

Home and Community Care (HACC) Program

Southern Metropolitan Region Regional Plan, 2003-06

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

December 2003



Glossary of terms

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

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Section 1 – HACC Regional Plan 2003-06

1.1. Context of the Regional Plan

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

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

1.2. Purpose of the Regional Plan

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

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

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

These are the subjects of the present Regional Plan.

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

1.3. Consultation with the sector

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

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

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

1.4. What is the HACC Program?

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

1.5. Characteristics of HACC service users in Victoria

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

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

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

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

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

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

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

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

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

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

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

1.6. Better planning & funds allocation

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

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

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

1. 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
TOTAL	\$11,188,055	\$11,711,065	\$12,437,152

Note: Growth allocations include those for the HACC Response Service

1.7.1.2. Victoria's additional commitment

Redressing funds inequity between regions

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

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

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

Improving services for people from culturally and linguistically diverse backgrounds

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

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

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

1.7.2. Research & development

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

1.7.3. Minor capital

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

Section 2 – Ministerial Priorities 2003-06

2.1. Introduction

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

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

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

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

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

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

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

2.2. Evidence and rationale

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

There are two main reasons for the Ministerial Priorities:

1. Demographic projections show that the greatest growth in persons in need over the next three years is among frail older people, and ageing people with disabilities. During the same period the Victorian population younger than 55 years will grow slightly, and shrink in rural regions.

2. The need to strengthen the basic HACC system in order to balance service provision against growing demand, by: expanding core HACC services; strengthening HACC's preventative, maintenance and support role; and improving people's capacity to self manage in a better stocked and more robust system, rather than be required to seek 'care packages'.

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

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

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

2.2.1. What do the data tell us?

2.2.1.1. Priority 1

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

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

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

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

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

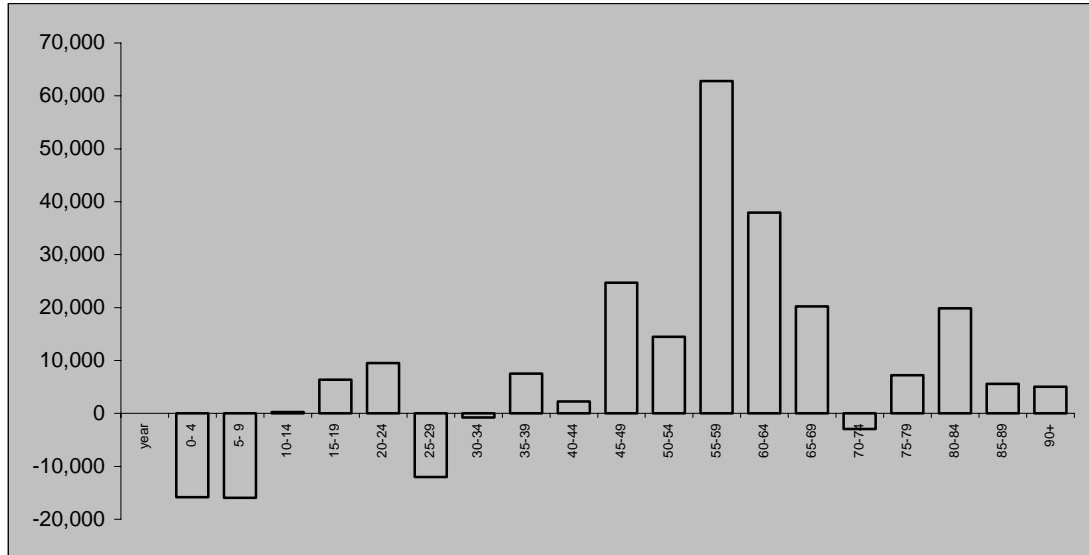


Figure 2.1: Changes in population groups 2001-06 Victoria
 Source: Department of Infrastructure *Victoria In Future*

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

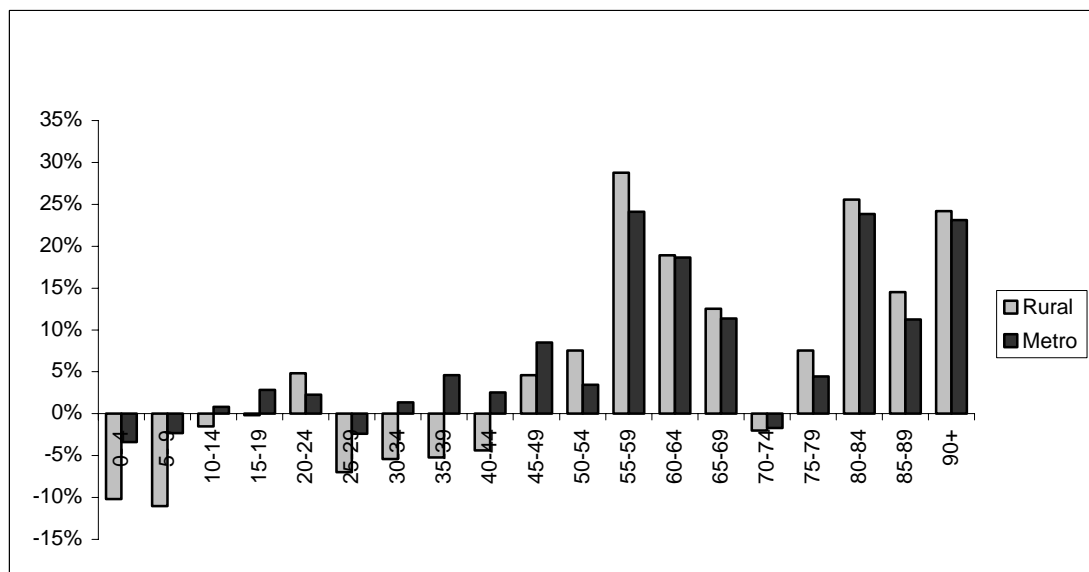


Figure 2.2: Comparison of population group changes: Rural and metropolitan regions
 Source: Department of Infrastructure *Victoria In Future*

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

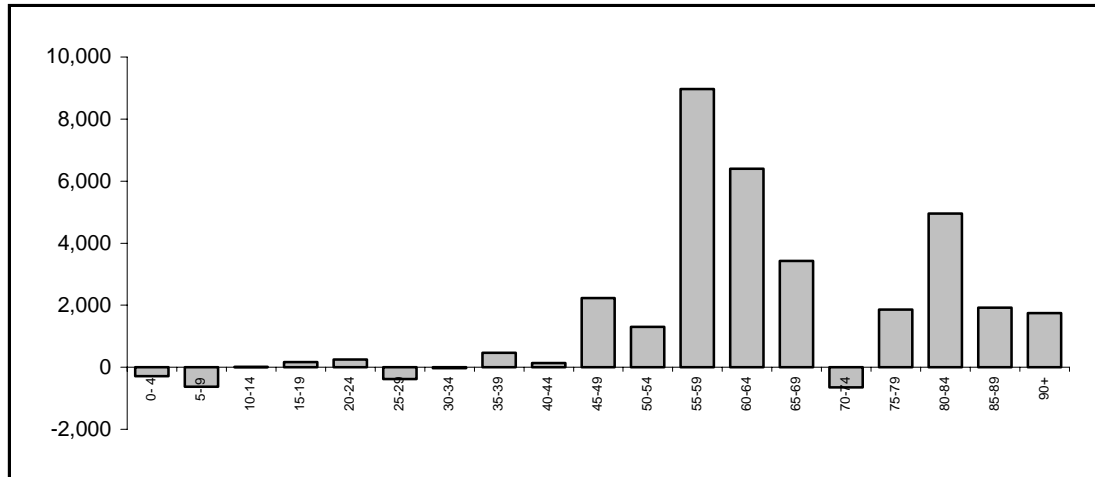


Figure 2.3: Changes in the estimated number of persons with a disability, 2001-06
Source: Department of Infrastructure *Victoria In Future* and *1998 ABS Disability, Ageing and Carers Survey*

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

2.2.1.2. Priority 2

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

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

somewhat different category from other service types because of its atypical (for HACC) client age profile, with younger people with disabilities predominating. For older persons, receipt of Respite is more evenly spread across all language groups.

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

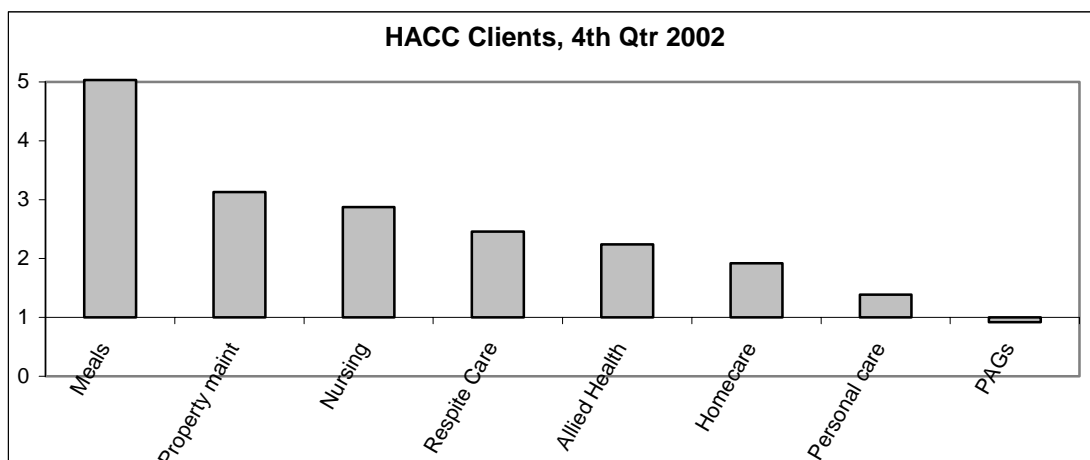


Figure 2.4: Ratio of rates of service provided to English/LOTE clients

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

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

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

2.2.1.3. Priority 3

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

2.3. Putting the Priorities into action

2.3.1. Statewide strategies

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

Developing culturally responsive services

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

Investing in the HACC workforce

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

Improving the quality of services

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

Effective program planning and evaluation

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

Targeting in the HACC program

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

Funding and accountability

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

Investing in research and development

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

2.3.2. Regional strategies

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

Section 3 – Regional context

3.1. Introduction

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

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

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

The additional regional data included:

- HACC Project Register
- SMR: Demographic and Social Statistics: 2002, DHS
- Developing Priorities: Promoting Collaboration and Diversity, Regional Plan 2002-03, SMR, DHS
- Quarterly Output Collection data
- Submission to the House of Representatives Standing Committee on Ageing Inquiry into Long Term Strategies to Address the Ageing Australia Population, City of Kingston March 2003
- ABS Census 2001.

3.1.2. The Region

SMR is a geographically large Region comprising the following ten local government areas in Melbourne's south east: Bayside, Cardinia, Casey, Frankston, Glen Eira, Greater Dandenong, Kingston, Mornington Peninsula, Port Phillip and Stonnington.

The Region has the largest population of the nine DHS regions with an estimated resident population as at June 2001, of 1,126,223 people. This represents 23.4% of the 2001 total Victorian population of 4,822,663. SMR is the second largest metropolitan region with a landmass of 2,883 square kilometres (sq kms).

The Region includes both highly urbanised and semi rural areas, densely populated suburbs and relatively sparse populations. Population density varies from 5,587 persons per sq km in St Kilda to 15 persons per sq km in Cardinia south. Of the local government areas, Port Phillip has the highest population density of 4,097 persons per sq km whilst Cardinia has the lowest population density for the Region at 37 persons per sq km.

3.1.2.1. Estimated residential population

Casey has the largest total population of the ten local government areas, with 16.2% of the Region's total population followed by Kingston with 11.9% and Mornington Peninsula with 11.8%. Cardinia has the smallest total population with 4.2%.

3.1.2.2. Age structure

The age structure of populations in the local government areas varies substantially. Port Phillip and Stonnington have relatively few children and adolescents and significantly greater proportions of young adults and 25 to 39 year olds than the regional average.

Port Phillip has almost half (46.6%) of its population in the age group 20 to 39 years. The high new growth areas of Casey and Cardinia have markedly greater proportions of children up to 14 years, slightly greater proportions of adults between 30 and 39 years and a relatively lower proportion of older people.

Bayside, Glen Eira, Mornington Peninsula and Kingston have a high percentage of persons aged over 60 years.

3.1.2.3. Population growth

The Region has grown 7.1% in the period 1996 to 2001, higher than the 6.3% growth rate of Melbourne.

Highest growth can be seen in Casey that has increased by 22.2% (33,033 people) over the five year period, while the population of Greater Dandenong has declined by 2.5% (-3,287 people) over the same period.

