

Home and Community Care (HACC) Program

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

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

Appendix B – Regional consultation

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Appendix D – List of HACC providers in Region

Appendix E – RREF & WREN explained

Appendix F – Service expansion proposed for Priority 1 activities in local governments areas of Region

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Section 1 – HACC Regional Plan 2003-06

1.1. Context of the Regional Plan

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

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

1.2. Purpose of the Regional Plan

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

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

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

These are the subjects of the present Regional Plan.

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

1.3. Consultation with the sector

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

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

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

1.4. What is the HACC Program?

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

1.5. Characteristics of HACC service users in Victoria

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

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

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

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

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

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

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

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

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

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

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

1.6. Better planning & funds allocation

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

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

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

1. Focused Ministerial Priorities for HACC growth funds

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

2. Consistent three year planning

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

3. More diverse means of funds allocation

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

4. Automatic allocation of minor capital

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

5. More focussed research and development program

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

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

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

2.2.1. What do the data tell us?

2.2.1.1. Priority 1

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

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

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

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

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

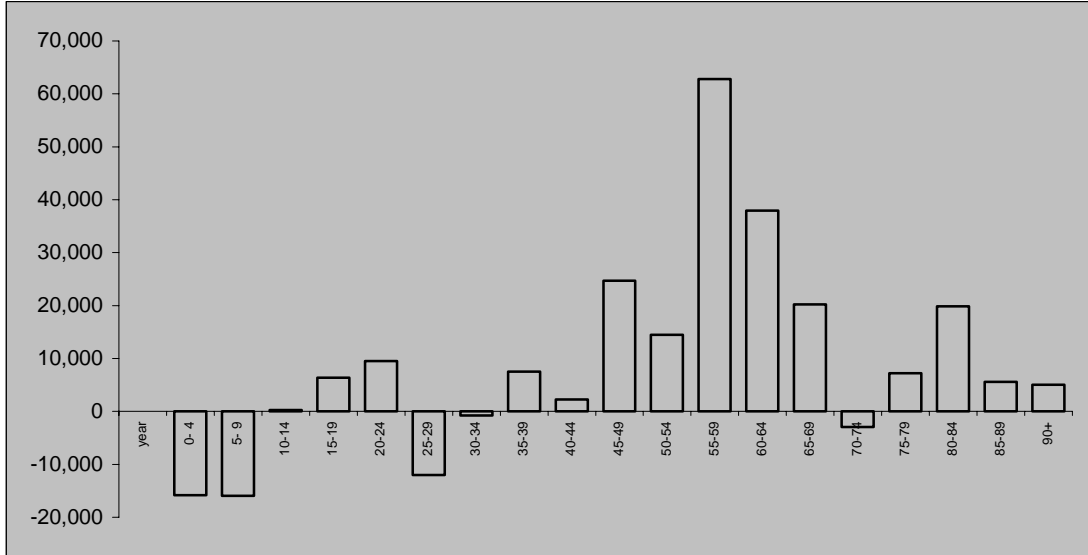


Figure 2.1: Changes in population groups 2001-06 Victoria
 Source: Department of Infrastructure *Victoria In Future*

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

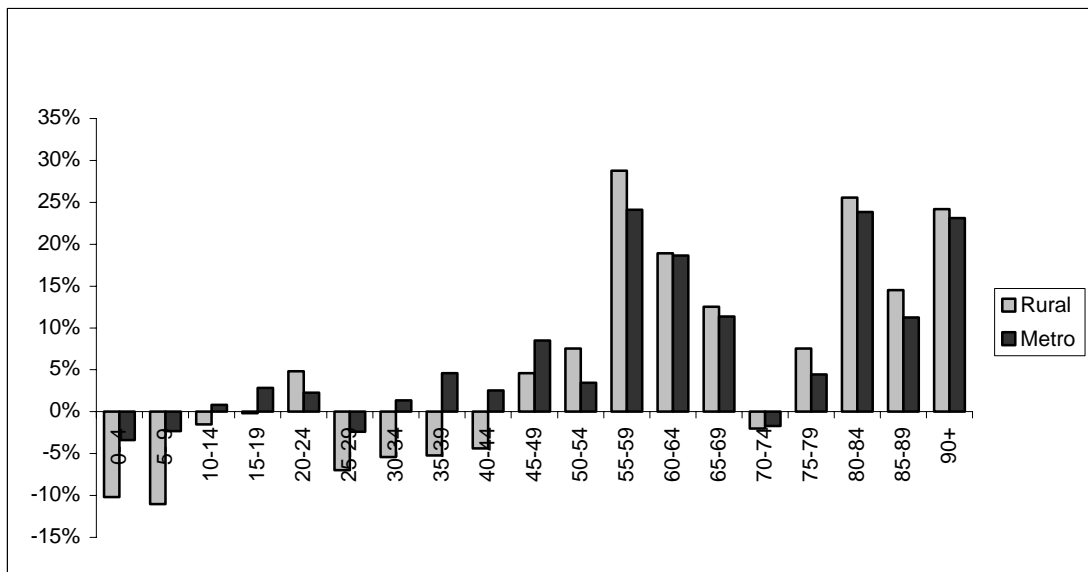


Figure 2.2: Comparison of population group changes: Rural and metropolitan regions
 Source: Department of Infrastructure *Victoria In Future*

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

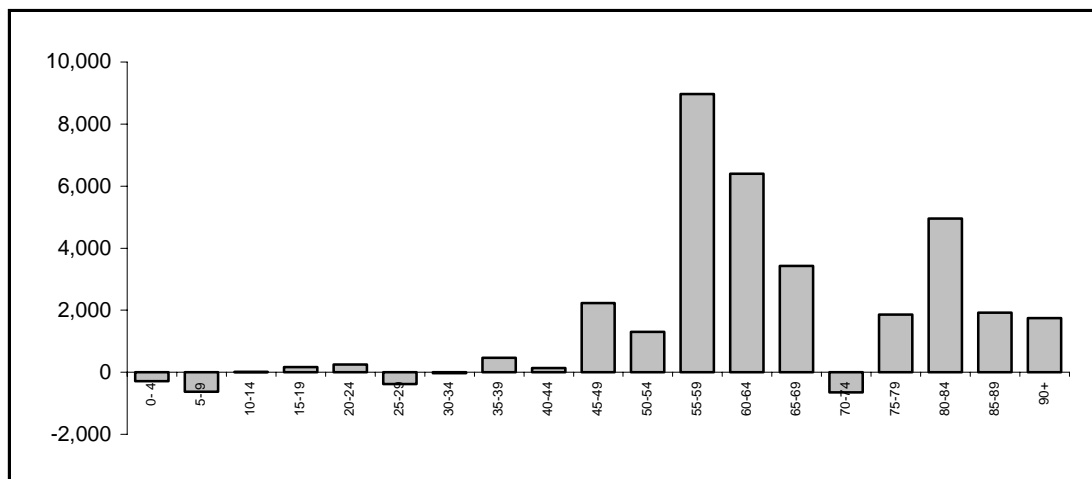


Figure 2.3: Changes in the estimated number of persons with a disability, 2001-06
Source: Department of Infrastructure *Victoria In Future* and 1998 ABS *Disability, Ageing and Carers Survey*

