
Allocation for the Home and  
Community Care Program  
In Victoria

Final Report

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March 2003

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## Foreword from The Minister for Aged Care

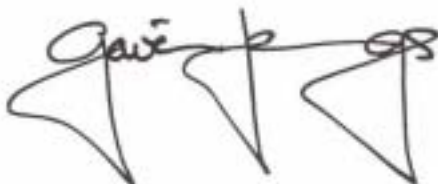
The services provided under the Commonwealth-State Home and Community Care Program (HACC), such as home care, home nursing and delivered meals, are already amongst the best recognised and most valued in the community. They will only grow in importance as our population ages. HACC serves around 180,000 people every year in Victoria, ranking third after GPs and hospitals in terms of number of people receiving a human service. It is the key funding stream for maintaining independence and preventing or delaying admission to care.

But HACC providers have been saying for some years that the way HACC goes about setting annual priorities and allocating growth funds is too complex and time consuming and needs to be streamlined.

I am pleased that the Department of Human Services recognised the validity of those concerns, and held consultations to enable stakeholders to consider a number of policy proposals. Whilst not every proposal received unanimous support, there was much agreement on basics, sufficient for a reform package to be developed for implementation from 2003-2004.

In endorsing the reform package, I have been keen to ensure that any changes make a real difference for the people who use HACC services and the agencies who provide them. We all want to see HACC growth funds result in more hours of service, of the kind people need most, planned, funded and delivered in the simplest and most effective way. Agencies need to be freed from unnecessary bureaucratic obstacles in applying for growth funds so their time can be used most effectively in the service of clients and their families. The reform package meets these tests and I commend it to you.

I would like to take this opportunity to thank the many HACC agencies and external and internal stakeholders who have devoted so much time and thought to contributing to these reforms. I am confident the end result will more than justify your efforts.

A handwritten signature in black ink, appearing to read 'Gavin Jennings', written over a stylized graphic element consisting of three downward-pointing triangles.

**Hon Gavin Jennings MLC**  
**Minister for Aged Care**



## Introduction

In September 2002 DHS released *Background and Consultation Papers* outlining the current process for planning and allocating growth funds in the Home and Community Care (HACC) Program, and proposing a number of ways in which these could be improved.

All the reform proposals were to be considered against the following:

- ◆ **Consistency and equity** – will the proposals result in a fairer, more consistent and less historically determined distribution of HACC resources?
- ◆ **Effectiveness** – will the proposals improve the effectiveness of the Program in meeting its objectives?
- ◆ **Simplicity and transparency** – do the proposals make the process of applying for and receiving funding simpler, more efficient and more transparent for agencies?
- ◆ **Longer term planning** – notwithstanding Government budgetary cycles, do the proposals support a longer term planning horizon for DHS and providers?
- ◆ **Partnerships** – do the proposals represent a step towards a more partnership-oriented approach with providers?
- ◆ **Stakeholder views** – do stakeholders consider that the merits of the proposals warrant the effort required to implement them?

The Papers can be found on [www.health.vic.gov.au/agedcare/hacc/index.htm](http://www.health.vic.gov.au/agedcare/hacc/index.htm).

An extensive consultation process was held with HACC's external and internal stakeholders from September 2002 to February 2003. Almost half of all HACC's 500 providers attended regional consultation sessions, and seventeen written submissions were received. Special workshops were held with key bodies such as the Municipal Association of Victoria, the Departmental Advisory Committee on HACC, the Victorian Association of Health and Extended Care and DHS' regional HACC staff and their managers. Advice has been provided at each key stage to the Commonwealth Department of Health and Ageing.

This *Final Report* distils the many ideas and proposals which have emerged during the course of the review process, into a reform package for 2003-06. The package has been endorsed by the Minister for Aged Care, the Hon Gavin Jennings MLC.



## Changes for 2003 –2006

The table on the following pages summarises the various elements of the reform package. To ensure agencies are fully informed of what the changes will mean for the HACC business cycle, there are a number of Appendices to this report, outlining the reforms in greater technical detail.

These cover the following:

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### How Will The New Approach Be Better Than The Old?

<b>From</b>	→	<b>To</b>
Complex, laborious annual submission process for growth funds	→	Simpler, more efficient process for allocating growth funds
High degree of funding uncertainty for agencies	→	Greater certainty for agencies
Very broad annual Ministerial priorities	→	Evidence based, 3 year strategic Ministerial priorities
No consultation over Ministerial priorities	→	Clear role for Departmental Advisory Committee on HACC (DAC), representing all major consumer and provider groups
Inequities within regions	→	Greater equity within regions
High level of regional variability, not always justifiable	→	More consistency
Opaque decision making	→	Transparency about decisions
No research program	→	Formal research program, with input from DAC
Annual planning	→	Triennial planning
DHS Regions – focus on business processes	→	DHS Regions – focus on service planning, partnerships and system improvement.