The high growth rates experienced in Casey and Cardinia during the 1991-1996 period have been maintained through to 2001 but a most significant change since the 1996 Census has been the increased growth rate in Mornington Peninsula. The Mornington Peninsula experienced an annual average growth rate of 2.5%, twice the rate of that for Melbourne.

3.1.2.4. Indigenous population

The Region has amongst the highest number of indigenous persons of all DHS regions with 14.7% of the state's total.

Data from these estimates indicate that Casey has the largest indigenous population with 23.2% of the total indigenous population in the Region. Mornington Peninsula and Frankston follow this with 16.1% and 15.5% respectively.

3.1.2.5. Ethnicity

Population estimates based on place of usual residence indicate that 283,595 persons in the Region were born in non-English speaking countries and 36,865 spoke no English or had a low proficiency.

Of persons born in non-English speaking countries, 61,694 (or 22%) were born in five countries: Greece, Vietnam, Italy, Sri Lanka and India.

3.1.2.6. Recent arrivals

Based on the place of usual residence data taken on the Census night (2001), SMR had 46,328 recent arrivals that spoke languages other than English. Greater Dandenong had the highest proportion followed by Glen Eira and Casey.

3.1.2.7. Income

The Region as a whole has very similar proportions of people at each income level compared to Melbourne but the pattern varies substantially across local government areas.

The outer areas of Greater Dandenong, Mornington Peninsula and Frankston have greater proportions of people at lower income levels than the regional average with Stonnington, Bayside and Port Phillip having greater proportions of people with higher income levels.

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

3.2.2.1. The agencies

Within the ten local government areas, DHS funds 75 HACC providers. HACC providers are a diverse group and include:

- 9 local governments (and a non-government organisation in Cardinia Shire)
- 9 community health centres
- 3 metropolitan health services
- 2 independent hospitals
- 36 non-government agencies
- 2 specific indigenous agencies
- 15 specific culturally and linguistically diverse (CALD) agencies.

Of the 75 agencies that currently receive funding for HACC activities seven have a cross regional service provision focus and three have a statewide focus.

95% of agencies have completed training and are beginning an assessment against the National Standards Instrument.

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

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

3.2.2.2. The SMR HACC service team

DHS HACC in SMR comprises four Agency Liaison Officers and is incorporated into the Primary Health and Co-ordinated Care Unit. Significant planning and service development is maintained by on-going consultation with the funded agencies.

The 75 agencies are supported and monitored by the HACC Agency Liaison Officers. The Region is divided into four districts and sector responsibilities are shared by three of the Agency Liaison Officers. The districts are Frankston - Mornington Peninsula; Kingston – Bayside; Inner South and South East. The provision of funding to community health services is identified as an additional agency liaison responsibility.

Individual team members also undertake portfolio responsibilities; these include indigenous services, CALD services, carers initiatives, HACC training program and social support. The Region is also a contributor to specific Statewide development working groups and initiatives.

3.3. How the Region communicates with the sector

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

3.3.1. SMR district planning groups

The SMR has on-going liaison with the HACC service sector via four district planning groups. These district planning meetings are an opportunity for local agencies to network, share information, be informed about Departmental and HACC service initiatives and undertake a co-ordinated district planning approach. The Agency Liaison Officer taking the lead for each District attends the district planning group with the HACC Team Leader attending each group twice per annum. DHS staff from the Supported Residential Services (SRS) program also attend these meetings on a regular basis.

3.3.1.1. Inner South District

The Inner South East Planning Group meets on the third Wednesday of each month at Caulfield House at Caulfield Rehabilitation Centre. The membership consists of representatives from three local government areas, three community health services, Inner South East Partnership in Community and Health, South Central Region Migrant Resource Centre and a significant number of non government organisations including cross-district agencies like Moira and Wesley Mission.

Recent issues for discussion have included the implications of the HACC Planning and Funds Allocation Review on the Community Aged Care Packages, Linkages and social support programs.

3.3.1.2. Kingston-Bayside District

The Coastal Planning Group meets on the third Thursday of each month at the Central Bayside Community Health Service. The membership consists of representatives from two local government areas, two community health services, Royal District Nursing Service, Kingston Bayside Primary Care Partnership, two migrant resource centres, a Linkages program and a significant number of non government organisations including cross-district agencies like Moira and Wesley Mission.

3.3.1.3. Frankston-Mornington Peninsula District

The Peninsula Care Planning Group meets on the third Wednesday of each month at the Mornington Peninsula Shire Council. The membership consists of representatives from the two local councils, the hospital, Royal District Nursing Service, the two community health services, the Project Manager of the Frankston - Mornington Peninsula PCP, six of the non government organisations based in the district, Department of Veteran Affairs, as well as agency representatives from other districts, for example South Central Migrant Resource Centre, Do Care and Foster Grandparents.

3.3.1.4. South East District

The South East District Planning Group meets on the second Tuesday of each month at a rotating venue around the district. Membership includes representatives from three local government agencies, the three community health services, Royal District Nursing Service, South East District Primary Care Partnership, South Eastern Region Migrant Resource Centre, Kooweerup Regional Health Service and Linkages. A significant number of non government organisation representatives regularly attend.

Sub-groups are developed to address specific development issues as they arise and the Agency Liaison Officer attends these meetings as appropriate. Recently these issues have included transport and case management.

3.3.2. Advisory and consumer mechanisms

The following specific purpose HACC advisory and consumer mechanisms currently exist:

3.3.2.1. Indigenous HACC Network

The Region has recently been meeting with agencies in SMR who are providing services to the indigenous population. The initial meeting has been with the program workers and their managers to:

- develop an improved two way understanding of the HACC Program and its operation in the context of the indigenous community
- strengthen the indigenous service system, networking and support.

3.3.2.2. HACC Equity and Access Program

The migrant resource centres meet bi-monthly with DHS to:

- review the progress of HACC CALD initiatives in the Region
- identify barriers and strategies that might prevent access to HACC services for CALD communities.

3.3.2.3. SMR Regional HACC Training Advisory Committee

The SMR HACC Training Advisory Committee meets monthly and consists of representatives from a diverse range of agencies across the Region, the HACC Regional Training Coordinator and a DHS representative.

3.3.2.4. Some training and development events in SMR over the past year

In the past twelve months the HACC service agencies have been invited to:

- The HACC Standards Implementation training workshop
- Information workshop on Privacy Act, implications for HACC service providers
- Consultations for the Better Planning and Funding Allocation Review
- A review of Service Development Grants focus group
- Information and training sessions to implement the new service guidelines for Personal Alarm Victoria.

3.4. The planning context

In developing recommendations for HACC service expansion, the Regional Plan has taken into account the fact that HACC operates and is influenced by the broader human services sector as well as initiatives within the HACC sector.

Significant demographic changes that impact on HACC service costs and demand include:

- An increasing ageing population that places considerable demand on agencies delivering core services, in particular local government
- The increasing numbers of older people and people with disabilities who have complex and diverse needs and require more hours of core services, places strain on agencies
- An expanding and ageing CALD population who are not proportionately represented as consumers of HACC core services, raises issues of workforce development, service relevance and access
- An under resourced indigenous population with significant health issues that impact on their ageing population. Again this raises issues of workforce development, service relevance and access.

Diversity of need and agency capacity that impact on HACC services include:

- Local and district planning demands are often varied and complex
- The diversity of agencies in the Region with varying infrastructures. Some have complex and developed infrastructures others are sole project workers with limited resources.

3.4.1. District profiles

3.4.1.1. Inner South East District

The Inner South East District consists of the cities of Port Phillip, Stonnington and Glen Eira.

City of Port Phillip

The city has a large transient population and a significant indigenous population in the St.Kilda area. Port Phillip has the highest percentage of public housing rental at 4.8% and 47.9% of households renting compared to the regional average of 24.8%. Special Residential Services are proportionally higher than in other districts. The Inner South East district has the most culturally and linguistically diverse 65+ population.

City of Stonnington

As part of the Inner South East sub region, the City of Stonnington has a diverse and changing demographic profile. Vulnerable groups in the community include people who are homeless, transient, with a psychiatric disability and people with an intellectual disability. The sector has identified increasing complexity in the needs of its residents requiring flexible service responses. Stonnington is part of the most densely populated and highly urbanised area in the Region.

City of Glen Eira

The projections for the 65+ HACC target population in the City of Glen Eira show that it will continue to decrease over the next three years. It has the second highest 80+ population in SMR.

3.4.1.2. Kingston Bayside District

The Kingston Bayside District consists of the cities of Kingston and Bayside.

City of Bayside

The City has the highest 80+ population in SMR. The overall proportion of Bayside residents speaking a language other than English is comparatively low compared to neighbouring local government areas and is estimated at 11.6% of its population.

City of Kingston

The City of Kingston will have a significant increase in its 70+ population between 2004 to 2006. The application of WREN has identified the City of Kingston as slightly under-resourced.

3.4.1.3. Frankston - Mornington Peninsula District

The Frankston-Mornington Peninsula District consists of the City of Frankston and the Mornington Peninsula Shire.

City of Frankston

The City of Frankston has a relatively stable population with a slightly higher proportion of younger people than the rest of the Region. 15% of residents have a disability. It has pockets of disadvantage that are among the highest in the Region and impact upon the health and well being of residents. A significant proportion of the Region's indigenous population live in the City of Frankston.

Mornington Peninsula Shire

The Peninsula has one of the largest populations in the Region and one of the fastest growing in the state. It is attractive as a retirement destination of choice and is expected to continue to experience significant growth and ageing of its population. The Shire also has pockets of significant disadvantage. The undersupply of Commonwealth funded low and high care nursing places on the peninsula causes a downward pressure that exacerbates the demand for HACC services particularly from clients with complex care needs. A significant proportion of the Region's indigenous population live in the Shire.

3.4.1.4. South East District

This district comprises the Cities of Casey and Greater Dandenong, and the Shire of Cardinia.

Casey and Cardinia form part of a high growth area but all three local government areas are expected to show increases in the HACC eligible population over the next three years.

City of Casey

The City of Casey has the largest population of the local government areas and the largest rate of population growth within SMR. It is anticipated that high rates of growth will continue.

Cardinia Shire

The Shire of Cardinia has a mix of both rural and urban populations. It has the smallest population share in SMR but has experienced high growth rates over recent years.

The City of Greater Dandenong

The City of Greater Dandenong is one of the most socio-economically disadvantaged municipalities in Victoria. It is also the most culturally and linguistically diverse municipality in the Region. The City of Greater Dandenong is expected to show increases in the HACC target population over the next three years despite the total population decreasing over recent years.

3.4.2. CALD regional initiatives to address key issues that impact on HACC planning

The SMR Regional Plan 2002-03 identified promotion of diversity and improving access to services for culturally and linguistically diverse communities as one of its key priorities. The Regional Diversity Strategy has been developed and quarterly Cultural Diversity Forums are held.

A number of initiatives have been undertaken to improve access to services for the CALD communities including the implementation of the HACC Equity and Access program and the development of culturally relevant services such as the South East District diverse meals project and the provision of ethnic meals in the Cities of Kingston and Stonnington. Service development projects include a needs analysis project for the Turkish community and another for the multicultural communities in the Frankston and Mornington Peninsula.

The HACC Equity and Access Program promotes collaboration between the migrant resource centres and mainstream service providers. The efforts to date will be consolidated by strengthening partnerships between mainstream providers, ethno specific agencies and migrant resource services through the cultural planning tool action plans implementation and reviews.

Fifteen ethno specific agencies in SMR provide Planned Activity Group activities to reduce social isolation for CALD elderly consumers. Participation in planned activities offers service linkage and access in a safe and non-threatening environment. SMR is committed to improving and extending the CALD population's participation and access beyond Planned Activity Groups to HACC Basic activities.

SMR is working with the two migrant resource services to coordinate access and equity initiatives, increase culturally sensitive and relevant practices in service provision in the broader service system through education, awareness raising and development of networks between mainstream providers and CALD communities and service promotion to CALD communities.

SMR is working with mainstream providers to actively promote and encourage utilisation of HACC Basic services amongst CALD communities through information forums, development of culturally relevant services, recruitment of bilingual workers, use of translation and interpreting services and translated service literature into languages for CALD communities in their catchments.

3.4.3. Indigenous issues that impact on HACC planning

3.4.3.1. Health issues

The life expectancy of indigenous people is estimated to be 8 to 18 years shorter than that of the non-indigenous community. Significant health problems in the community include the management and support of people with chronic illness; including managing the support needs for people with diabetes, renal failure and acquired brain injury.