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

2.2.1.2. Priority 2

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

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

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

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

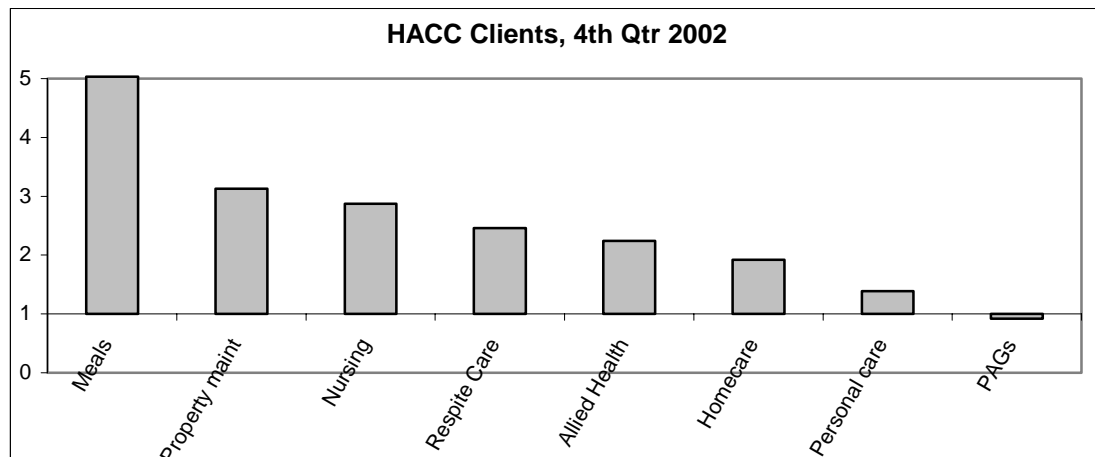


Figure 2.4: Ratio of rates of service provided to English/LOTE clients

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

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

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

2.2.1.3. Priority 3

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

2.3. Putting the Priorities into action

2.3.1. Statewide strategies

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

Developing culturally responsive services

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

Investing in the HACC workforce

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

Improving the quality of services

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

Effective program planning and evaluation

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

Targeting in the HACC program

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

Funding and accountability

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

Investing in research and development

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

2.3.2. Regional strategies

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

Section 3 – Regional context

3.1. Introduction

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

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:

- Koori HACC needs analysis project
- Aboriginal service plan
- Primary care alliances Community Health Plans
- The Disability Adjusted Life Year (DALY) information
- ABS 2001 Census information
- WMR CALD Aged Care Strategic Plan 2003-08.

Data Limitations WMR CALD Aged Care Strategic Plan 2003-08.

Accuracy of service use data is also dependent on the consistency of service providers in completing cultural identity information on their clients. Major improvements have been made in this area however some data collections are still incomplete. The discussion about CALD has referred to:

- the number of people born in a non-English speaking country
- the number of people within the LGA who speak a language other than English.

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.

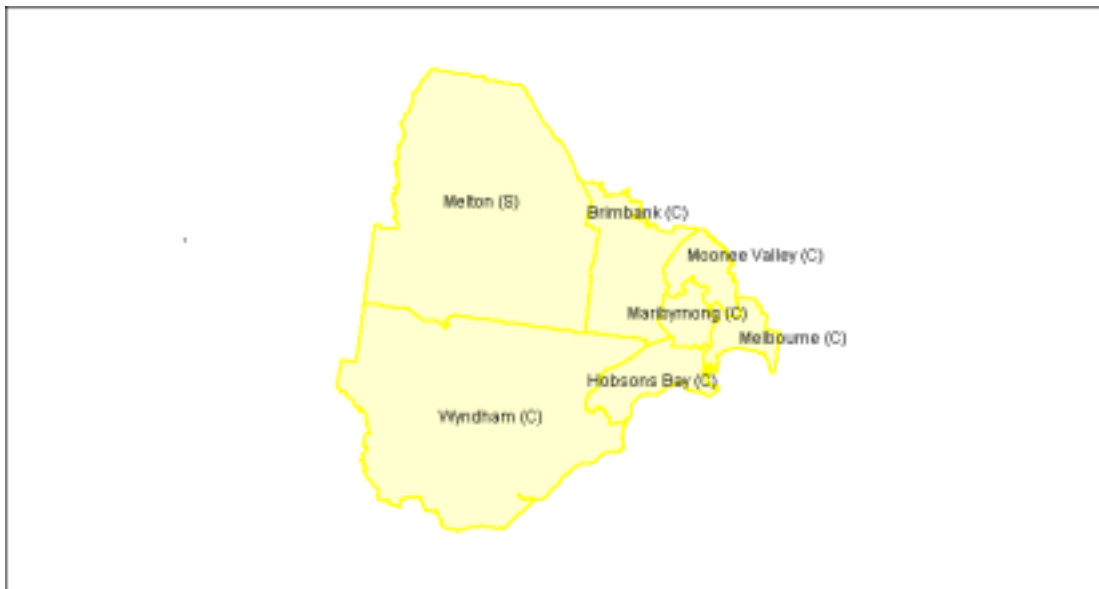


Figure 3.1: Local government areas in Region

3.2.2 Overview of the Western Metropolitan Region

The WMR is a region of great diversity with areas of affluence and poverty. It has one of the most culturally diverse populations in Victoria with over a third of the Region's population born outside Australia or speaking a language other than English. The Region has established inner municipalities with reasonably static populations, developing outer suburbs with rapidly expanding populations and several municipalities with populations who have poor health status in comparison with state data (WMR Health and Social Wellbeing profile January, 2002).

A WMR Primary Care Partnership project, *Western Metropolitan Region Culturally and Linguistically Diverse Aged Care Strategic Plan 2003 – 2008*, was undertaken during 2003 by Katherine Wositzky from Katherine Wositzky Social Research. Regional and local demography of the CALD elderly was sourced from the ABS census 2001. A further data set describing the CALD elderly population has been provided from ABS Census 2001 data in Appendix C. The figures and percentages in the two data sets are slightly different due to different methodology in using the data. However, the overall inferences are the same in both data sets. Therefore, as the regional data has been widely disseminated in the Region and is being used by agencies, the Region has elected to use this data in this plan. The Region has elected to use this data in this plan.

Brimbank

The Disability Adjusted Life Year (DALY) is a measure of morbidity and mortality. This is used as an indicator of the health status for areas within Victoria. The population in Brimbank has a high rate of years of life lost due to ill health with a DALY rate above the Victorian average for males (WMR Health and Social Well Being Profile, Jan 2002). Brimbank's population has a high level of socio-economic disadvantage (WMR Health and Social Well Being Profile, Nov 2002), and an inequitable share of HACC funding per capita when compared to other

local government areas within the Region. There are 10,346 people over the age of 70 years living in Brimbank; by 2006 this figure will rise to 11,557. Approximately 0.32% of Brimbank's population (543 people) are from an ATSI background (Effective Change 2003).