Reform Element	Replaces	System Benefit
<p><b>Three year Ministerial priorities</b></p> <p>3 year strategic framework for HACC growth funds 2003-06, based on:</p> <ul style="list-style-type: none"> <li>increasing supply of core HACC services – evidence from recent reports</li> <li>demographic evidence about growth in frail aged, ageing of people with disabilities and increasing proportion of older people from CALD backgrounds</li> <li>strengthening service system, both mainstream and specialist, through organisations working closely together.</li> </ul> <p>Refer to Appendix One, page 9</p>	<p>One year Ministerial priorities</p> <p>In 2002-03 these were:</p> <ul style="list-style-type: none"> <li>general demand</li> <li>special needs population</li> </ul> <p>Argued that these were:</p> <ul style="list-style-type: none"> <li>too broad to provide real guidance</li> <li>not evidence based</li> <li>encouraged dispersion of scarce growth funds across too many priorities.</li> </ul>	<p>Targeted priorities over 3 years allow more effective use of funds.</p> <p>Fewer unsuccessful funding applications.</p> <p>Next triennium’s proposed priorities generally supported by stakeholders.</p> <p>Opportunity to revisit other priority areas, such as social support, in the next triennium.</p>
<p><b>Three year planning</b></p> <p>3 year planning horizon for State and Regional HACC Plans.</p>	<p>One year State and Regional HACC Plans, as per Commonwealth-State HACC Amending Agreement.</p> <p>One year Plans will still be required for the Commonwealth.</p>	<p>DHS is moving to 3 year Program Plans and Service Agreements with agencies.</p> <p>Gives agencies much more stability, certainty and internal planning capacity.</p>
<p><b>Regional Plans</b></p> <p>Public Regional Plans using a common template.</p>	<p>Nine different Regional Plans, not always publicly available.</p> <p>No obligation to explain planning decisions.</p>	<p>Transparent, consistent decision making.</p> <p>This is particularly important given change to direct allocation of some growth funds (see below).</p>
<p><b>Intra-regional equity</b></p> <p>Local area formula for recurrent growth funds (indicative).</p> <p>Based on HACC population weighted for low income and health status.</p> <p>Regions can decide to allocate % annual growth (no more than 20-30%) to equalising between local areas.</p> <p>Refer to Appendix Two, page 17</p>	<p>There is already a regional formula for growth funds (the RREF).</p> <p>In the absence of a better measure, some regions have been using the RREF for indicative local area allocation even though it is not suitable for this purpose.</p>	<p>An appropriate formula provides a transparent, justifiable starting point for allocating regional growth funds across local areas.</p> <p>Regions will be able to amend the formula result in response to local circumstances but will need to explain why in their Regional Plans.</p> <p>Consistent methodology across the State.</p>
<p><b>Central and regional planning for cross-regional services and special needs groups</b></p> <p>Central pool for cross-regional (3 regions or more) and Statewide services. Benchmark (minimum) of 5% annual growth funding.</p> <p>Regions need to ‘top slice’ growth funds for:</p> <ul style="list-style-type: none"> <li>shared service provision across adjoining regions</li> <li>special needs groups where service provision crosses LGA boundaries</li> </ul>	<p>There is already a central pool for cross-regional and Statewide services. Changes are:</p> <ul style="list-style-type: none"> <li>establishment of benchmark for growth funds</li> <li>definition of ‘cross-regional’ is now 3 or more regions, replacing 2 or more regions</li> </ul>	<p>Balances relative priorities of local, sub-regional, cross-regional and Statewide service provision.</p> <p>Ensures adjoining regions take greater responsibility for shared service provision.</p>

<b>Reform Element</b>	<b>Replaces</b>	<b>System Benefit</b>
<p><b>Funds allocation</b></p> <p>Direct allocation of annual growth funds where this yields demonstrable benefits for clients and the service system over limited or open competition.</p> <p>Subject to the State or regional planning process and Ministerial agreement.</p> <p>Refer to Appendix Three, page 19</p>	<p>Every dollar of HACC growth funds subject to competitive annual processes.</p> <p>But <i>DHS Funds Allocation Policy</i> already provides for a more diverse range of funding mechanisms, depending on circumstances.</p>	<p>Competitive processes will apply to around half the annual funding round.</p> <p>However, most growth funds are needed for 'more of the same'. Annual submission round wastes agency time and effort.</p> <p>Direct allocation is appropriate when:</p> <ul style="list-style-type: none"> <li>• there is only one provider (eg Bush Nursing Centres)</li> <li>• Govt wishes to grow a particular service setting (eg allied health in community health centres)</li> <li>• there is a strong system effectiveness benefit from consolidation (eg only giving additional Linkages packages to the current Linkages agencies, using a population needs approach rather than competitive submission)</li> <li>• partnership is more important than competition (eg with local government given its significant commitment of own purpose funds)</li> </ul>
<p><b>Minor capital</b></p> <p>Direct allocation of annual minor capital using a formula, based on:</p> <ul style="list-style-type: none"> <li>• benchmark annual investment of 1% total Program outlays in minor capital</li> <li>• minimum automatic annual grant for every agency</li> <li>• differential rates, based on capital intensity of activities</li> <li>• agency allocation based on combination of funding attributable to existing service provision and funding linked to current growth allocation</li> </ul> <p>Refer to Appendix Four, page 23</p>	<p>Minor capital subject to annual competitive growth round.</p>	<p>Minor capital is not an end in itself, but an input designed to support high quality outputs.</p> <p>Agencies should not have to apply and acquit separately for minor capital.</p> <p>Proposal offers large saving in agency and DHS time and effort, plus greater certainty and stability for agencies.</p>
<p><b>Research and evaluation</b></p> <p>5% of annual growth funds set aside annually for central research program and local service reviews and evaluations.</p> <p>Clearing house to collect and disseminate existing and future project findings.</p> <p>Refer to Appendix Six, page 27</p>	<p>Many small regional Service Development Grants.</p> <p>No way of sharing learning from existing projects.</p>	<p>Program-and practice-relevant research a wise investment of non recurrent funds.</p>