3.4.3.2. Complex care needs

There is a strong need to provide support for people with very high care needs in the indigenous community. The demand for the provision of complex care arises from the range and interaction of multiple factors related to health, social support, mental health, welfare support and unemployment. A holistic approach that permits flexibility in service delivery is needed to successfully address issues with indigenous clients.

3.4.3.3. Distrust of mainstream and indigenous community organizations

There is a history of lack of consultation and past experience with unacceptable service delivery outcomes. Indigenous community workers can be apprehensive about referring clients to other relevant organisations and mainstream services given issues of waiting lists or the cultural appropriateness of services. To gain the trust of the indigenous community, agencies will need to invest time in providing services and demonstrate the capacity to deliver practical and timely service outcomes. This issue also negatively impacts on the distance that indigenous providers travel in order to deliver services to clients.

3.4.3.4. Strengthening capacity and responsiveness of organizations and workers

Experience has shown that the significant demand and expectation placed on indigenous HACC workers linking indigenous clients into services puts them under considerable workplace pressures and at risk of 'burn out'. Strengthening the capacity of organizations, both indigenous and mainstream, to support their staff in providing services to the indigenous population is a significant issue. Cultural awareness training is of particular importance in mainstream agencies in assisting staff to deliver culturally appropriate services to indigenous clients.

3.5. Data

3.5.1. Population

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

3.5.1.1. Regional HACC population 2003-06

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

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

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

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

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

LGA	2003-2004		2004-2005		2005-2006	
	WREN pop'n	% 70+	WREN pop'n	% 70+	WREN pop'n	% 70+
Bayside	10,135	62.7%	10,129	62.0%	10,153	61.3%
Cardinia	5,355	49.6%	5,524	50.0%	5,701	50.3%
Casey	19,678	45.1%	20,625	45.6%	21,612	46.0%
Frankston	16,914	58.8%	17,223	58.9%	17,595	59.2%
Glen Eira	16,978	63.7%	16,893	63.1%	16,827	62.5%
Greater Dandenong	22,534	57.3%	22,809	57.6%	23,143	58.0%
Kingston	20,813	62.0%	21,043	62.1%	21,269	62.1%
Mornington Peninsula	25,360	66.9%	25,871	66.9%	26,453	67.1%
Port Phillip	10,914	54.0%	10,991	53.3%	11,089	52.8%
Stonnington	9,265	57.9%	9,259	57.4%	9,307	57.2%
Total	157,945	58.7%	160,367	58.6%	163,150	58.6%

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

Figure 3.2 shows the estimated relative amount of change in the HACC target population by local government area on the 30 June each year. This is important in being able to identify where pressure on HACC services might be likely to ease or intensify over time.

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

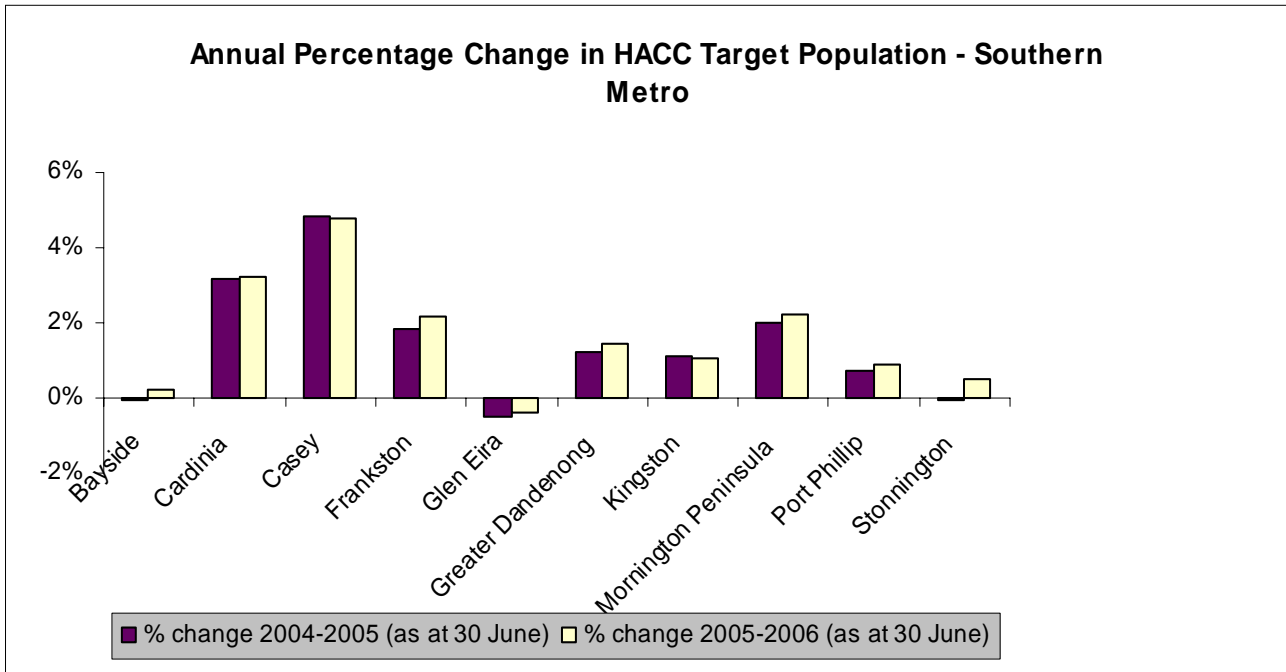


Figure 3.2: Annual percentage change in the growth in HACC target population by local government area

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

3.5.1.2. Special needs populations

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

Data about people from culturally and linguistically diverse backgrounds (CALD) is provided in Section 3.5.1.3. Data about the indigenous community is provided in Section 3.5.1.4.

3.5.1.3. 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 this is the best available indicator of the nature of service delivery required.

The HACC CALD system

22.4% of metropolitan Melbourne's CALD aged 65+ population lives in SMR. This population makes up 19.26% of the regional aged 65+ population in SMR. There is a diversity of 67 languages spoken at home with varying English language proficiency across the communities.

Dandenong is the most culturally diverse locality in the Region (and one of the most culturally diverse communities in Victoria) with residents from 151 different countries of birth representing 42% of its 65+ population. Cardinia is the least diverse local government area in the Region with 11% of its population born overseas.

Distribution of CALD population

The larger and more established ethnic communities are the Italian, Greek, Polish, German and Russian communities concentrated in the Cities of Greater Dandenong, Kingston, Glen Eira and Port Phillip. The Italian and Greek communities are well represented in all municipalities in the Region.

Demand for aged services in the Chinese, Vietnamese, Croatian, Serbian and Spanish communities are growing and these communities are concentrated in the City of Greater Dandenong, Kingston and Glen Eira. In terms of recent arrivals, the smaller communities from Afghanistan, Ethiopia, Sudan and Somali are located in the City of Greater Dandenong, Kingston and Casey.

Allocation of HACC resources to ethnic communities

SMR funds fifteen ethno specific agencies, two migrant resource services and 58 mainstream providers to provide social support and other HACC services to CALD communities and to develop culturally relevant services in the Region.

HACC clients - English versus non-English speakers

The English language proficiency skills of the CALD communities are variable with proficiency skills lower for the Russian, Vietnamese and Chinese communities and higher for the Netherlandic, French and Jewish communities. Translation and interpreting services are of higher priority for communities with lower English language skills as proficiency impacts on access to services.

Figure 3.3 shows the relative English language proficiency for selected 65+ populations by language spoken at home.

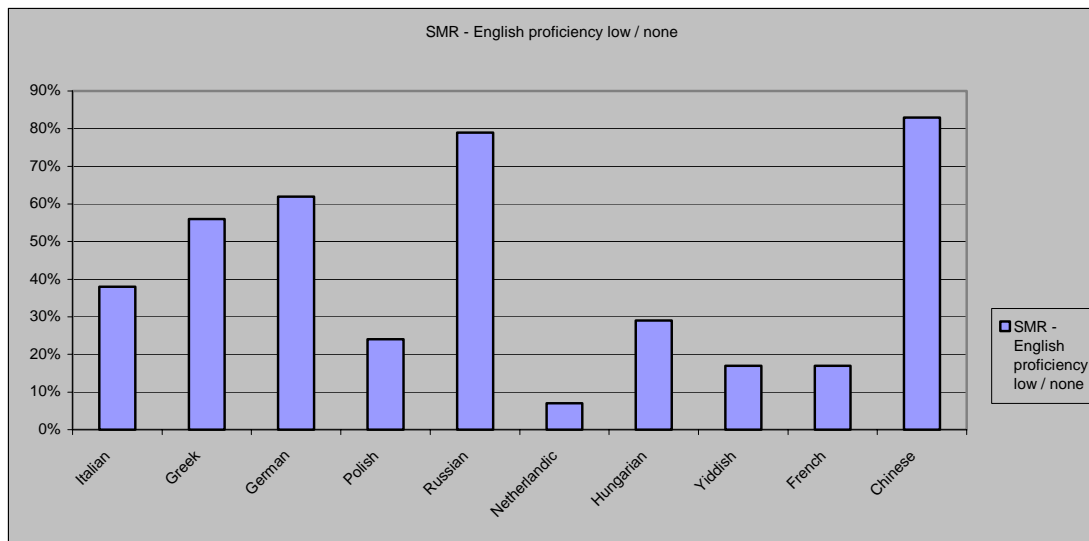


Figure 3.3. English Language Proficiency by language spoken at home for 65+ population
 Source: ADEC from 1996 census

Figure 3.4 shows CALD population projects 1996 to 2026.

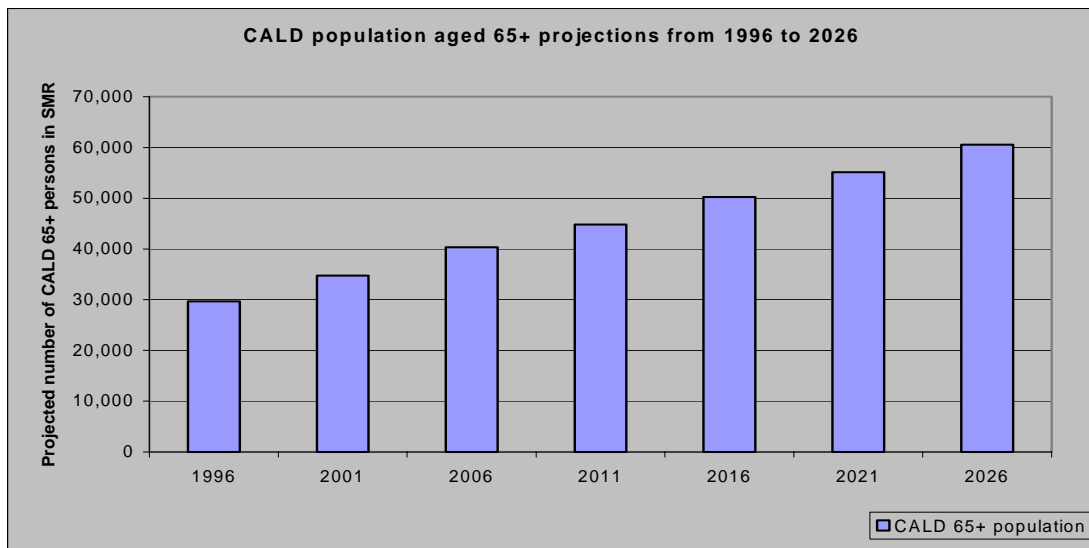


Figure 3.4. Projections for the CALD population aged 65+ in SMR from 1996 to 2026
 Source: AIHW 2001 projections

3.5.1.4. Profile of the indigenous population

The Region has amongst the highest number of indigenous persons of all regions with 14.7% of the state's total. Given the difficulty in identifying the true numbers of the indigenous population, estimates indicate that Casey has the largest indigenous population with 23.2% of the total indigenous population. Mornington and Frankston have 16.1% and 15.5% respectively.

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

Table 3.2: Experimental estimates of total indigenous population

LGA	0-49	50-69	70+	Total
Bayside	93	17	5	115
Cardinia	167	14	8	189
Casey	865	71	14	950
Frankston	579	44	11	634
Glen Eira	173	28	13	214
Greater Dandenong	487	60	9	556
Kingston	266	25	11	302
Mornington Peninsula	595	54	10	659
Port Phillip	266	38	5	309
Stonnington	147	14	5	166
Total	3638	365	91	4,094

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.

3.5.2. Service provision

3.5.2.1. HACC Basic service provision

The focus of analysis of the service provision data is on identifying the relative levels of resourcing of each HACC activity in the Region by looking at Minimum Data Set (MDS) data.

In SMR, the accuracy of MDS data is still variable. A small proportion of agencies do not report regularly and a number of agencies still have significant reporting difficulties that mean the data cannot be relied upon at this stage.