The Brimbank area has a culturally diverse population. Approximately 65% of the 65+ aged population were born in a non-English speaking country.

The top ten languages other than English spoken at home within the local government area include, in order of greatest prevalence, Italian, Maltese, Greek, Polish, Croatian, Vietnamese, German, Macedonian, Chinese and Ukrainian (Census 2001).

DHS service funding data for Brimbank shows that the following activities are under funded per capita relative to the metropolitan regional averages for service provision; Home Care, Personal Care, Property Maintenance, Delivered Meals, Nursing, Allied Health and Assessment and Care Management.

Hobsons Bay

The Hobsons Bay population has a high level of socio-economic disadvantage within the WMR and a high rate of years of life lost due to ill health, with a DALY rate above the Victorian average for males (WMR Health and Social Well Being Profile, Jan 2002). There are 7,546 people over the age of 70 living in Hobsons Bay; by 2006 this figure will have risen to 7,835. Approximately 0.35% of Hobsons Bay's population (298 people) are from an ATSI background (Effective Change 2003).

Approximately 37% of Hobsons Bay's 65+ aged population were born in a non-English speaking country.

The top ten languages other than English spoken at home within the local government area include, in order of greatest prevalence, Italian, Greek, Maltese, Polish, German, Croatian, Macedonian, Chinese, Vietnamese and Ukrainian (Census 2001).

DHS service funding data for Hobsons Bay shows that the following activities are under funded per capita relative to the metropolitan region averages for service provision; Home Care, Personal Care, Nursing, Allied Health and Assessment and Care Management.

Maribyrnong

DALY information for WMR shows that Maribyrnong has higher rates of years lost to ill health and premature death for both males and females than the rest of the WMR and the Victorian average. People within this local government area also have a high level of socio-economic disadvantage when compared to other local government areas within the WMR, (WMR Health and Social Well Being Profile, Jan 2002). The Maribyrnong HACC target population will grow by approximately 1% by 2004-05 and a further 1% by 2005-06, (chart five). Approximately 0.46% of Maribyrnong's population (286 people) are from an ATSI background (Effective Change 2003).

Approximately 40% of Maribyrnong's 65+ aged population were born in a non-English speaking country.

The top ten languages other than English spoken at home within the local government area, in order of greatest prevalence, include; Italian, Greek,

Vietnamese, Chinese, Polish, Macedonian, Croatian, Maltese, German and Ukrainian (Census 2001).

DHS service funding data for Maribyrnong shows that the following activities are under funded per capita relative to the metropolitan region averages for service provision; Home Care, Personal Care, Property Maintenance, Nursing and Assessment and Care Management.

Melbourne

Anecdotal evidence depicts Melbourne as having a high number of people who are homeless, insecurely housed and with varying needs related to the general population. This cannot be adequately measured by traditional data gathering techniques, for example, the Census. Approximately 400,000 people travel into the city to work and travel home again at the end of each day, (Moonee Valley/Melbourne Community Health Plan 2002). The resident population of Melbourne is changing with many new housing developments in the area. The HACC needs of this population now and into the future, is largely unknown at this stage.

Approximately 27% of Melbourne's 65+ aged population were born in a non-English speaking country.

The two most prevalent language groups are Italian and Chinese (Census 2001).

Data for Melbourne's resident population shows a high rate of years of life lost due to ill health with a DALY rate above the Victorian average for males (WMR Health and Social Well Being Profile, Jan 2002). There are 2,747 people over the age of 70 living in Melbourne; by 2006 this will have risen to 2,800. Approximately 0.37% of Melbourne's population (193 people) are from an ATSI background (Effective Change 2003).

People living within Melbourne receive an average of \$646.00 of HACC service per annum within the HACC target group population, compared to the regional average of \$471.00. As Melbourne is well resourced per capita compared to other local government areas within the Region, it is proposed that the Region negotiates targets between the activities to meet demand rather than providing additional resources in this local government area.

Melton

Melton Shire Council is currently experiencing substantial population growth, which is predicted to continue into the future. New housing estates account for this population movement.

There are 1,882 people over the age of 70 living in Melton. The 70+ population of Melton will increase by over 24.7% by 2006 and a further 66% by 2010. The HACC target population will grow by approximately 7% by 2004-05 and a further 7% by 2005-06. Approximately 0.61% of Melton's population (327 people) are from an ATSI background (Effective Change 2003).

Approximately 27% of Melton's 65+ aged population were born in a non-English speaking country.

The top ten languages other than English spoken at home within the local government area, in order of greatest prevalence, include; Italian, Croatian, German, Polish, and Spanish (Census 2001).

DHS service funding data for Melton shows that the following activities are under funded per capita relative to the metropolitan region averages for service provision; Personal Care, Allied Health and Assessment and Care Management. People living within Melton receive an average of \$364.00 of HACC funds per annum, compared to the Regional average of \$471.00.

Moonee Valley

Moonee Valley has a high number of people aged 65 years and over and a correspondingly high number of people living with a disability within the municipality. Levels of profound and severe disability are comparatively higher than most other regional local government areas.

There are 10,867 people over the age of 70 living in Moonee Valley, the local government area has the highest 70+ population in the WMR. This population will increase by 2% by 2006 and 5% by 2010. The HACC target population will grow by approximately 1% by 2004-05 and 1% by 2005-06. About 0.28% of Moonee Valley's population (310 people) are from an ATSI background (Effective Change 2003).

Approximately 41% of Moonee Valley's 65+ aged population were born in a non-English speaking country.

The most prevalent language spoken at home other than English is Italian.

DHS service funding data for Moonee Valley shows that the following activities are under funded per capita relative to the metropolitan region averages for service provision; Home Care, Personal Care, Nursing, Allied Health and Assessment and Care Management. People living within Moonee Valley receive an average of \$464.00 of HACC funds per annum, compared to the Regional average of \$471.00.

Wyndham

Wyndham will experience the highest level of population growth of any of the local government areas within the Region over the coming years. Currently there are 3,712 over the age of 70 living in Wyndham; by 2006 this number will have risen to 4,107. Approximately 0.68% of Wyndham's population (601 people) are from an ATSI background, this is the highest population percentage in the WMR (Effective Change 2003). Wyndham also has high numbers of younger ATSI people living in the area that needs to be considered in long term planning.

Approximately 32% of Wyndham's 65+ aged population were born in a non-English speaking country.

The most prevalent language spoken at home other than English is Italian.

DHS service funding data for Wyndham shows that the following activities are under funded per capita relative to the metropolitan regional average for service provision; Personal Care, Delivered Meals and Assessment and Care Management. The provision of Delivered Meals per capita is significantly lower than both the metropolitan region and WMR averages.

3.2.2. The HACC sector

Within the seven local government areas, DHS currently funds 69 HACC providers. HACC providers are a diverse group and include:

- 7 local governments
- 3 community health centres
- 2 hospitals
- 36 non-government agencies
- 21 CALD agencies

Of these 69 agencies, 6 provide services statewide and 22 provide cross regional services.