## **Next Steps**

- ◆ Information sessions for the field hosted by Central Office and regional staff will be held in every region in late March and early April 2003 to work through the changes.
- ◆ Central Office will develop and release a three year Statewide HACC Plan. This will give an indication of the Program work plan for the triennium to provide a framework for regional and agency planning and service development.
- ◆ There will be extensive consultation with agencies in April and May 2003 on the new 3 year HACC Regional Plans.
- ◆ Central and regional staff will be available as a 'help desk' for agencies through the first funding period, as the HACC sector becomes accustomed to the new funding arrangements.



## Appendix One

### Strategic Ministerial Priorities for the HACC Program 2003-2006

#### Summary of Proposal

- ◆ The strategic framework has two elements:
  - š from a *system* perspective, using growth funds to increase the supply and improve the responsiveness of 'HACC Basic' services; and consolidating the 'HACC Basic' service system around the key local government and health sector providers (based on evidence from a range of recent reports)
  - š from a *target group* perspective, recognising through growth funds the high rate of increase in the frail aged\* and older disabled sub-populations over the next three years (based on demographic and service provision data).
- ◆ Priority for 'HACC Basic' translates into:
  - š more hours of in home support (home care, personal care, assessment and care management, property maintenance and delivered meals)
  - š more hours of health care (nursing and allied health)
  - š attention to ensuring these 'HACC Basic' services are responsive to their recipients' diverse needs and preferences.
- ◆ There is *no* change to the eligibility of younger people with disabilities for HACC services, subject to the usual priority or access guidelines, nor to the ongoing funding of agencies serving people with disabilities.
- ◆ However, there is greater clarity for the sector in relation to growth funding for the next three years:
  - š within the population of people with disabilities, the priority for growth funds is responding to the ageing of people with disabilities, given the projected rate of growth of the 55-74 year old disabled population over the next three years
  - š increasing people with disabilities' access to HACC services is a priority, but the way this is implemented needs to take close account of the limits on disability-specific services set in the *HACC Amending Agreement 1998*. This complements the Government's inclusion framework articulated in the Disability State Plan.
- ◆ There will be an expanded, higher value added role for DHS regional staff in strengthening the service system, particularly the relationship between mainstream, multi-cultural and ethno-specific providers.

\* "Frail aged" has the same meaning as in the Home and Community Care Act 1985 of the Commonwealth, namely older and frail persons with moderate, severe or profound disabilities who, in the absence of basic maintenance and support services provided or to be provided within the scope of the [HACC] Program, are at risk of premature or inappropriate long term residential care

\*\*"Between 1996 and 2001 the number of older people from culturally and linguistically diverse backgrounds living in Victoria is projected to increase by 71%, reaching 225,000 or 30.8% of the total older population. This is well above the Australian national average (22.4%)" (Australian Institute of Health and Welfare, Projections of Older Immigrants: People from Culturally and Linguistically Diverse Backgrounds, 1996 - 2026, Australia, p. 40)

## **A triennial strategic framework for the HACC Program in Victoria**

This paper outlines a three year Ministerial strategic framework for HACC 2003-2006 which:

- ◆ has been formulated in partnership with the Departmental Advisory Committee on HACC, representing the major consumer and provider sectors in the Program
- ◆ is evidence based wherever possible (taking account both of the imperfect state of knowledge about 'what works?' in community care and the need to accommodate local conditions and issues)
- ◆ takes a view about the desired forward directions for the HACC service system as a whole, not just the relatively small proportion of overall funding represented by the annual growth funding round, and uses annual funding as an important lever for advancing systemic objectives
- ◆ provides constructive assistance in funds allocation decisions.

### **Proposed system-wide strategic priorities for 2003-06**

#### **a. Systemic focus**

The first proposed element of the Ministerial strategic framework for 2003-06 is ***expanding direct service and strengthening the basic HACC service system***.