The Region has therefore, compiled a database of current HACC funding by activity by local government area that presents a more accurate picture of the HACC resources available across the Region. This information is also presented in Figures 3.5b to 3.11b. While the figures representing both the MDS and the 'total funding available' are in most cases very similar (as one would expect), there are some notable exceptions. For example the overall position of HACC funding in Stonnington is quite different between the charts, a result of a significant MDS reporting problem in that catchment.

Figures 3.5a-3.11a below show the per capita service provision of 'Priority 1' activities by local government area. The per capita data is derived from the HACC MDS divided by the HACC target population (WREN) for each local government area. The line across the bars represents the metro average.

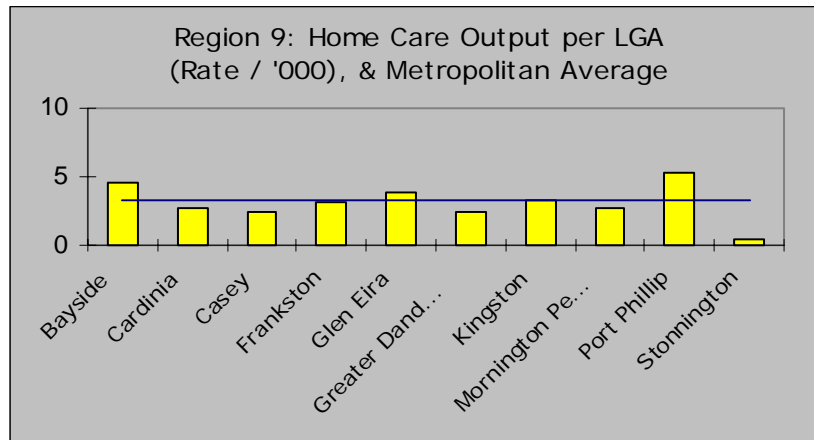


Figure 3.5a. Hours of Home Care per 1,000 target population (MDS)

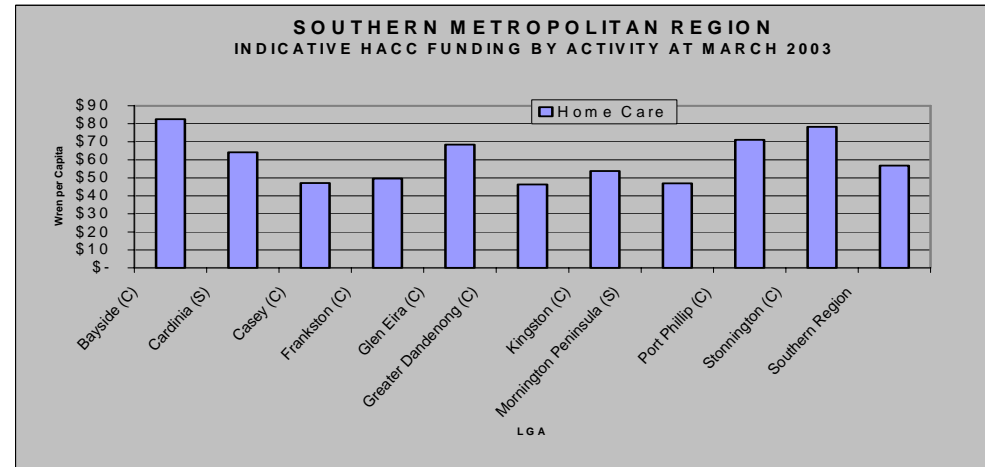


Figure 3.5b. Funding per capita for Home Care (\$)

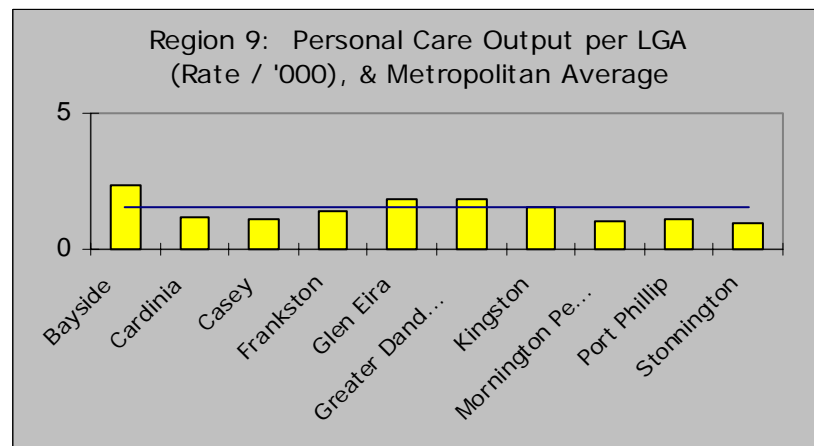


Figure 3.6a. Hours of Personal Care per 1,000 target population (MDS)

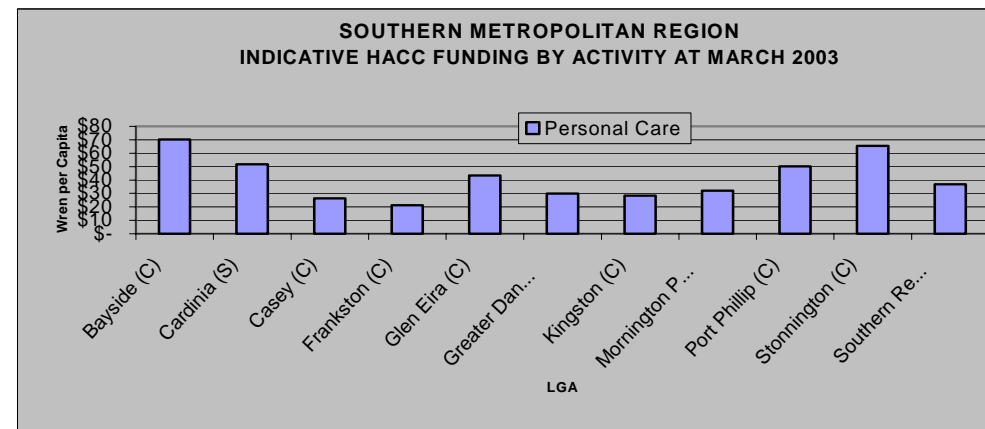


Figure 3.6b. Funding per capita for Personal Care (\$)

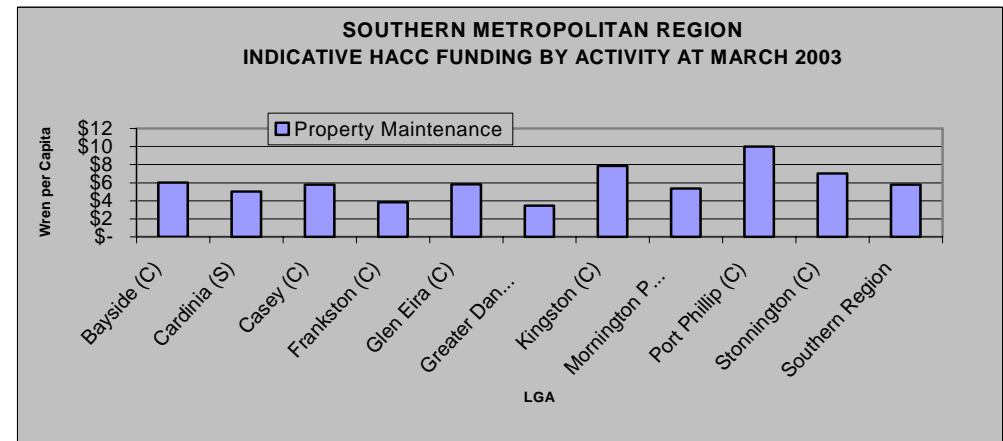
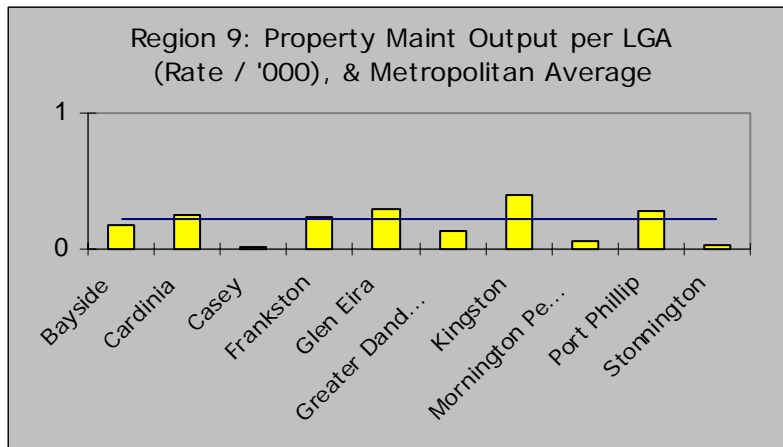


Figure 3.7a. Hours of Property Maintenance per 1,000 target population (MDS) Figure 3.7b. Hours of funding per capita for Property Maintenance (\$)

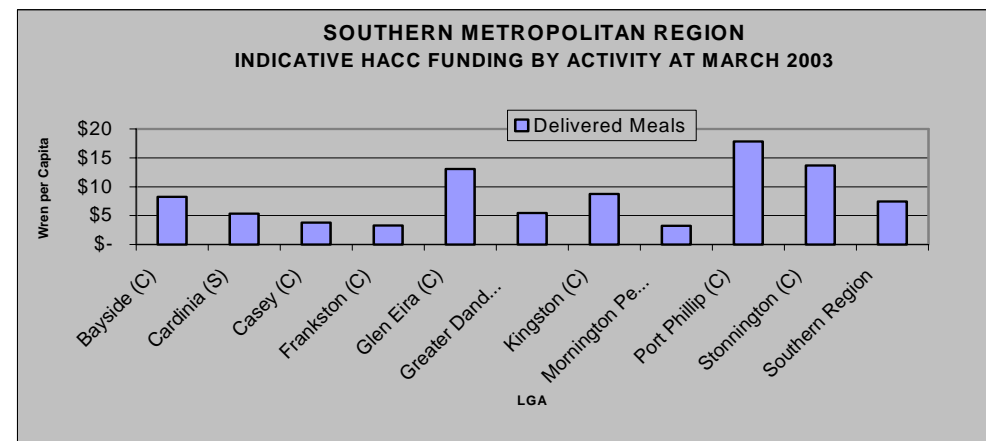
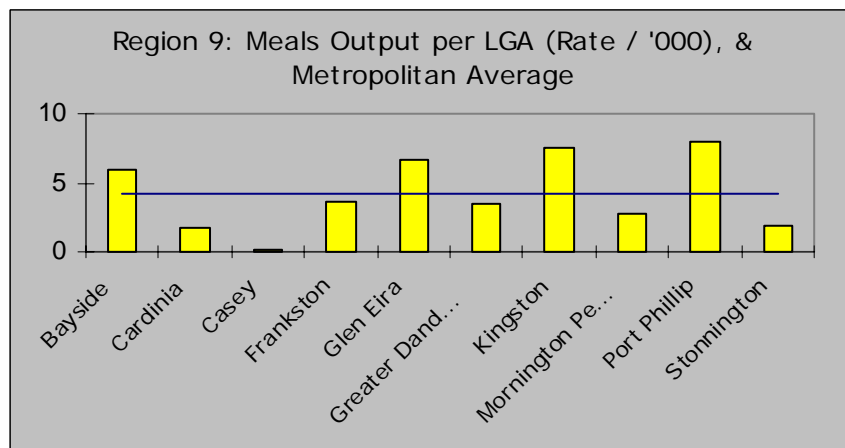


Figure 3.8a. Meals per 1,000 target population (MDS) Figure 3.8b. Hours of funding per capita for Delivered Meals (\$)

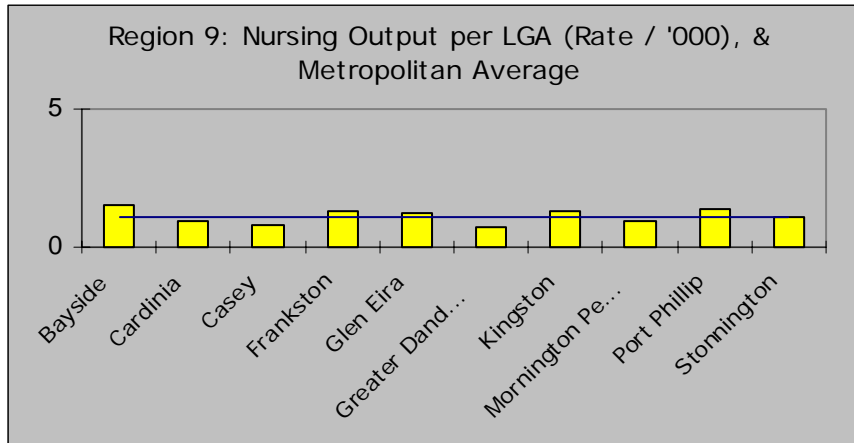


Figure 3.9a. Hours of Nursing per 1,000 target population (MDS)