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

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

The Region has three Primary Care Partnerships that provide a planning and co-ordinating support role in the primary care sector and include HACC funded agencies.

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, 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.

DHS regularly consults with the following HACC advisory and consumer groups:

3.3.1 Aged Services Network

The Aged Services Network (ASN) meets bi-monthly and is a key point of consultation for the WMR DHS. The ASN develops and implements strategies to facilitate improved communication between service providers and Government officers, advises government bodies on regional funding and service needs, facilitates research and working groups around key issues and encourages consultation with consumers and carers in the planning and delivery of services.

The ASN membership consists of the following representatives:

- intensive care brokerage programs
- community health
- ethnic services
- local government
- community nursing
- palliative care
- disability sector
- Council On The Ageing (COTA) Vic
- Aged Care Assessment Service (ACAS)
- Division of General Practitioners
- Western Healthcare Network
- residential care sector
- carers
- ASN Training
- State Government representatives (ex-officio)
- Commonwealth Government representatives (ex-officio).

3.3.2 Ethnic Services Network

The Ethnic Services Network (ESN) meets bi-monthly and provides a forum for peer and professional support for agencies that provide HACC and other services to CALD communities in the WMR. The ESN advocates to funding bodies and policy makers on behalf of their membership and the communities they work with. The membership consists of the following representatives:

- HACC funded ethno specific agencies
- HACC agencies funded for Planned Activity Groups
- Other HACC funded non-government agencies.

3.3.3 Western Region Disability Network

The Western Region Disability Network (WRDN) meets bi-monthly and is a key point of consultation between DHS and the HACC/Disability sector. The WRDN plays a key role in the planning and development of disability services in the WMR through consultation, information sharing and networking. The membership consists of the following representatives:

- Parents of individuals with a disability
- Individuals with a disability
- Local government
- St. Albans Lifestyle Options
- Care Connect
- Carer Links West
- WIN Support Services.

3.4. The planning context

3.4.1 Broad planning context

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

The WMR works with the Regional networks to plan, develop and consult about ongoing funding, new initiatives, service gaps and innovative projects within the Region and beyond. The Region is also informed by regional and statewide directions outlined in the following documents; the *Final Report for the Home and Community Care (HACC) Strategic Plan for the Western Metropolitan Region 2000-2005 (NARI 2001)*, WMR Primary Care Partnership Community Health Plans, the *Victorian Homelessness Strategy (DHS April 2001)*. There are a number of other initiatives and projects that inform HACC planning that focus on carers, ageing issues, ATSI populations and issues for people living with a disability. Statewide DHS HACC projects that inform regional planning include the implementation of the HACC National Service Standards, Equity and Access projects and workforce development.

The planning process for HACC has been broadly influenced by the following:

- The triennial Ministerial Priorities
- WREN/RREF formulas
- MDS information
- 2001 Census data.

The factors within the Region that have directly influenced the development and content of the plan include:

- Regional/Cross Regional and Statewide projects that relate to systematic reviews and development
- Consideration of current/new budget allocations and funding per capita within the Region
- Consideration of each local government area population and health. (The application of the WREN population formula ensures local government area resource allocations take account of these issues, where the demand for Government subsidised service would be expected to be high)
- Current levels of service provision by HACC activity type
- The total population increase for each local government area over the next ten years
- The work of Primary Care Partnerships which includes documented population profiles, studies and service model developments
- Waiting lists and demand for service
- Other work/research undertaken within the Region that relates to the HACC population and models of service provision.

Specific projects that have been taken into account in HACC program planning in the Region include the HACC Strategic Plan, transport projects, aged care projects, homeless and insecurely housed target group projects, the Koori HACC Needs Analysis project, DHS Aboriginal Services Plan, Community Health Plans and Hospital Admission Risk Program (HARP) projects. Each of these projects is discussed below.

3.4.1.1 The HACC Strategic Plan

The Region commissioned the development of a five-year HACC strategic plan in 2000. This plan assists the Region in considering specific population and systemic issues that impact on HACC services in WMR.

The strategic plan documents the demand for HACC and discusses issues for specific local areas, reporting, service access considerations and other matters that need to be factored into the further development of the HACC sector.

3.4.1.2 Transport

Community Transport in Victoria is experiencing increasing consumer demand. In response to this DHS and the Department of Sustainability and Environment (formerly Infrastructure) is funding a project entitled "Transport Connections". The aim of this project is to provide funds to support the development of innovative ways to utilise current transport programs/vehicles in rural and rural interface areas in Victoria.

Wyndham City Council was funded in the 2002-03 HACC funding round in the local government areas of Wyndham, Hobsons Bay and Maribyrnong to support the implementation of a staged expansion of integrated transport services across this catchment (Westbay PCP). This project is funded on a recurrent basis. This model, if successful, will be used to develop a similar structure for other areas in the Region.

3.4.1.3 Equity and Access Workers

Equity and Access Projects have been developed to improve service delivery to high needs groups by identifying needs, raising the communities and service providers awareness of unmet needs, providing training and information and assisting in the planning, coordination and development of services. In the WMR Equity and Access Officers exist in the aged, acute and the CALD sector.

3.4.1.4 Homeless and insecurely housed program

In the past four years statewide recurrent funding of \$7.2 million has been provided via the HACC Program to support HACC eligible people within the community who are homeless or insecurely housed. In the WMR within the past two years a total of \$242,409 (12% of the 2001-02 and 12% of the 2002-03 WMR growth budgets) has been allocated specifically to this target group. These growth funds have enabled the development of new or expansion of existing service models to people in this target group.

Due to the rapid expansion of HACC funds to this target group in recent years it is proposed that the service system development be consolidated, within the context of the broader homeless and insecurely housed service sector, over the next three years to allow funded agencies to evaluate the service delivery models and ensure that HACC service initiatives are meeting the needs of those in the HACC target group. Further work with the broader sector, agencies and DHS, to facilitate access to HACC services for this target group, will continue over this consolidation period.

3.4.1.5 WMR Koori HACC needs analysis project

In the past a clear profile of HACC eligible ATSI population in the WMR has not existed. In 2001-02 statewide consultations with Koori groups identified the need to carry out a needs analysis. The aim of the needs analysis was to:

- Map the ATSI population in the WMR
- Identify access and equity issues for the ATSI populations in the WMR
- Determine current HACC service provision in the WMR
- Identify needs of the ATSI community in the WMR
- Inform decisions about service development and delivery.

The outcomes of this project have informed the planning and development process for HACC services to the ATSI community in the WMR.

3.4.1.6 Aboriginal Services Plan

The WMR has also been involved in the development of a WMR Aboriginal Services Plan that is a whole of DHS approach to developing and providing a full range of services to the ATSI community in the WMR. This has involved a collaborative approach between all sections of the Department.