The overarching strategic intent is to: make headway against population-driven demand for core HACC services, with special reference to people from non English speaking backgrounds; strengthen HACC's preventative, maintenance and support role; and improve people's capacity to self manage in a better stocked and more robust system, rather than be required to seek 'care packages'.

In proposing an objective of re-consolidating and strengthening the basic HACC system, Victoria is drawing on the evidence contained in a range of recent reports from the non-Government sector. Whilst there are some minor differences in emphasis and approach, all the reports cited below base their recommendations for reform on:

- ◆ current and projected future demand for basic HACC services, arising not only from population growth and ageing but families' preferences for home based care, demand management strategies in the acute sector, reduced supply of family carers and the ageing of Victoria's post-war immigrants
- ◆ the need to strengthen and quarantine the community care system's capacity for early intervention, prevention and maintenance, given the constant pressure to undertake *crisis* rather than *timely* intervention
- ◆ the proliferation of Commonwealth, State and Commonwealth-State funding community care programs in recent years with overlapping target groups and objectives but discrete planning, funding and reporting frameworks. This creates navigation difficulties for consumers and families which can only be solved by a new reconsolidation strategy of the kind which originally created the HACC Program in 1985.

- ◆ the poor articulation between 'HACC Basic', HACC Linkages and the Commonwealth's Aged Care Packages, including long waiting lists for packages, the difficulties created by maintenance of effort arrangements within HACC, the low purchasing power of CACPs relative to clients' needs and the fragmenting effect on the service system of large numbers of small CACP providers.

The relevant reports are:

- ◆ *Funding Levels for Linkages and Community Aged Care Packages*, December 2002 (A Position Paper from the Aged Services Network, Western Region)
- ◆ *Community Care Services for Older People: Current Issues*, November 2002 (An Issues Paper prepared by Catholic Health Australia)
- ◆ *Targeting HACC Services – Local Impacts: A Local Government perspective on future models of care for high needs clients*, October 2002 (A report by the Municipal Association of Victoria to the Myer Foundation)
- ◆ *Complex Care Needs – Complex Issues: A Study of Linkages Clients aged 16-64 who have High Cost Care Needs*, August 2002 (A report by the Community Care Issues Network)
- ◆ *A Vision for Community Care: A Discussion Paper*, August 2002 (A paper convened by Aged and Community Services Australia in collaboration with ACROD, Alzheimer's Association, AAG, ACCNS, ADGP, AMA, Australian Society for Geriatric Medicine and Carers Australia)

Clearly, not all of the issues raised in these reports can be addressed by reform of the HACC growth funding round process, particularly questions of Commonwealth and State roles and responsibilities and the overall quantum of funds available to the aged residential and community care systems.

However, one area where some progress *could* be made is in strengthening the quantity of, and linkages between, basic HACC services.

The proposal for *core system strengthening* utilises the opportunity of HACC's annual growth funding to implement the policy perspective now being advanced consistently by the community care sector, namely:

- ◆ it is time to revisit the fragmentation of funding streams, the tight specification of target groups and the growth of highly specialised agencies, and consider again the merits of a broadly based, adequately funded program capable of meeting a range of clients' and carers' needs in a range of different ways
- ◆ notwithstanding the increasing complexity and acuity of many people seeking HACC services, it is vital to protect the system's capacity to provide small quantities of service which nevertheless make a significant difference to independence and quality of life

- ◆ given the level of stakeholder support for the HACC targeting strategy prepared for HACC officials by Anna Howe and Len Gray and the overwhelming responsibility of the Commonwealth for clients in the 'HACC Plus' stream, the most appropriate next step for a State Government is to re-invest resources in 'HACC Basic'

### **Special needs groups**

The Victorian Ministerial priorities in 2001-02 and 2002-03 identified four special needs groups, derived from the national HACC Program Guidelines. These were:

- ◆ people living in rural and remote areas
- ◆ people in the HACC target group who are homeless or insecurely housed
- ◆ people from culturally and linguistically diverse backgrounds
- ◆ people from Aboriginal and Torres Strait Islander backgrounds (including Kooris)

The following discussion explains how these groups will be affected by the new triennial framework for HACC growth funds.

#### *Rural and remote*

Services for people in remote or isolated communities have not been separately identified in the priority framework. However, they will benefit over the next three years from:

- ◆ expansion in core service provision across the State
- ◆ work underway in DHS to more adequately deal with the costs of 'excessive travel' through the unit price (likely to come on stream from 2004-05)
- ◆ direct formulaic allocation of minor capital to agencies based on actual funding. The formula brings more minor capital funding into DHS' rural regions than the current system.

#### *People who are homeless or insecurely housed*

Consistent with the Government's *Victorian Homelessness Strategy*, significant HACC growth funds, totaling \$7.2m over three years, have been made available to HACC clients belonging to this special needs group. It is now timely to review the impact and effectiveness of these initiatives whilst allowing the service system breathing space to assimilate the new funding, particularly as innovative service models have been required to appropriately reach and support these isolated and complex clients.