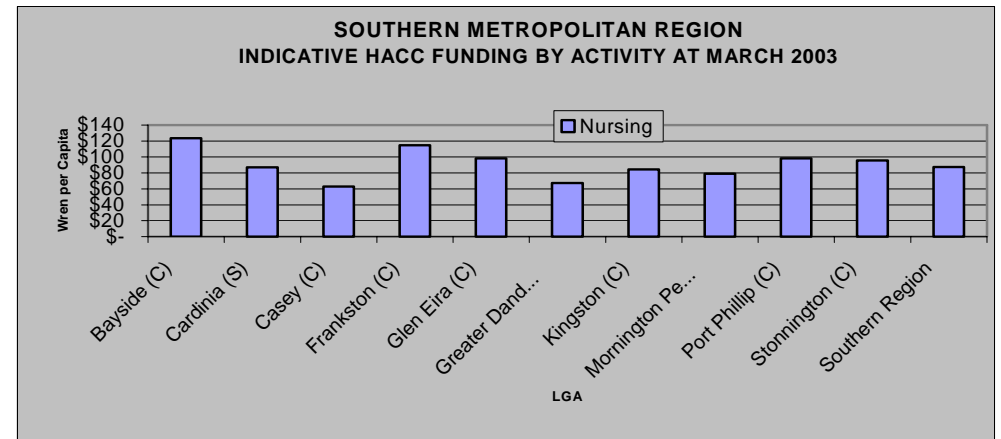


Figure 3.9b. Hours of funding per capita for Nursing (\$)

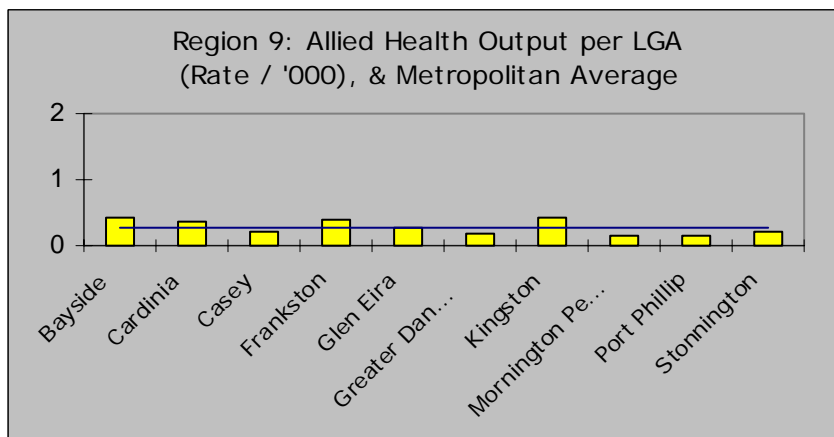


Figure 3.10a. Hours of Allied Health per 1,000 target population (MDS)

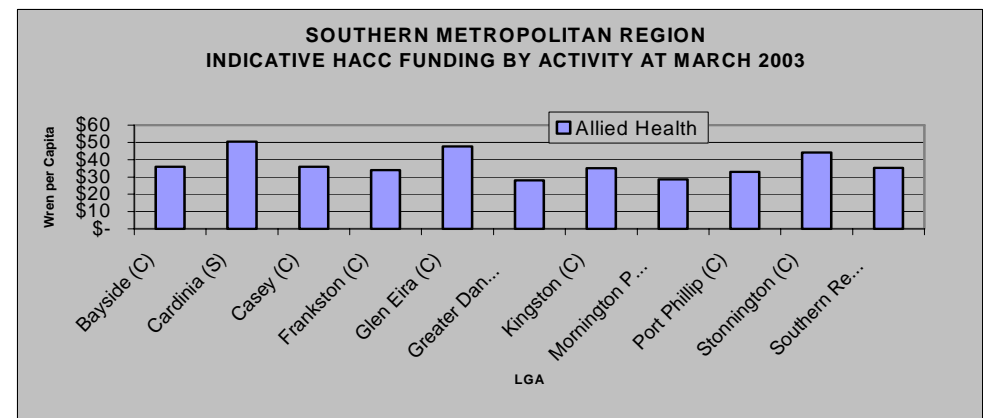


Figure 3.10b. Hours of funding per capita for Allied Health (\$)

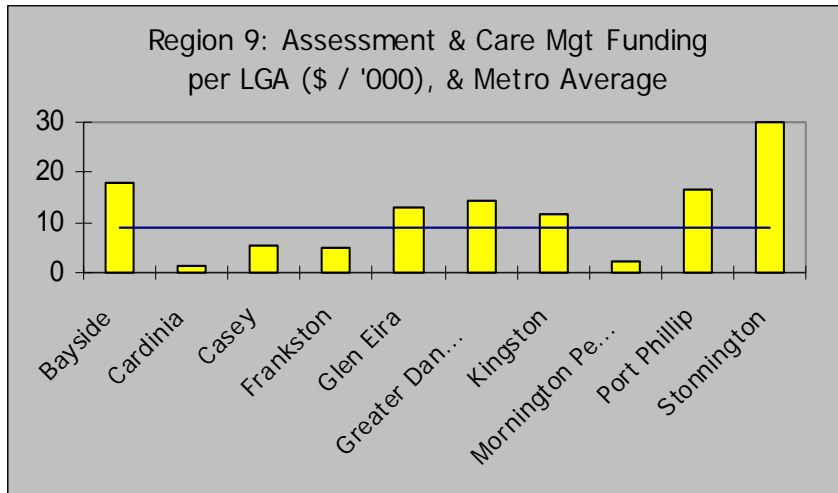


Figure 3.11a. Dollars of Assessment and Care Management per 1,000 target population 2002

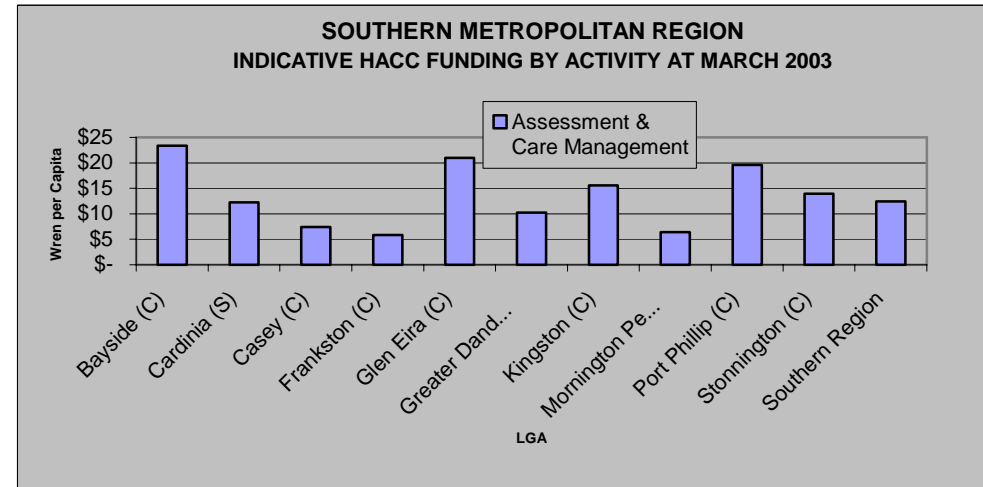


Figure 3.11b Funding per capita Assessment and Care Management per capita 2003

3.5.2.2. HACC clients from CALD communities

Analyses of recent MDS data for SMR indicated that 12.06% of HACC services consumers spoke a main language at home other than English (see Figure 3.12). The data from local government areas indicated that the proportion of people from CALD communities using HACC services varied from 20.17% in the City of Greater Dandenong to 1.69% in the Mornington Peninsula. Usage of HACC Basic services is proportionally lower for the 65+ CALD population relative to the regional 65+ population.

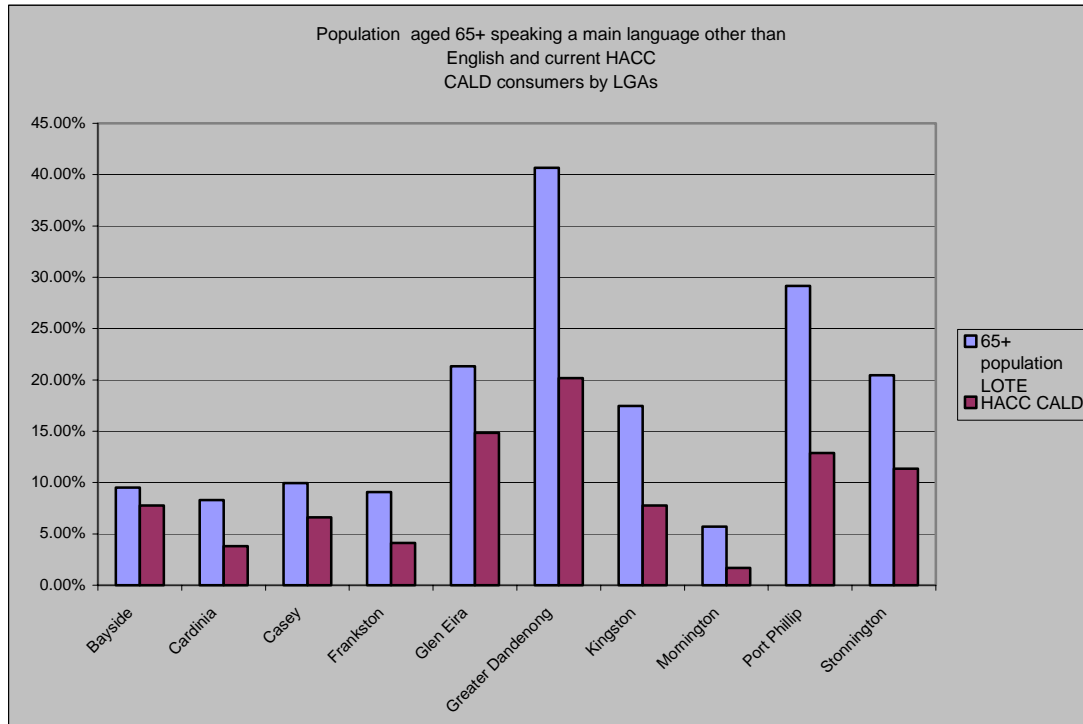


Figure 3.12: Population aged 65+ speaking a main language other than English and percentage of HACC consumers speaking a main language other than English by local government areas.

Source: ABS census 2001 and HACC MDS Data 2003

Figure 3.13 shows the number of HACC clients by activity by English compared to non-English speaking populations.

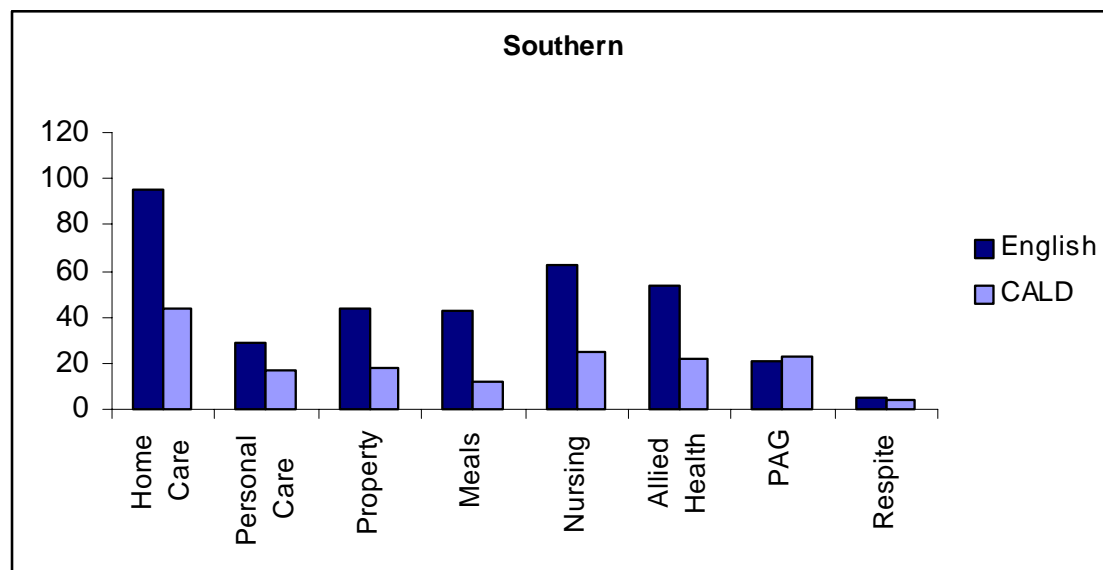


Figure 3.13: the number of HACC clients per 1000 in population, for both English speaking and non-English speaking populations. (Source: MDS 2002)

Source: MDS data 2002

3.5.3. 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 Table 3.3). The comparison provides a picture of relative HACC funds inequity between local government areas. This information is critical in determining how well the local government areas are resourced for HACC in relation to their relative share of the WREN population.