3.4.1.7 Primary Care Partnership Community Health Plans

Primary Care Partnerships (PCP) Community Health Plans 2003-04

Brimbank-Melton Primary Care Partnership Community Health Plan identified the growth corridor as a priority due to the exponential growth expected to be experienced in the Brimbank-Melton areas and the recognised shortage of available resources to meet the needs of these communities. The plan also

identified that a large section of the population in Brimbank-Melton are young people aged between 12-24 years. Poor socio-economic status and lack of access to appropriate services have been identified as increasing risk factors associated with young people's health and wellbeing. A two-year health promotion strategy will be implemented to address the needs of young people. It was also identified that Brimbank-Melton have a high proportion of the ageing CALD population. Identified needs for this community are social isolation, lack of transport, shortage of bilingual workers/interpreters and a low health status. Health promotion strategies will look at addressing these needs and service coordination strategies will be targeted at identifying gaps in services.

The Moonee-Valley Melbourne Primary Care Partnership Community Health Plan identified the strengthening of partnerships and the development of collaborative approaches between the primary care sector and general practitioners as a major priority. It also identified the need to further service coordination and program development between the primary care and the acute/subacute sector to reduce hospital demand and promote a preventative focus to health care provision. The Community Health Plan also identifies Moonee-Valley Melbourne PCP's ongoing development of service coordination activities, integrated service planning and health promotion.

WestBay Alliance Community Health Plan identified community building and community connectedness as a priority. This builds on work that is currently being done through neighbourhood renewal to ensure people are aware of services that are available, and that service gaps and client needs are identified. The Community Health Plan also identified carer's information for general practitioners. A large number of carers reside in the WestBay catchment area and are unaware of the services available to them. As general practitioners are the most important link to the service system for carers, it is a high priority to ensure that general practitioners are aware of what is available. WestBay will also focus on ensuring the sustainability of the reform of primary care and the continued improvement of the primary care systems for the local community.

3.4.2 Regional HACC Planning Context

This section describes the specific factors taken into consideration in the planning for both the expansion of services through growth funds and the further development of the HACC sector.

The planning process for HACC has been influenced by the following HACC initiatives/factors:

- Base recurrent funding per capita (that is funds allocated to agencies in previous years) in each of the local government areas. Working toward equitable access to services for people regardless of where they live within the WMR is a priority for the Region
- The health and well being of populations, (whilst the WREN is a weighted resource allocation formula which takes into account socio-economic and health status, other factors also need to be considered such as people's knowledge of the HACC service system, one's ability to navigate the service system, language barriers, homelessness and living arrangements. These are also factors, which impact on a person's need for Government subsidised services)
- Population growth in the HACC target group, specifically within the next three years

- Groups with special needs within the HACC target group, e.g. ATSI people, people from a CALD background
- Consideration of the needs of all people who fall into the HACC target group
- Service usage data, for those groups who are under-represented as HACC service users comparative to population and ethnicity statistics.

The Region will expand the service system resourcing positions within the Region. This will support the development of the service system to increase access to services for those populations currently under represented in specific HACC basic type activities like, Property Maintenance, Personal Care, Home Care etc.

3.5. Data

3.5.1. Population

The data in Section 3.5.1 builds a picture of the HACC population across the Region. This picture is important in helping to identify where the likely pressures will be on the service system over 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 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 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+
Brimbank	23,350	49.5%	23,923	50.2%	24,500	50.9%
Hobsons Bay	12,429	57.9%	12,560	57.8%	12,723	57.8%
Maribyrnong	11,734	62.6%	11,802	62.1%	11,896	61.7%
Melbourne	3,966	46.5%	4,042	46.1%	4,126	45.7%
Melton	4,769	37.3%	5,117	37.5%	5,502	37.8%
Moonee Valley	16,370	60.9%	16,491	60.9%	16,635	61.0%
Wyndham	8,293	39.2%	8,627	39.2%	8,991	39.3%
Total	80,911		82,563		84,374	

* 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.

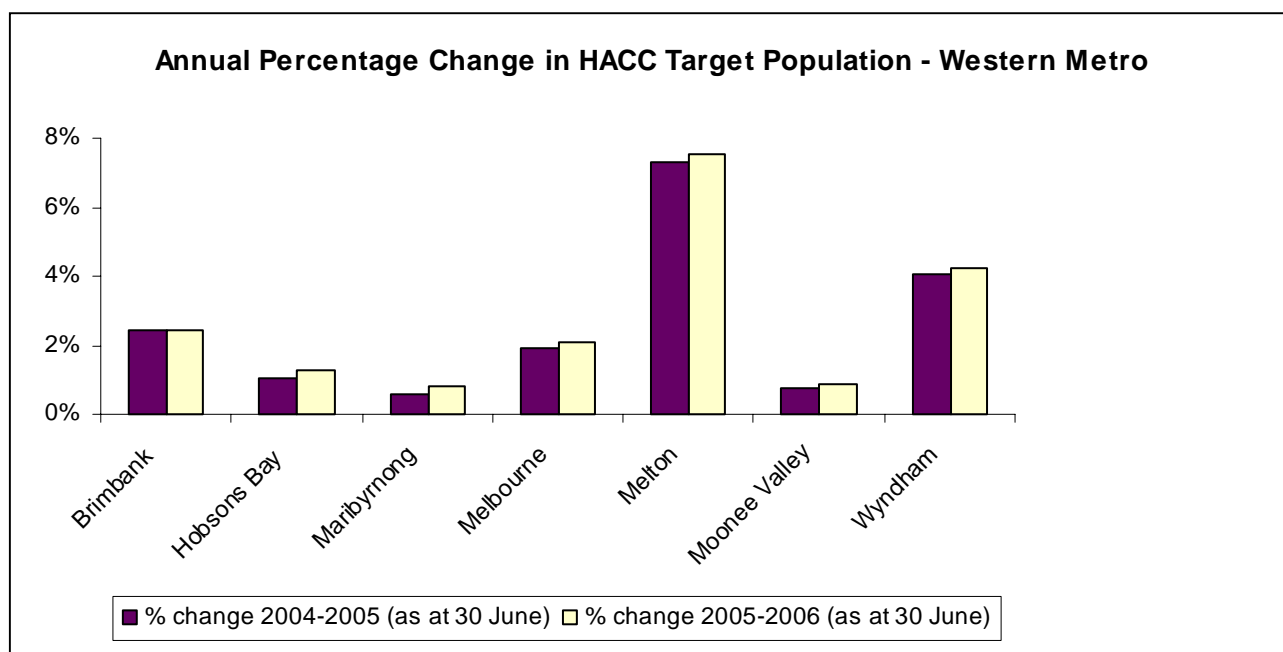


Figure 3.2: Annual percentage change in the growth in HACC target population by local government area

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.

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 at home by local government area. Language spoken at home has been used as a proxy for cultural identification.

Regional data analysis regarding people from CALD is provided in Section 5.4.

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

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

Table 3.2: Experimental estimates of total Indigenous population

LGA	0-49	50-69	70+	Total
Brimbank	512	29	2	543
Hobsons Bay	270	22	6	298
Maribyrnong	244	39	3	286
Melbourne	172	20	1	193
Melton	296	25	6	327
Moonee Valley	270	34	6	310
Wyndham	567	30	4	601
TOTAL	2331	199	28	2558

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.

Further regional specific ATSI information is provided in Section 5.5.