#### *People from culturally and linguistically diverse backgrounds*

In 2003-06, greater attention will need to be given to -

- (a) ensuring that when growth funds are allocated to the priority HACC services, namely the in-home support and health care activities, they take on the responsibility of being fully responsive to the distinctive needs and preferences of *all* the HACC consumer population and
- (b) creating stronger links and synergies between ethno-specific organisations.

Some of the ways in which this can be achieved include: assistance in recruiting bi-lingual staff; development of culturally appropriate service models within existing activities; formal sub-contracting or informal auspicings arrangements between local government and other mainstream providers, and ethno-specific agencies; and more attention to working with and through larger auspice bodies such as Migrant Resource Centres and Ethnic Communities Councils.

People from culturally and linguistically diverse backgrounds will benefit from:

- ◆ an increase in the quantum and responsiveness of 'HACC Basic' services
- ◆ stronger two way relationships between mainstream, multi-cultural and ethno-specific service providers
- ◆ automatic provision of minor capital every year, with a particular emphasis on supporting agencies offering Planned Activity Groups
- ◆ consideration of ethnicity as a *price* weight in HACC unit prices, recognising that high quality, culturally responsive service provision comes at a cost
- ◆ highest priority in the proposed new research program to re-shaping HACC in the light of Victoria's increasing cultural diversity
- ◆ more broadly, the Government's policy and financial commitments to positive ageing

### *Indigenous communities*

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.

## **b. Population focus**

The second proposed element of the Ministerial strategic framework for 2003-2006 is **focus on the frail aged and the ageing of people with disabilities.**

Using demographic data to establish priorities is a key element of a more evidence based approach to planning and funds allocation.

The HACC Program serves three principal populations: frail older people, younger people with disabilities, and carers. Within the younger population, a distinction can usefully be drawn between the ageing of people with disabilities (55-74) and children and prime aged adults (0-54).

To complement evidence about the service system, the Program's funding priorities should also draw on available evidence about population growth in these populations over the planning period.

There are at least three different methodologies which could be used to determine relative growth within the overall HACC population. These are:

- ◆ by reference to the total Victorian population;
- ◆ by reference to people with moderate, severe or profound activity restriction as measured by the ABS Survey of Disability, Ageing and Carers; or
- ◆ by reference to the existing rate of utilisation of HACC services within the populations, based on the HACC Minimum Data Set

On all three measures, population driven demand growth over the next three years is negligible for the population younger than 55 (and negative in rural regions).

**c. Translating systemic and population priorities into activity types**

Given the broadness of these two strategic priorities, further guidance needs to be provided on how these might be translated into funds allocation decisions on the ground.

The table on the next page lists the HACC activities which are expected to be of highest priority for growth funding for 2003-06, with a rationale drawn from system issues, demographic data and broader DHS reform directions.

<b>Purpose</b>	<b>Activities</b>	<b>Rationale</b>
Provide basic in-home support to frail aged and ageing people with disabilities	Home Care Personal Care Delivered Meals Property Maintenance Assessment & Care Management	<ul style="list-style-type: none"> <li>● Strengthen maintenance and support services within 'HACC Basic' system</li> <li>● Address population driven demand for in-home support</li> <li>● Respond to need for low level preventative support for frail aged and older people with disabilities</li> <li>● Increase capacity for self management, reduce reliance on 'packages'</li> <li>● Support local government's role as gateway to service system for frail aged, part of broader primary health reform</li> <li>● Ensure mainstream system's responsiveness to Victoria's diversity</li> </ul>
Provide basic health care to frail aged and ageing people with disabilities	Nursing Allied Health	<ul style="list-style-type: none"> <li>● Strengthen clinical services within 'HACC Basic' system</li> <li>● Address population driven demand for functional health services</li> <li>● Improve articulation with acute sector</li> <li>● Increase capacity for self management, reduce reliance on 'packages'</li> <li>● Support community health's role in broader service system for people with chronic illness associated with ageing</li> <li>● Ensure mainstream system's responsiveness to Victoria's diversity</li> </ul>
Increase quantity and quality of services for people from CALD backgrounds	As above, plus Flexible Service Response	<ul style="list-style-type: none"> <li>● Develop new collaborative direct service delivery arrangements between mainstream, multi-cultural and ethno-specific organisations</li> <li>● Recognise the service system impact of the ageing of Victoria's CALD communities</li> </ul>
Increase quantity and quality of services for Indigenous communities	As above, plus Flexible Service Response	<ul style="list-style-type: none"> <li>● Increase availability of appropriate maintenance and support</li> <li>● Respond to the lower health status and reduced life expectancy of Indigenous people</li> </ul>

**d. Impact on younger people with disabilities**

HACC serves an important function in the overall disability system. Its broad, functional eligibility criteria mean it is able to support many younger people with disabilities who would not meet the strict impairment-based eligibility criteria in the specialist disability legislation. Further, it is able to provide a range of supports in a relatively simple and non-stigmatising way, consistent with the inclusive values embodied in the Disability State Plan.