Table 3.3: Comparison of HACC recurrent funding with proportions indicated by WREN populations

LGA	Recurrent \$ 2002-03	Current \$ per capita	% of recurrent budget (2002-03)	WREN 2003-04
Bayside	\$6,144,409	\$606	9.2%	6.4%
Cardinia	\$2,748,919	\$513	4.1%	3.4%
Casey	\$6,993,624	\$355	10.5%	12.5%
Frankston	\$6,747,650	\$399	10.1%	10.7%
Glen Eira	\$8,460,286	\$498	12.7%	10.7%
Greater Dandenong	\$7,532,619	\$334	11.3%	14.3%
Kingston	\$8,382,090	\$403	12.6%	13.2%
Mornington Peninsula	\$8,742,267	\$345	13.1%	16.1%
Port Phillip	\$5,696,139	\$522	8.6%	6.9%
Stonnington	\$5,144,291	\$555	7.7%	5.9%
Total	\$66,592,293	\$422	100.0%	100.0%

Figure 3.14 shows the relative gap between the distribution of recurrent funding and the distribution of the HACC target population (WREN) 2003-06. This information has guided recommendations about the application of growth funds for equalisation across local government areas.

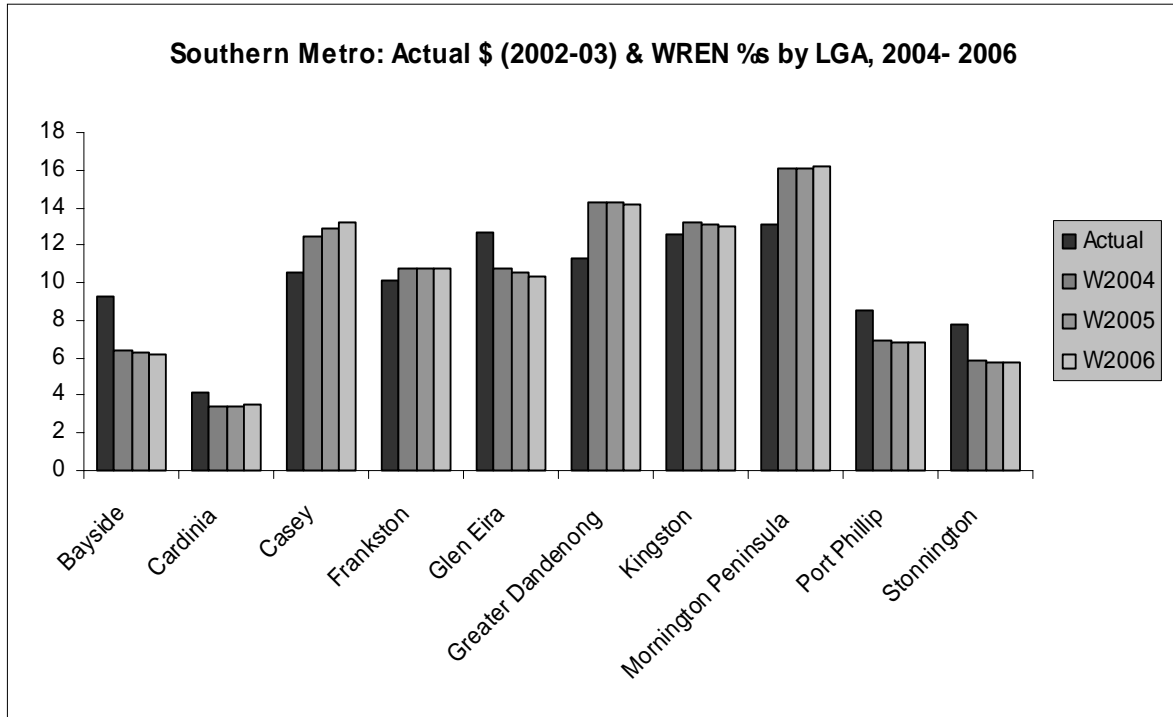


Figure 3.14: Proportion of actual recurrent budget (30 June 2003) and WREN population proportions 2003-06 by local government area

Section 4 - Conclusions

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

4.1. Data analysis and sector consultation re HACC Basic

Analysis of information showed that from a HACC perspective, the Cities of Greater Dandenong, Casey, Kingston, Frankston and the Shire of Mornington Peninsula are relatively under funded in HACC services.

4.1.1. Analysis by district

4.1.1.1. Inner South East District

City of Port Phillip

Data analysis and sector feedback have identified the priority areas as Allied Health, Home Care and Assessment and Care Management.

City of Stonnington

Data analysis and consultation with agencies have identified Allied Health and Assessment and Care Management as the priority activities.

City of Glen Eira

Analysis of the quarterly output data and consultation with the agencies indicate that the priorities are in Home Care, Personal Care, Property Maintenance and Allied Health.

4.1.1.2. Kingston Bayside District

City of Bayside

Data analysis and sector consultation indicate that the priorities for City of Bayside are Home Care and Allied Health.

City of Kingston

Data analysis and consultation with the Coastal Planning Group have identified significant demands in Assessment and Care Management, Home Care, Personal Care, Property Maintenance and Allied Health.

4.1.1.3. Frankston - Mornington Peninsula District

City of Frankston

The data indicates that priorities for Frankston are Assessment and Care Management, Delivered Meals, Personal Care, Property Maintenance and Allied Health. That these activities are under resourced is supported by an examination of agency quarterly output returns, the submissions received in the HACC funding round for 2002-03, advice of waiting lists for service delivery as well as anecdotal information gained in discussion with service providers and consultation with the Peninsula Care Planning Group.

Mornington Peninsula Shire

Similarly, the data indicates that for the Mornington Peninsula, the priorities are Home Care, Assessment and Care Management, Delivered Meals and Allied Health. This is supported by an examination of the quarterly data output report for the main provider of these services in the District as well as a review of the submissions made in the previous funding round indicating need and current waiting lists for these services.

4.1.1.4. South East District

City of Casey

The data indicates that priorities for Casey are Assessment and Care Management, Delivered Meals, Personal Care, Home Care, Allied Health and Nursing. The data suggests that these activities are significantly under resourced in the local government area. The anecdotal information provided supports this (with Personal Care identified as a growing priority), as does an examination of agency quarterly output returns and Council advice of waiting lists for service delivery.

Cardinia Shire

The data indicates that priorities for Cardinia are Assessment and Care Management, Delivered Meals, and Property Maintenance. However anecdotal information and data reporting also indicate a need for additional Home Care and Personal Care. Cardinia also report a great need for care management for an increasing number of complex clients.

The City of Greater Dandenong

The data indicates all activities are under resourced in this local government area. The local providers report increasing demand for all services but most particularly Property Maintenance, Home Care, Personal Care and Allied Health. This is supported by agency data and advice regarding waiting lists and unmet demand.

4.2. Data analysis and sector consultation regarding the CALD community

The key findings from the data analysis showed that:

- People from CALD communities are under represented in services such as Home Care, Property Maintenance, Nursing, Delivered Meals and Allied Health. The most accessed HACC activity is Planned Activity Group at 22% that correlates proportionately to the total Victorian CALD 65+ population (19.83%).
- The significant CALD populations in the Cities of Greater Dandenong, Port Phillip, Kingston, Stonnington and Glen Eira highlight the need to focus on reducing the disparity between HACC usage by the CALD population and the general HACC population. Priority will be given in these catchments to identifying barriers to HACC service usage for their CALD communities and strategies to improve access for CALD residents.
- There is currently limited consumer input in the development of culturally relevant services. Strategies need to be identified to engage CALD communities to seek their input in service development and development of HACC CALD Networks.

- There are currently only a small number of partnerships between service providers to promote culturally sensitive and relevant services. The sector strongly supports further development of collaborative direct service delivery arrangements between mainstream, multicultural and ethno specific organizations.
- Most agencies have developed cultural planning tool action plans and equity and access policies. The efforts to date can be consolidated and incorporated into agency practices as part of their daily operations.
- Mainstream and generic HACC providers have benefited from the cross cultural awareness training coordinated by the migrant resource services. The expansion of cultural awareness training as part of the HACC workforce development is an identified priority and the progress to date will be consolidated and built on.

4.3. Data analysis and sector consultation regarding the indigenous community

MDS data indicates that there is some uptake of Home Care and social support services. Taken together with Quarterly Output Collection Data and other data available from agencies concerning known usage of services by the indigenous community would indicate that the following services should be considered a higher priority for growth funding over the next three years: Home Care, Personal Care, Volunteer Co-ordination and Planned Activity Group Core.

There is evidence of non-disclosure of indigenous status amongst HACC clients as well as under reporting in the level of service provision from agencies making a thorough review of data for indigenous clients difficult. The primary data has therefore been supplemented with agency information.

The Region works with agencies that receive block funding for establishing and consolidating programmes that meet the complexity of care needs of the indigenous community. Flexible Service Response has been identified by indigenous and mainstream service providers as a high priority in the Region as this activity allows the agency to respond to the complex needs of indigenous clients through the provision of a wide range of services including transport, social support and health and well being.

This funding also allows for the time needed by agencies to establish rapport with the indigenous community.

4.4. Conclusion

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

Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
1	Increase HACC Basic	2003-06	<ul style="list-style-type: none"> Increase is designed to redress current level of inequity in the regional distribution of funds 	<ul style="list-style-type: none"> Increased client numbers across Region More service provided
1	Increase HACC Response Service across Region	2003-06	<ul style="list-style-type: none"> Increase is proportional to reallocation of Personal Alert Victoria (PAV) units (funded by Aged Care) 	<ul style="list-style-type: none"> Increased client numbers across Region More service provided
2	Strategies to increase the quality and quantity of HACC Basic for people from a CALD background	2003-06	<ul style="list-style-type: none"> Develop closer working relationships between mainstream and the ethno-specific sector Improve cross cultural training Enhance consumer engagement 	<ul style="list-style-type: none"> Increased client numbers across Region More service provided
3	Enhance access to services for indigenous people	2003-06	<ul style="list-style-type: none"> Increase access in the Inner South District Build on existing projects 	<ul style="list-style-type: none"> Increased client numbers across Region More service provided

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

5.1. Introduction

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

Broadly speaking, the recommendations address the following questions

- What do the data tell us?
- Do the data need supplementing? If so, what with and how?
- Is there funds inequity between local government areas? If so, does it need to be redressed? Why? How?
- What is the proposed growth allocation for each local government area?
- What are the special needs in the Region? How will Priorities 2 and 3 be met?
- What Priority 1 activities should be expanded in each local government area
- What funding allocation method should be employed for each activity / bundle of activities?
- What service development issues should be addressed over the next three years? How?

5.2. Funds equalisation or not?

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

Whilst in past funding rounds in SMR there has been a strategic approach to improving regional equity across local government areas, this effort needs to be maintained for a number of years in order to ultimately achieve a more equitable distribution of funding. It is for this reason the Region is recommending the maximum possible 30% equalisation rate.

In relative terms, the most under-resourced local government areas in the Region are (in order of most disadvantaged):

- Greater Dandenong
- Mornington Peninsula
- Casey
- Kingston
- Frankston.

Given the variance within these local government areas, the most disadvantaged should receive the largest increase in its funding base as reflected in Figure 5.1 below which shows the impact of allocation of Priority 1 funds if:

- Greater Dandenong receives 28% (of the equalisation pool)
- Mornington 29%
- Casey 21%
- Kingston 12%.
- Frankston 10%.

The determining principle is that the most disadvantaged should have the greatest percentage improvement in their WREN per capita funding base and this pattern be consistent through to the most advantaged. For example, while Greater Dandenong is slightly more disadvantaged than Mornington, the latter receives a greater proportion of the equalisation pool but has a lower rate of improvement towards equity than Greater Dandenong.