3.5.2. Service provision

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

Figures 3.3 – 3.9 below show the per capita service provision of 'Priority 1' activities by local government area. The per capita data is derived from the HACC MDS divided by the HACC target population (WREN) for each local government area. The line across the bars represents the metropolitan average. Figures 3.3 – 3.9 provide a picture of the relative levels of service across each local government area, and relative to the metropolitan average.

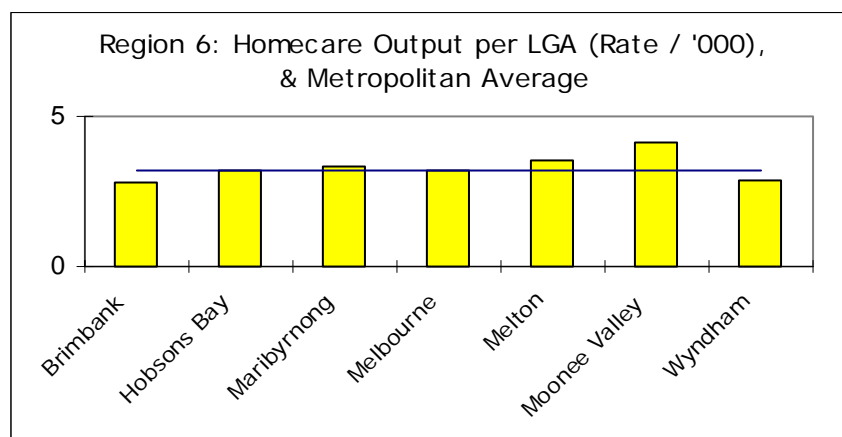


Figure 3.3: Hours of Home Care per 1,000 target population

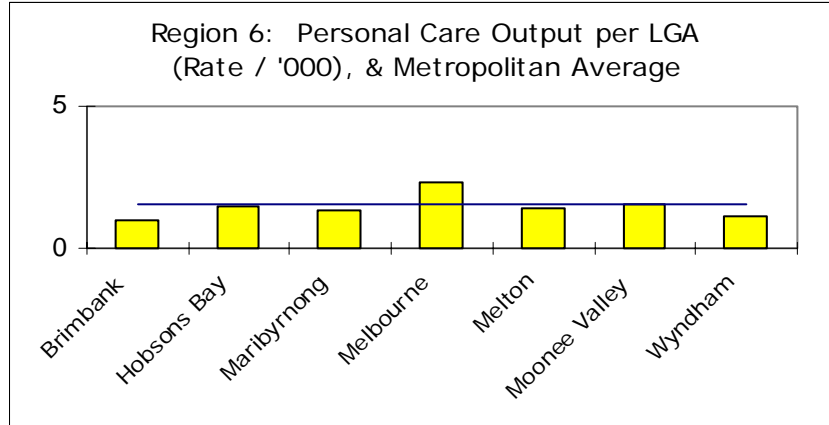


Figure 3.4: Hours of Personal Care per 1,000 target population

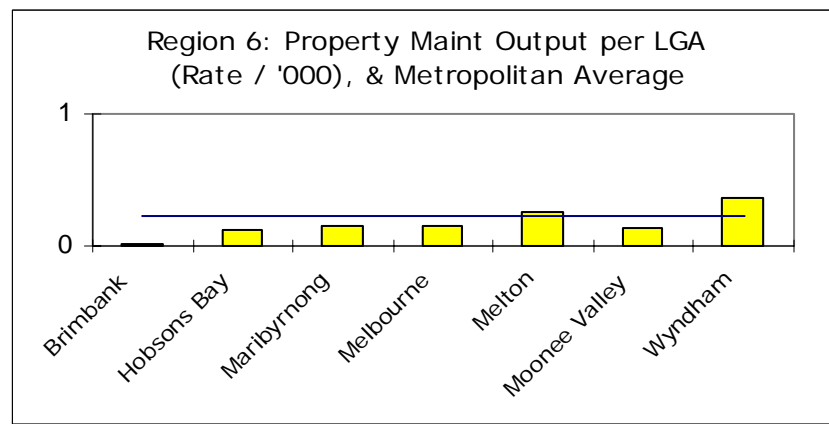


Figure 3.5: Hours of Property Maintenance per 1,000 target population

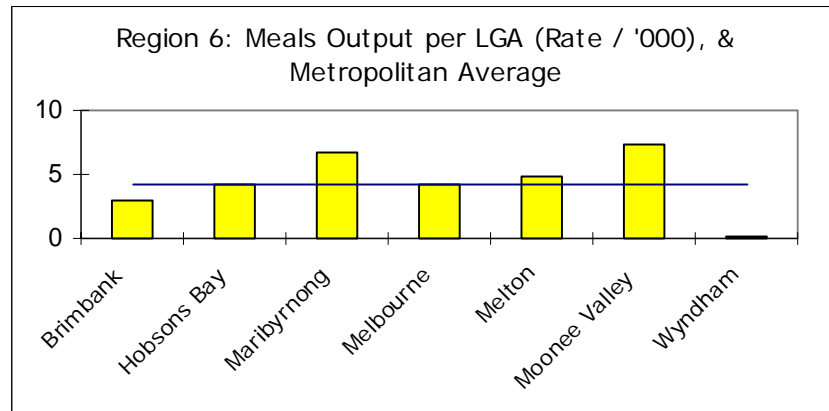


Figure 3.6: Meals per 1,000 target population

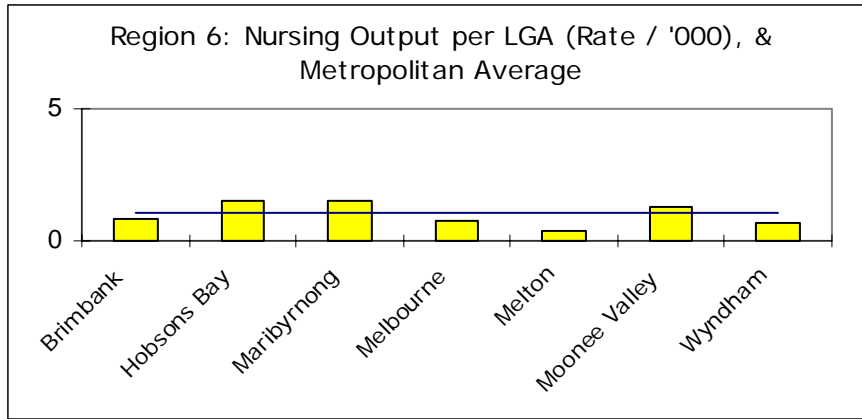


Figure 3.7: Hours of Nursing per 1,000 target population

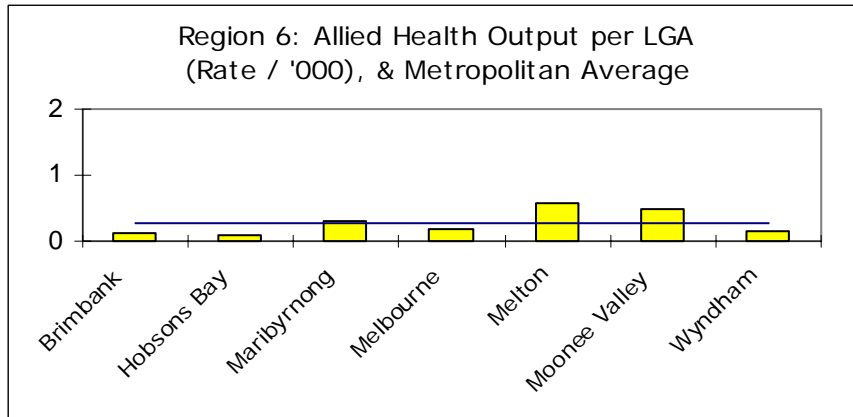


Figure 3.8: Hours of Allied Health per 1,000 target population

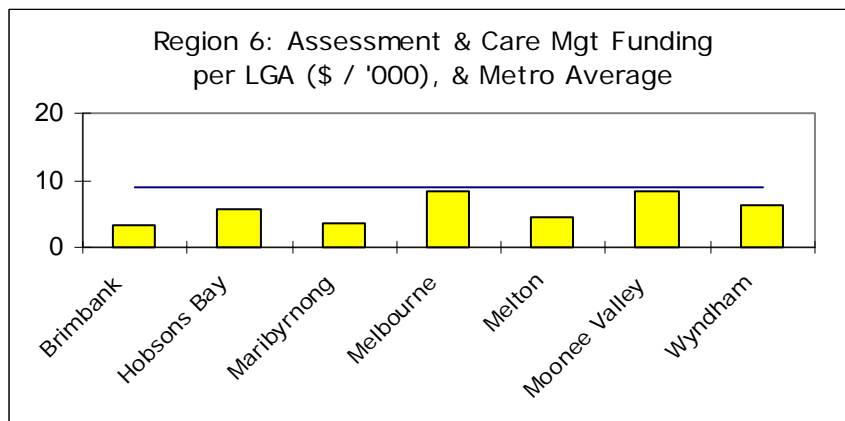


Figure 3.9: Dollars of Assessment and Care Management per 1,000 target population

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 columns 4 and 5 in 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

Local government area	Recurrent \$ 2002-03	Current \$ per capita	% of recurrent budget (2002-03)	WREN 2003-04
Brimbank	\$8,707,153	\$373	23.7%	28.9%
Hobsons Bay	\$6,160,532	\$496	16.8%	15.4%
Maribyrnong	\$5,703,232	\$486	15.5%	14.5%
Melbourne	\$2,889,741	\$729	7.9%	4.9%
Melton	\$1,735,839	\$364	4.7%	5.9%
Moonee Valley	\$7,864,743	\$480	21.4%	20.2%
Wyndham	\$3,655,216	\$441	10.0%	10.2%
Total	\$36,716,457	\$454	100.0%	100.0%