The combination of the proposed new systemic and demographic priorities for growth funding in 2003-06 will *not* affect younger people with disabilities' right to receive HACC services in any way, subject to the normal processes of determining eligibility, need and priority.

However, it will potentially have some impact on the relative growth within the suite of HACC services used by people with disabilities over the triennium.

It is envisaged personal care, nursing and allied health will assume more importance in the next triennium's growth funding process. This reflects the distinctive needs associated with the ageing of people with a disability.

There is also likely to be a slight change over time in the balance between the quantum of HACC-funded service people with disabilities receive from mainstream providers such as local government, community health or nursing services on the one hand, and specialist disability providers on the other.

Specialist disability services are a 'no growth' area in the HACC Agreement, and there has been some concern expressed by the Commonwealth around the boundary between HACC and the Commonwealth/State and Territory Disability Agreement. It is proposed that, given the level of population driven demand for 'generic' maintenance and support services which are equally available and useful to frail aged people and people with disabilities, these should be the principal focus of HACC growth effort over the next 3 years.

## Appendix Two

### Formula for Allocating Regional Growth Funds Between Local Areas

#### Overall approach

The *Consultation Paper* proposed that a formulaic approach – based on the Regional Resource Equity Formula (RREF) - be used to distribute growth funds *within* regions, in the same way as the RREF is used to distribute growth funds *between* regions. However, rather than the five weighting factors in the RREF, a simpler formula was proposed using two weighting variables only – burden of disease and socio-economic status, on the grounds that people on low incomes and/or in poor health are most likely to require publicly-subsidised HACC services.

Consultation participants were supportive of this approach, particularly if DHS moves over time to recognising specific needs like rurality and CALD through price rather than population weights. It was generally recognised the Koori populations are too small to be incorporated in a local area formula, and specially targeted strategies are needed to support Koori communities.

The agreed approach is as follows:

- ◆ The formula should be indicative, that is, there should be some capacity for regions to deviate from the formulaic allocations in response to local conditions. However to meet the need for transparency the rationale for this deviation should be made clear in the public Regional Plan
- ◆ All HACC funds should be included in equity calculations (that is, both Commonwealth/State matched and State unmatched) but NOT local governments' own source funding
- ◆ The exact proportion of total regional growth which can be shifted between local government areas (LGAs) should not be specified as a maximum percentage, but left to regional discretion. It will then be subject to (a) consultation with stakeholders and (b) confirmation with Central Office and ultimately with the Minister
- ◆ There should be capacity to allocate a proportion of regional growth funds to the purpose of addressing inter-regional inequity. The exact proportion is left to regional discretion because the degree of intra-regional inequity varies between regions. However it should be noted that too rapid a move to LGA-level equalisation has the danger of overshooting if the basis for equity changes, so a 20-30% topslice is the maximum regions will be considering.

## **Changes to the Regional Resource Equity Formula (RREF), 2003-06**

When the new RREF was adopted in 2001, it was acknowledged that new and better measures could be incorporated as they became available. The following changes have been made in calculations for 2003-2006.

### **Measuring socio-economic disadvantage**

Recognising the unsatisfactoriness of the current measure of socio-economic disadvantage, Median Household Income (MHHI), this has now been replaced with the proportion of all people aged 65 and over earning less than \$300 per week, as a proportion of all people 65 and over.

### **Calculating the base population and weighting factors**

Three changes have been made to reflect recent data and program developments:

- ◆ updated residential care data have been used to estimate the base population
- ◆ 50% of persons eligible for DVA services have been subtracted from the base population, instead of 100%, given recent developments in the Veterans Home Care Program
- ◆ 2001 Census data has been used to calculate weights for CALD and Koori populations, replacing 1996 Census data.

## Appendix Three

### Funding Allocation Methods in the HACC Program

In previous years, HACC growth funds have all been subject to an advertised submission process. The *Consultation Paper* proposed that, consistent with DHS' broader funds allocation framework, HACC should move to a range of funding mechanisms. This recognises that different approaches suit different sectors of a complex funding and service system. The four DHS funding allocation methods are:

- ◆ Commercial tendering (for services to the Department rather than the community)
- ◆ Advertised submissions
- ◆ Invited submissions
- ◆ Direct allocation

Although this proposal was not unanimously agreed, it is consistent with Government's wider partnership and funding framework and has the support of the majority of stakeholders.