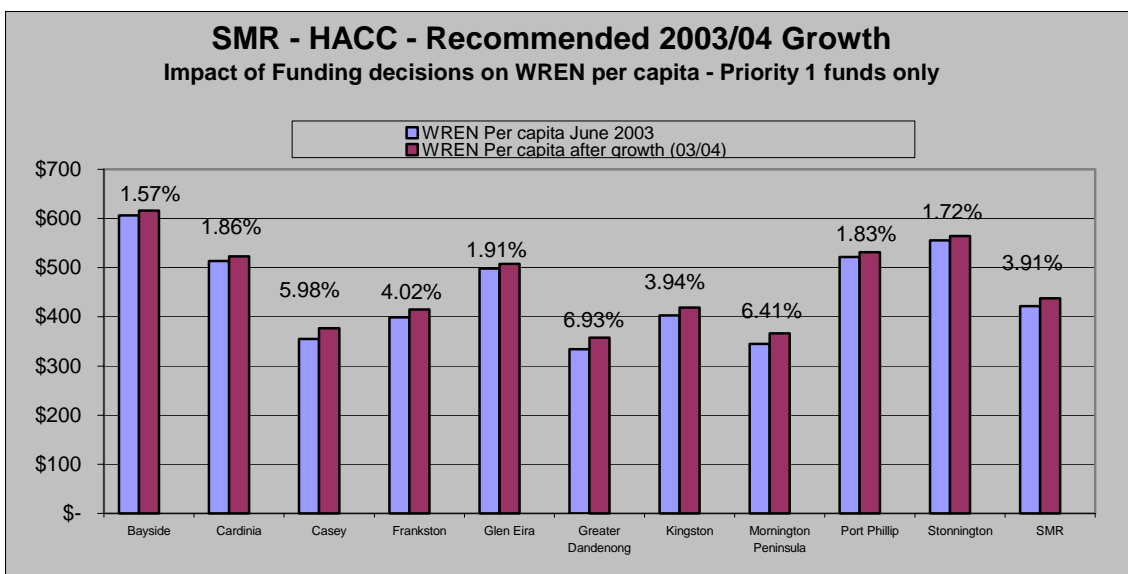


Figure 5.1 Recommended growth 2003 – 04

5.3 Recurrent growth allocations

The following Tables 5.1.a, b and c identify the recurrent growth allocations to the Region and local government areas for Priorities 1 to 3, subject to yearly reviews and budget confirmation. The growth allocations reflect the overall planning goals for the Region. It is important to note that the recommendations for 2003-04 are detailed, while those for the out-years are subject to change when the Regional Plan is adjusted for 2004-05 and 2005-06.

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

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

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

2003-04	Priority 1 Total (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Bayside	\$ 96,555	\$ -	\$ -
Cardinia	\$ 51,017	\$ -	\$ -
Casey	\$ 418,121	\$ -	\$ -
Frankston	\$ 270,969	\$ -	\$ -
Glen Eira	\$ 161,750	\$ -	\$ -
Greater Dandenong	\$ 522,212	\$ -	\$ -
Kingston	\$ 330,087	\$ -	\$ -
Mornington Peninsula	\$ 560,115	\$ -	\$ 12,000
Port Phillip	\$ 103,981	\$ -	\$ 40,000
Stonnington	\$ 88,268	\$ -	\$ -
Region Wide	\$ 62,800	\$ 130,000	\$ -
Total	\$ 2,665,875	\$ 130,000	\$ 52,000

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

2004-05	Priority 1 Total (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Bayside	\$ 99,007	\$ -	\$ -
Cardinia	\$ 53,997	\$ -	\$ -
Casey	\$ 360,137	\$ -	\$ -
Frankston	\$ 243,842	\$ -	\$ -
Glen Eira	\$ 165,122	\$ -	\$ -
Greater Dandenong	\$ 434,339	\$ -	\$ 20,000
Kingston	\$ 296,278	\$ -	\$ -
Mornington Peninsula	\$ 471,816	\$ -	\$ 24,000
Port Phillip	\$ 107,436	\$ -	\$ -
Stonnington	\$ 90,509	\$ -	\$ -
Region Wide	\$ 62,800	\$ 140,000	\$ -
Total	\$ 2,385,283	\$ 140,000	\$ 44,000

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

2005-06	Priority 1 Total (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Bayside	\$ 102,400	\$ -	\$ -
Cardinia	\$ 57,496	\$ -	\$ -
Casey	\$ 388,029	\$ -	\$ -
Frankston	\$ 258,440	\$ -	\$ 40,000
Glen Eira	\$ 169,709	\$ -	\$ -
Greater Dandenong	\$ 460,152	\$ -	\$ 20,000
Kingston	\$ 311,684	\$ -	\$ -
Mornington Peninsula	\$ 501,631	\$ -	\$ 24,000
Port Phillip	\$ 111,845	\$ -	\$ -
Stonnington	\$ 93,872	\$ -	\$ -
Region Wide	\$ 62,800	\$ 150,000	\$ -
Total	\$ 2,518,059	\$ 150,000	\$ 84,000

5.3.1 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.

5.3.2. Recommended expansion of activities – Priority 1

Following the data analysis and conclusions described in Sections 3 and 4, the following activities have been recommended for expansion. The data and analysis in Section 4 has been supplemented with advice and feedback from the sector. Therefore, the actual recommendations have been modified slightly from those priority areas identified in Section 4. (Service expansion recommended in each local government area is depicted in Appendix F).

5.3.2.1. Training

The HACC Regional Training Co-ordination function will have additional funds allocated to increase the capacity of HACC agencies to use traineeships and access other training and learning opportunities that are funded from a variety of sources and also to address HACC specific training needs.

This is a developmental function to enhance the capacity of HACC agencies to identify training needs and access appropriate training. It is the responsibility of the Vocational Education System to fund vocational training.

SMR currently has a training budget of approximately \$73,000. It is recommended that this be increased by \$10,000 per annum to \$100,000 by 2006 via direct allocation to the existing agency that carries out this function.

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

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

ACTIVITIES	Units	\$
Home Care	41,182	\$ 1,006,488
Personal Care	12,772	\$ 356,850
Property Maintenance	4,965	\$ 176,506
Allied Health	7,454	\$ 534,974
Nursing	2,080	\$ 130,749
Delivered Meals	28,857	\$ 35,494
ACM	-	\$ 362,013
SSR HACC Response Services	-	\$ 52,800
SSR Training	-	\$ 10,000

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

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

ACTIVITIES	Units	\$
Home Care	30,735	\$ 769,912
Personal Care	15,055	\$ 431,175
Property Maintenance	4,658	\$ 169,738
Allied Health	6,880	\$ 506,093
Nursing	2,040	\$ 131,437
Delivered Meals	20,514	\$ 25,848
ACM	-	\$ 288,266
SSR HACC Response Service	-	\$ 52,800
SSR Training	-	\$ 10,000

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

ACTIVITIES	Units	\$
Home Care	30,705	\$ 788,197
Personal Care	15,676	\$ 460,247
Property Maintenance	5,234	\$ 195,490
Allied Health	7,032	\$ 530,213
Nursing	2,040	\$ 134,742
Delivered Meals	22,015	\$ 28,399
ACM	-	\$ 317,971
SSR HACC Response Services	-	\$ 52,800
SSR Training	-	\$ 10,000

5.3.4. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Personal Care (hours)	Property Maint (hours)	Allied Health (hours)	Nursing Blair (hours)	Delivered Meals (meals)	Assessment and Care Man (\$)	Service System Resourcing (\$)
Cardinia	MECWA	Direct	300	300				1,000	\$23,881	
Casey	City of Casey	Direct	2,900	4,600	200				\$62,624	
Casey, Cardinia, Greater Dandenong	Southern Health	Direct				2,762				
Casey, Greater Dandenong	RDNS	Direct					2,080			
Greater Dandenong	The City of Greater Dandenong	Direct	5,710	2,600	2,100				\$65,561	
Region	Vision Australia	Direct								10,000
Bayside	Bentleigh Bayside CHS	Direct				264				
Port Phillip	Inner South CHS	Direct				290				
Stonnington	Bayside Health	Direct				122				
Stonnington	Inner South CHS	Direct				122				
Glen Eira	Bentleigh Bayside CHS	Direct				180				
Glen Eira	Bayside Health	Direct				268				
Bayside	Bayside City Council	Direct	2,000						\$28,728	
Glen Eira	Glen Eira City Council	Direct	3,289		765					
Kingston	City Of Kingston	Direct	6,831	1,234	570				\$42,368	
Port Phillip	City of Port Phillip	Direct							\$78,247	
Stonnington	City of Stonnington	Direct	2,694							
Stonnington	Prahran Mission	Direct						3,995		

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Personal Care (hours)	Property Maint (hours)	Allied Health (hours)	Nursing Blair (hours)	Delivered Meals (meals)	Assessment and Care Man (\$)	Service System Resourcing (\$)
Port Phillip	Sacred Heart Mission	Direct						4,000		
Frankston	Frankston City Council	Direct	1,733	3,250	1,330			16,651		
Frankston, Mornington Pen	Peninsula Health	Direct				1,526				
Mornington Peninsula	Mornington Peninsula Shire Council	Direct	15,725					3,211	\$60,603	
Mornington Peninsula	Peninsula Community Health Centre	Direct				1,000				
Glen Eira	Yet to be determined	Invited		788						
	Southern Health - Kingston	Direct				170				
Kingston	Central Bayside	Direct				750				
Region	Bayside Health (HACC Response Service)	Direct								\$ 52,800
Total			41,182	12,772	4,965	7,454	2,080	28,857	\$362,013	\$62,800

Stakeholders indicated broad agreement with the agency allocation proposals.

5.4. Priority 2

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

5.4.1. Introduction

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

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

5.4.2. Project recommendations

Based on the data analysis in Sections 3 and 4, sector consultation, and in line with the SMR priority to establish stronger community participation in planning for multicultural affairs¹, the following strategies are recommended 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:

- To work with HACC Basic providers to provide culturally friendly gateways for CALD residents to access HACC Basic services
- To promote cross cultural awareness training for the HACC workforce and relevant service providers across the Region
- To engage CALD consumers and communities to participate in service development of culturally relevant services
- To encourage and facilitate better linkages between ethno specific agencies and HACC Basic providers
- To consolidate Aged Care funding activities for Ethnic Service Development into the HACC activity, Service System Resourcing.

¹ SMR Regional Plan 2002-2003

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

Issue	Initiative	2003-04	2004-05	2005-06
Better pathways for CALD clients to HACC Basic services	Establish closer working relationships between Migrant Resource Centres and HACC Basic providers to improve access and utilisation of HACC services			
Workforce development	Improving and encouraging cross cultural training for mainstream HACC service providers also linking to ethno specific agencies			
Consumer engagement	Expanding HACC Access and Equity Program to facilitate consumer engagement – develop networks and incorporation in cultural planning tools action plans			
Promoting Best Practice	The balance of individual strategies needs further negotiation with stakeholders.			
Total		\$130,000	\$140,000	\$150,000

5.4.4. Allocation process, 2003-04

The organisations uniquely placed to facilitate these strategies with active cooperation of HACC Basic Providers are the two Migrant Resource Centres. Negotiations are underway with Migrant Resource Centres and HACC Basic service providers to clarify the specific strategies to best achieve the objectives above.

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

Catchment	Name of Agency	Allocation Method	Service System Resourcing (\$)
Sub-Region	South Central Migrant Resource Centre	Direct	\$65,000
Sub-Region	South East Migrant Resource Centre	Direct	\$65,000
			\$130,000

Stakeholders indicated broad agreement with the agency allocation proposals.

5.5. Priority 3

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

5.5.1. Introduction

An analysis of ATSI communities and the issues that have been prioritised for 2003-06 is provided in Section 3.5.1.4. It should be noted that the ATSI recommendations have been developed via a two-pronged process:

- The development of statewide program and or service development projects through the Victorian Indigenous Committee on Aged Care and Disability (VICACD)
- The development of recommendations for local service expansion and development through the local Networks in partnership between DHS regional offices and local communities.

5.5.2. ATSI Statewide directions for service development

In 2002-03, VICACD identified four themes for Statewide and cross regional ATSI projects. They were:

- Workforce development
- Data
- Organisational capacity
- Lack of access.

During 2002-03, HACC initiatives to address these priorities included:

- ATSI Training Initiative to provide accredited training in Certificate III in Community Services (Aged Care) to HACC workers in aboriginal agencies. Groups of workers in Loddon Mallee and Hume Regions have completed their training with the metropolitan group to finish their course in October 2003
- A project delivered by Victoria University to assist aboriginal agencies to develop and implement a strategy to improve their capacity to meet data reporting requirements and to improve the quality of their data
- ATSI HACC Policies and Procedures Project to develop policies and procedures manuals to support agency-level implementation of the Victorian HACC Program Manual
- ATSI Needs Analysis Project in Loddon Mallee, Hume and Western Metropolitan Regions, and in selected areas of Barwon-South Western and Grampians Regions, has identified the service needs of indigenous people in these areas and made recommendations for consideration in the development of the regional plans
- ATSI Communication Strategy Project developed and implemented strategies for communicating information about HACC services for indigenous people via brochures and posters at main points of entry to the service system.