Figure 3.10 shows the relative gap between the distribution of recurrent funding and the distribution of the HACC target population (WREN) 2003-06. This information has guided the regional recommendations about the application of growth funds for equalisation across local government areas.

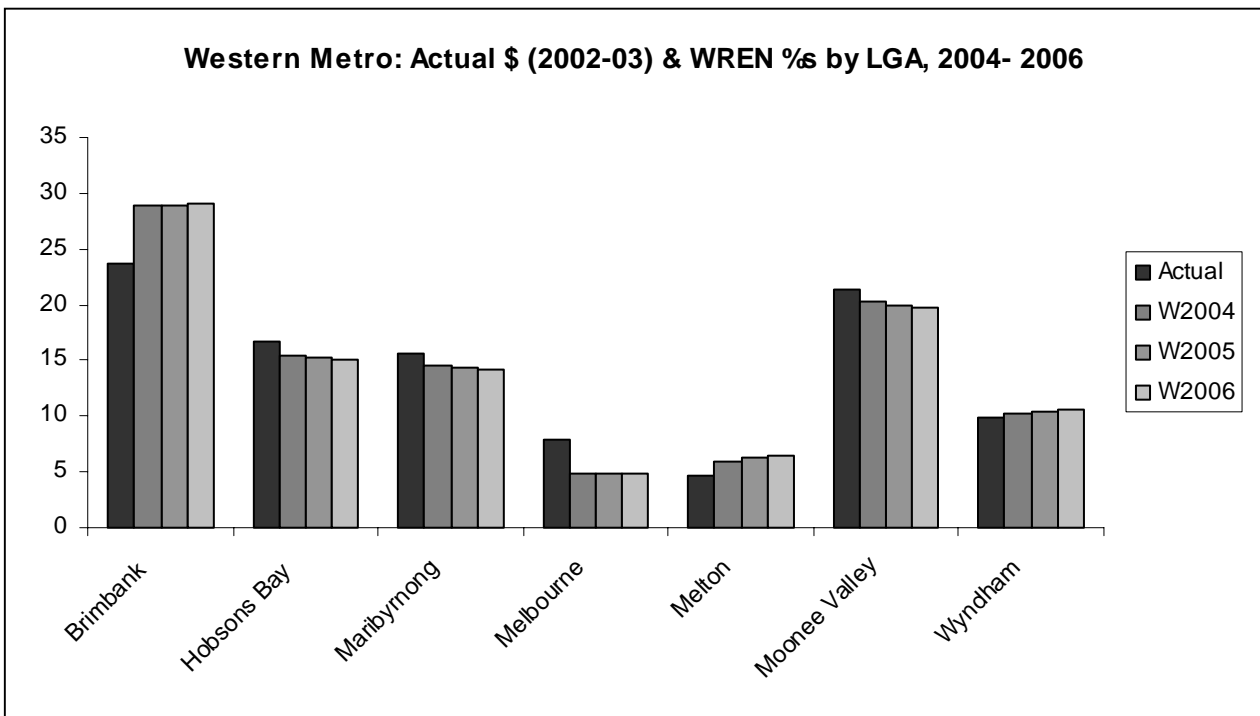


Figure 3.10: Proportion of actual recurrent budget (30 June 2003) and WREN population proportions 2003-06 by local government area

Section 4 - What do the data tell us?

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

4.1. Primary data analysis

The analysis of the primary data (population, service provision and funding shown in Sections 3.2 - 3.4.) indicates the following:

- Whilst the RREF allocation between Victorian regions indicates that WMR as a whole is comparatively under-resourced, intra-Regional per capita funding data indicates that there are three local government areas currently comparatively under resourced within the WMR. The WREN allocation analysis shows that Brimbank is substantially under-funded, followed by Melton and Wyndham. It is proposed that growth budget allocations will be used to redress intra-Regional inequity.
- Each area will experience growth in their WREN population in the next three years. This is the primary reason that only growth funds will be used to address inequity. The primary data shows that there are significant ATSI populations in WMR that are further explained in Section 5.5.3.
- MDS data shows that the areas of Brimbank, Melton and Wyndham appear consistently under the metropolitan average for service provision for most of the HACC Basic and health activities presented in Section 3.5.2.
- The primary data also shows that people of a CALD background are under represented in the HACC basic and health activities in comparison with the English speaking population.