#### **When is direct allocation appropriate?**

DHS' funds allocation policy provides that direct allocation should be preferred over either invited or advertised submissions when:

- ◆ There is a sole or major provider, either of a particular service type or in a particular geographic area, so emphasis should be placed on rigorous planning rather than submission processes (eg local governments deliver 95% of the home care hours in the State; bush nursing centres are the only health care providers in very small population centres; DHS has a deliberate policy of consolidating its Linkages providers so adequate economies of scale and case management expertise can be achieved)
- ◆ Capacity building for particular kinds of organisations provides a more substantial and lasting public benefit than competitive processes (eg Koori agencies)
- ◆ There is greater community benefit from a stable partnership relationship than from subjecting the organisation to competition (eg the Royal District Nursing Service, which has a leadership role in metropolitan nursing)
- ◆ The Government has a policy to roll-out a service response through a particular service setting (eg allied health in community health services/rural hospitals).

## **When are competitive processes appropriate?**

A competitive process should be utilised when:

- ◆ There are several organisations all able to offer a particular activity
- ◆ There would be a community benefit from encouraging the entry of new providers into a particular activity or particular geographic area
- ◆ There are issues of performance or accountability associated with providers, such that it would be undesirable to have growth funds flowing automatically

## **Funds allocation methods for 2003-2006**

The Minister for Aged Care has agreed to the following:

- ◆ **Direct allocation** for the sectors/activities listed in the table on the following page (subject to \*). Detailed decisions as to agencies and funding quantum will be made each year according to the State and Regional HACC Plans, which will themselves be subject to detailed regional and sectoral consultation.

*\*The framework provides that where competition is more desirable than certainty, or there are serious concerns about performance and/or accountability, regions will recommend a submission process.*

- ◆ **Invited or advertised submissions** for other regional activities
- ◆ **Invited or advertised submissions or competitive tender** for the Statewide and cross regional funding pool
- ◆ **Invited submission or competitive tendering** for research and evaluation projects

**Proposed areas for direct funding allocation method,  
2003-06**

<b>Agency Type</b>	<b>Activity</b>
Local Government	Home care
Local Government	Personal care
Local Government	Respite
Local Government	Delivered meals
Local Government	Property maintenance
Local Government	Assessment and care management
Royal District Nursing Service	Metropolitan nursing
Migrant Resource Centres, Ethnic Communities Councils	Various
Various	Regional training co-ordination
Various	Linkages
Community Health/Public Hospital (1)	Allied health
Community Health/Public Hospital (1)	Nursing
Small rural agencies (2)	Various
Agencies with Indigenous-specific activities	Various
Various	HACC response service

- (1) Overlaps with small rural agencies  
 (2) As defined by Victorian Rural Human Services Strategy. Covers Bush Nursing Centres, Multi Purpose Services, Healthstreams agencies and 'D' and 'E' hospitals



## Appendix Four

### Formulaic Approach to Minor Capital

Delivering safe, high quality services to the HACC client group requires regular maintenance, refurbishment or upgrading of infrastructure such as vehicles, clinical equipment, Planned Activity Group venues and IT hardware and software. Thus, minor capital can be viewed as an essential input for the production of most HACC outputs.

In order to achieve significant improvement in the transparency, predictability and efficiency of HACC minor capital funding, the Minister for Aged Care has endorsed a formulaic approach to this area, based on the following parameters:

- ◆ All agencies need at least some minor capital funding every year. The minimum level has been set at \$1000 per annum, which can be saved up over a number of years (maximum is \$50k)
- ◆ A minimum benchmark of 1% of total Program outlays has been established for minor capital – at present this is approximately \$3m per annum. Unless there are major changes to HACC at a Commonwealth-State level, DHS will not fall below this total amount, and funding for minor capital will grow proportionately to the total Program
- ◆ A mathematical formula has been developed which automatically links an agency's recurrent funding with its minor capital funding, obviating the need for a competitive minor capital funding round
- ◆ Agencies neither need to apply for minor capital nor to separately acquit for it. Accountability is through the production of the agreed quantity and quality of services and the general financial reporting requirements in the service agreement
- ◆ 80% minor capital will be distributed according to the formula. 20% will be held back as regional contingency funds. This will be reviewed for 2004/05
- ◆ Based on their relative capital-intensity, rates set out on page 24 have been established for each activity. Allied health and delivered meals will be reconsidered for 2004/05, the latter following the findings of the DHS/MAV review of food services
- ◆ Around 60% of each agency's allocation will be derived from applying these rates to the agency's recurrent base. Around 40% will be derived from applying a weighted scale of these rates to the agency's new growth funds
- ◆ Minor capital funding for Indigenous-specific activities will be doubled in recognition of DHS' obligations for capacity building in this sector

The field did not support a system of 'equalising' between agencies which received funding well above formula over the last three years, towards those which received well below the formula. Accordingly, this element of the original proposal has been omitted from final calculations

**Minor Capital Rates Applicable To Recurrent Funding 2003-04**

<b>Activity</b>	<b>% Per \$ Recurrent Funding</b>
Planned Activity Group (core and high)	3
Nursing	1.5
Allied health	1.5
Property maintenance	1.5
Home care	1
Personal care	1
Respite (home & community and overnight)	1
Flexible service response	1
Service system resourcing	1
Assessment and care management	1
Volunteer coordination	1
Linkages	0.5
Delivered meals	0
Volunteer coordination (other)	0
Transition	0