On 10 April 2003, VICACD proposed building on this service development work to support ATSI communities over the next three years. The focus proposed was:

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

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

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

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

The next step is for DHS, in consultation with VICACD, to develop a workplan for the triennium, and project briefs to implement the above tasks. It is expected that further service development projects will be proposed each year when the Regional Plans are adjusted.

In addition, VICACD proposed that it should review and redefine its role as the key point of consultation for DHS on ATSI HACC issues in Victoria. The review would include consultation with VICACD and regional network members and DHS central and regional office staff to develop documentation establishing effective processes for the operation of the networks. VICACD has also identified a need for the document to incorporate a three-year strategic plan for the triennium in order for VICACD to be proactive in setting its own agenda.

Other issues referred to each Network for local consideration and action as appropriate were:

- The need to increase the cultural awareness of mainstream agencies to enhance access of ATSI people to mainstream services
- The management of cross boarder service provision
- Planning for seasonal changes in population.

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

5.5.3. ATSI sector

5.5.3.1. ATSI services in SMR

A Regional Aboriginal Services Plan, currently being developed with the indigenous community, focuses in part, upon expanding services for elders and upon working with indigenous and mainstream agencies to develop capacity to be more culturally relevant and responsive. This collaborative initiative aims to develop and deliver services with new approaches that are effective in supporting families with complex needs.

In recognition of the distinct groups of indigenous communities in SMR, the Region has focused development in three distinct areas: Inner South District, South East District and the Frankston and Mornington Peninsula District.

Within the HACC funded sector, a number of projects have been undertaken to enhance access to services for the indigenous community. Two of these are with indigenous agencies and seven are with mainstream agencies supporting indigenous workers. This latter group include a local government, community health services and a neighbourhood house programme.

In recent years, HACC services in the South East and Frankston - Mornington Peninsula districts have been the focus of development. In the South East, a partnership initiative between a mainstream agency and an indigenous agency focuses on capacity building and responsiveness in meeting the needs of the indigenous community. On the Mornington Peninsula, work has begun within a mainstream agency to develop culturally appropriate home care services for indigenous elders.

5.5.4. Expansion of services

In 2003-04 the Region will focus on:

- Development in the Inner South district to improve access to the HACC services for indigenous HACC clients
- The Region will also continue to work with current projects to ensure that recent initiatives particularly on the Mornington Peninsula are consolidated and strengthened as agencies build capacity and workforce issues are addressed.

In 2004-05 and 2005-06, the Region will continue work to increase accessibility to the full suite of HACC services for indigenous clients with a focus on:

- Developing the capacity of mainstream service providers to be more culturally relevant and responsive and facilitating complementary initiatives through indigenous agencies
- Encouraging partnerships and collaboration to better develop relationships between local community health centres, local government agencies and indigenous agencies.

In summary, HACC service expansion for indigenous communities for 2003-06 is recommended as follows:

2003/2004	
Flexible Service Response and/or Service System Resourcing through invited submission. Invitees to be identified through PCP and District Planning Group	Inner South District
Flexible Service Response (Home Care project) (direct)	Mornington Peninsula
2004/2005	
Flexible Service Response and/or Service System Resourcing	South East District, Mornington Peninsula
Home Care	Mornington Peninsula
2005/2006	
Flexible Service Response and/or Service System Resourcing	Frankston, South East District, Mornington Peninsula
Home Care	Mornington Peninsula

Flexible Service Response & Service System Resourcing Projects

The objective of these projects is to increase the uptake of HACC services by the indigenous HACC population. This will be measured through the MDS reports.

Projects will:

- focus on developing the capacity and responsiveness of key indigenous services
- focus on developing the responsiveness and cultural appropriateness of key mainstream services provided through councils and community health services which serve indigenous communities as well as information and advocacy services
- target particular mainstream services that facilitate access to health services to address health issues specific to the indigenous HACC population.

5.5.6. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Flexible Service Response (\$)
Inner South District		Invited	40,000
Mornington Peninsula	Mornington Peninsula Shire Council	Direct	12,000
			52,000

Stakeholders indicated broad agreement with the agency allocation proposals.

5.6. Impact of Priorities 1-3 proposals

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

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

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

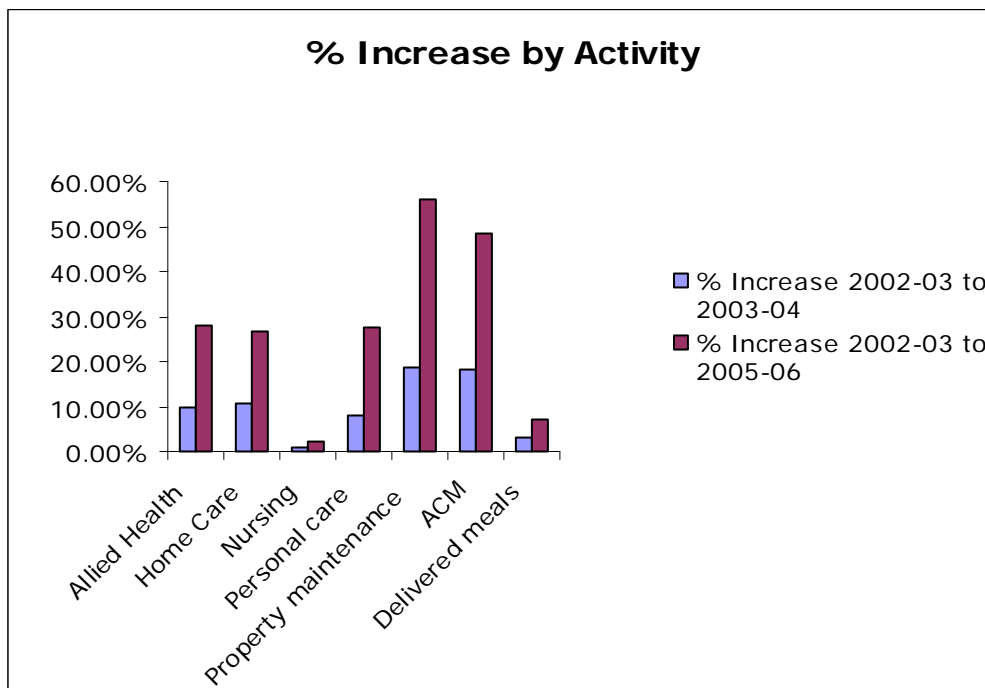


Figure 5.2. Percentage increase of Priority 1 activities, 2003-04 and 2003-06

The table and the graph below provide a summary of the impact of the distribution of growth funding for 2003-06 in each local government area.

- The first bar shows the recurrent base budget 1 July 2003 (excluding the consolidation of a number of Aged Care funding activities into more appropriate activities funded within HACC)
- The second bar shows the recommended recurrent base budget at 1 July 2006 (including consolidation funds) and reflects funding allocations as recommended in the Regional Plan
- The third bar shows the WREN population share by local government area for 2005-06; and indicates proposed progress towards redressing HACC funds inequity between local government areas.

Table 5.3: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

LGA	Recurrent \$ 1/7/2003	% of recurrent funding, excluding consolidation, 1/7/2003	WREN 2003-04	Recurrent \$ + growth, including consolidation 1/7/2006	% of funding, 1/7/2006	WREN 2006
Bayside	\$6,144,409	9.2%	6.4%	\$6,523,537	8.7%	6.2%
Cardinia	\$2,748,919	4.1%	3.4%	\$3,142,849	4.2%	3.5%
Casey	\$6,993,624	10.5%	12.5%	\$8,238,203	11.0%	13.2%
Frankston	\$6,747,650	10.1%	10.7%	\$7,626,278	10.1%	10.8%
Glen Eira	\$8,460,286	12.7%	10.7%	\$9,139,951	12.2%	10.3%
Gr. Dandenong	\$7,532,619	11.3%	14.3%	\$9,075,860	12.1%	14.2%
Kingston	\$8,382,090	12.6%	13.2%	\$9,466,339	12.6%	13.0%
Mornington Peninsula	\$8,742,267	13.1%	16.1%	\$10,434,005	13.9%	16.2%
Port Phillip	\$5,696,139	8.6%	6.9%	\$6,101,087	8.1%	6.8%
Stonnington	\$5,144,291	7.7%	5.9%	\$5,452,099	7.3%	5.7%
Total	\$66,592,293	100.0%	100.0%	\$75,200,207	100.0%	100.0%

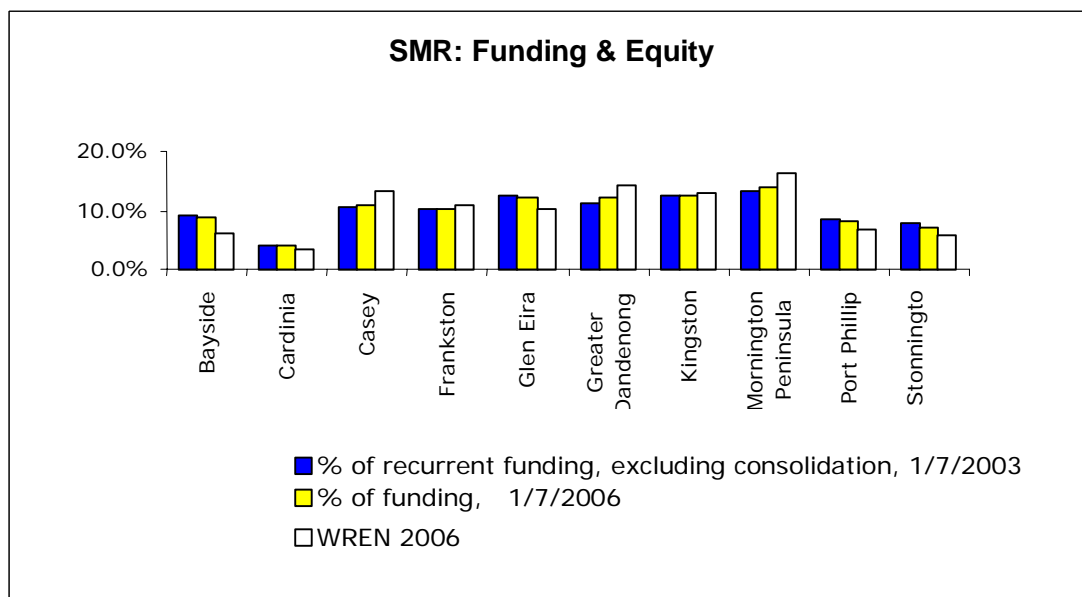


Figure 5.3: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

Section 6 – Non-recurrent funding

6.1. Introduction

This section outlines recommendations for the use of non-recurrent funds.

6.2. Regional development initiatives

Up to \$30,000 may be allocated for projects and development initiatives in each of the three years. Project briefs or abstracts should accompany project initiatives, especially for invited or open submission processes.

SMR seeks to encourage strategic planning of social support activities, and networking amongst social support providers as follows:

2003-04

- A project to inform future planning for the implementation of a cohesive strategy to develop relevant support services in the Mornington Peninsula district. It is recommended that \$10,000 be allocated via an invited submission.
- A one day workshop to progress the recommendations of the Social Support Project (2002-03), and build support across the Port Philip, Stonnington, Kingston, Bayside and Glen Eira local government areas. It is recommended that \$5,000 be allocated via an invited submission.
- Skill development and training initiatives for social support agencies across the Region. It is recommended that \$15,000 be allocated via an invited submission.

2004-05

- Targeting the South East District to inform future planning for the implementation of a cohesive strategy to develop relevant support services.
- \$10,000 is recommended.
- The SMR seeks to strengthen and resource the capacities of targeted agencies to respond to recommendations identified in their HACC Standards Implementation Action Plans.
- Other projects will be identified through the HACC Standards Implementation Action Plans.

2005-06

- Projects will be identified through the HACC National Standards Implementation Action Plans.

6.3. Minor capital discretionary funding

A minimum of 1% of total program outlays has been established for minor capital. Up to 20% of the regional' allocation will be reserved for discretionary purposes. This is to allow the region some capacity to redress unintended consequences of the first year implementation of the new policy.

Minor capital funding to small organisations over the last 2 years will be reviewed. The remaining percentage of minor capital discretionary funding will be distributed to those organisations that have received minimal or no minor capital funding during this period.