## Appendix Five

### New HACC Planning and Funds Allocation Cycle

<b>Step 1 – End February</b>
Ministerial 3 year priorities agreed. Priorities and guidelines distributed to regions and agencies.
<b>Step 2 – March</b>
Regional Plan template developed. Populated with demographic data, service provision averages, indicative local area allocations as per formula.
<b>Step 3 – March &amp; April</b>
Regions work on 3 year Regional Plans in consultation with Central Office. Translate Ministerial strategic framework and regional data into indicative allocations x area x service type x funding allocation method, indicate service development priorities and initiatives for special needs populations.
<b>Step 4 – April &amp; May</b>
Regions consult with stakeholders on Regional Plan. Regions work with agencies on 3 year growth funding (ongoing).
<b>Step 5 – June</b>
Regions and Central Office finalise indicative allocations for 2003-04 and seek Ministerial agreement for direct allocations. Central Office commences development of Draft Victorian HACC Plan 2003-06 incorporating Regional Plans.
<b>Step 6 – July</b>
Letter of offer received from Commonwealth Minister. Minor capital, research funding and Statewide/cross regional pool 'top sliced' from allocation. Central Office determines unit prices for 2003-04. Regions amend Regional Plans to reflect available funding levels and unit prices. Indexation for 2003-04 paid to agencies retrospective to 1/7.
<b>Step 7 – By 31 August</b>
Victorian Minister signs off 2003-06 Victorian HACC Plan and sends to Commonwealth Minister. Commonwealth Minister signs off 2003-2004 Annual Plan (incorporated into Victorian 3 Year Plan).

<b>Step 8 – First Week Sept</b>
Statewide and Regional Plans published. Provide indicative proportions of recurrent growth funds to be allocated x area x activity for 2004-05 and 2005-06
<b>Step 9 – Mid-September – Mid October</b>
Regions issue invitations to submit for funding and/or advertise where direct allocation not applicable. Central Office advertises for submissions for Statewide/cross regional funding.
<b>Step 10 – Mid October – Mid November</b>
Regions assess regional submissions; Central Office and regions assess Statewide/cross regional submissions. Central Office prepares recommendations for Minister. Minor capital allocations calculated by Central Office based on formula.
<b>Step 11 – End November</b>
Minister signs off funding allocations. Agencies notified of actual recurrent and minor capital funding for 2003-04. Business Report for previous financial year due to Commonwealth.
<b>Step 12 – 1 January</b>
Recurrent growth funding for 2003-04 commences. Also occurs in January 2005 and January 2006 for 2004-05 and 2005-06 allocations respectively.
<b>Step 13 – June</b>
Regions and Central Office update Statewide and Regional Plans and prepare Annual Plan for Commonwealth Minister. Also occurs in June 2005 for 2005-06.
<b>Step 14 – July - January</b>
Following Steps 5 – 12 unit prices determined, indexation paid to agencies, Annual Plan approved by State and Commonwealth Ministers, growth funding and minor capital distributed to agencies.

## Appendix Six

### Research Program Utilising Non-Recurrent Funds

In 2002-03, approximately \$0.5m was made available for Service Development Grants (SDGs), which use non-recurrent funds to support service development initiatives in the HACC program.

The *Consultation Paper* said:

*Service development grants play a critical role in supporting innovation at both HACC program and individual agency level. However, there is a view that too many service development projects have failed to generate worthwhile outcomes. There are also problems of duplication and disconnection. At various times there have been separate projects funded in different regions to do the same, or very similar, things. Alternatively, projects have been funded in individual regions that would have benefited from a multi-regional focus. And there has been no routine way of ensuring that the knowledge gained from individual projects is disseminated.*

There was strong support in the sector for the concept of dedicating a proportion of non-recurrent funds annually to research, evaluation and innovation initiatives. Accordingly, the reform package includes the establishment of a minimum level of **5% of annual growth funds** to be dedicated to this purpose.

There was also concern to use the funds more effectively, across two dimensions:

- ◆ ensuring that the findings of the various funded projects are centrally assembled and disseminated, to minimise duplication and improve practice more widely
- ◆ establishing a substantial central research program, with input from the Departmental Advisory Committee on HACC, to consider the major demographic, social and technological changes affecting the Program.

In response, DHS has commissioned consultants to report by 30 June 2003 on:

- ◆ setting up a central repository and web-based clearing house for existing and future project reports
- ◆ options for major research projects

For 2003-04, and assuming that approximately \$0.5m will be available for this purpose, it is proposed to reform Service Development Grants as follows:

- ◆ approximately half the available funds will be able to DHS regions to support service evaluation and service development initiatives, consistent with the 3 year strategic priorities
- ◆ the remaining funds will be used for practice-relevant research in key areas. As noted in Appendix One, high priority will be given to issues associated with the growing cultural and linguistic diversity of Victoria's older population.