4.2. Additional information to supplement the primary data

In addition to the primary data, other data has been examined to enhance the picture of the Region. This data has been documented in Sections 3.2-3.4 and is summarised here.

Whilst the MDS (service output) data indicates which local government areas are providing a lower amount of service than the metropolitan average, the validity of this data can be affected by a number of variables between quarters. This data, taken from two quarters (July–December 2002), and annualised provides a ‘snap shot’ of service provision at a particular period of time. WMR found the funds provided per capita by activity type compared to the metropolitan average by activity type, to be a more robust guide of current resource allocation and provides an indicator of where additional funds might be required.

MDS data shows that CALD populations are under represented in HACC basic and health activities. Further data about the size of specific CALD populations, age, health and broader familial issues have been used in considering the HACC service needs of this population.

The WMR Koori HACC Needs Analysis project has been used to consider potential HACC eligible ATSI clients’ knowledge of services available, determine their current utilisation of HACC services and identify the current need for HACC related services in the WMR ATSI communities. The data indicated that agencies

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lacked knowledge about the ATSI population including what is available. It was evident that there was no obvious point of entry into the HACC service system for the ATSI population in the WMR.

4.3. Conclusion

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

Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
Ministerial Priority 1	Ensure equitable access to HACC services for people living within WMR.	3-10 years	Apply growth funds to activity types where data indicates that per capita funds are lower than metro and Regional averages. Use growth funds to incrementally increase under-resourced local government area budgets to WREN formula percentages.	Equitable allocation of resources throughout the WMR, resulting in equitable access to services for HACC eligible clients regardless of where they reside.
Ministerial Priority 1	Increase HACC Response Service across Region	2003-06	Increase is proportional to reallocation of Personal Alert Victoria (PAV) units (funded by Aged Care)	Increased client numbers across Region. More services provided
Ministerial Priority 2	Increase service access and usage for and by HACC eligible CALD populations in WMR.	2003-06	Increase service access and usage for/by CALD populations in WMR by enhancing links between culturally specific gateways to HACC (usually ethno-specific services) and HACC basic/health service providers. This will be achieved by funding a Regional Service System Resourcing position to support systemic change to create a greater awareness of and access/gateway to HACC services and culturally appropriate service delivery for people of a CALD background.	Higher level and more sustained usage of HACC service by HACC eligible people from a CALD background.
Ministerial Priority 2	Increase HACC service access and support establishment of new programs for new and emerging HACC eligible CALD populations in WMR	2004-06	Support and establish links to social support activities and HACC basic services for new and emerging CALD communities within WMR.	Greater use of HACC services by identified small and emerging communities with limited networks and knowledge of services available via the HACC Program.
Ministerial Priority 3	Increase access to and usage of HACC services for ATSI people living in WMR.	2004-ongoing	Fund a Regional ATSI specific Assessment and Care Management position to improve access to and utilisation of HACC services for the ATSI community in WMR.	Higher level of HACC service usage by HACC eligible ATSI peoples in WMR.
Ministerial Priority 1, 2 and 3	Provide training to support services to work toward the implementation of strategies, two and three (above).	2004-ongoing	Increase the WMR HACC training budget to expand training within the Region to support the strategies two and three listed above.	Regionally identified training provided to management and direct care staff. Feedback on training received and subsequent training requests considered by the WMR HACC Training Advisory Committee.

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Priority	Strategy	Timeframe	Strategy Description	Anticipated Outcome
Regional development initiative – Service Development Grant	To further develop work on the implementation of service coordination.	January – July 2004	To complete developmental work within the three WMR PCP's targeting the care planning component of service coordination by exploring the role of the keyworker, PPS's about development of care plans with carers/clients inputs, ensure privacy requirements are met within multidisciplinary care planning, how collaboration with G.P's will occur, business rules around reviewing clients within the context of service coordination, initiation of reassessments and providing feedback to referral agencies.	Agreed and documented Practices, Processes, Protocols and Systems by the PCP's in the WMR regarding the Care Planning component of service coordination.

Note: Please refer to Section 2, Page 6 for an overview of the Ministerial priorities.

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

In developing the Region’s recommendations the following criteria were taken into consideration:

- Analysis of data
- Analysis of funds inequity between local government areas
- Growth allocation for each local government area
- Special needs in the Region and 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.

5.2. Recurrent growth allocations

Table 5.1 identifies the Commonwealth/State indicative recurrent growth allocations to the Region and local government areas for Priorities 1–3, subject to confirmation.

Table 5.1a: Indicative growth allocation by priority and local government area

2003-04	Priority 1 (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Brimbank	\$ 618,117	\$ -	\$ -
Hobsons Bay	\$ 130,311	\$ -	\$ -
Maribyrnong	\$ 143,404	\$ -	\$ -
Melbourne	\$ -	\$ -	\$ -
Melton	\$ 134,704	\$ -	\$ -
Moonee Valley	\$ 188,307	\$ -	\$ -
Wyndham	\$ 152,644	\$ -	\$ -
Region Wide	\$ 30,500	\$ 80,000	\$ 80,000
Total	\$ 1,397,987	\$ 80,000	\$ 80,000

Table 5.1b: Indicative growth allocation by priority and local government area

2004-05	Priority 1 (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Brimbank	\$ 544,670	\$ -	\$ -
Hobsons Bay	\$ 100,107	\$ -	\$ -
Maribyrnong	\$ 108,307	\$ -	\$ -
Melbourne	\$ -	\$ -	\$ -
Melton	\$ 136,217	\$ -	\$ -
Moonee Valley	\$ 150,053	\$ -	\$ -
Wyndham	\$ 148,876	\$ -	\$ -
Region Wide	\$ 25,500	\$ 70,000	\$ 70,000
Total	\$ 1,213,729	\$ 70,000	\$ 70,000

Table 5.1c: Indicative growth allocation by priority and local government area

2005-06	Priority 1 (incl Training and HACC Response Service)	Priority 2 CALD	Priority 3 ATSI
Brimbank	\$ 592,223	\$ -	\$ -
Hobsons Bay	\$ 128,842	\$ -	\$ -
Maribyrnong	\$ 128,756	\$ -	\$ -
Melbourne	\$ -	\$ -	\$ -
Melton	\$ 158,922	\$ -	\$ -
Moonee Valley	\$ 175,378	\$ -	\$ -
Wyndham	\$ 175,434	\$ -	\$ -
Region Wide	\$ 26,500	\$ -	\$ 80,000
Total	\$ 1,386,055	\$ -	\$ 80,000

5.3. Priority 1

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

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

- Should funds equalisation be applied?
- What should be proposed in order to best meet the needs of the HACC target population?

5.3.1 Funds equalisation or not?

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

Specifically, funds equalisation across the WMR local government areas has been recommended for 2003-04 for the following reasons:

- Presently there are three local government areas that appear under resourced within the Region when the recurrent allocation of funds for each local government area is compared with proportions indicated by WREN populations. These local government areas are Brimbank, Melton and Wyndham.
- The WREN percentage for Brimbank is 28.9% compared to the current allocation of recurrent HACC funds at 23.7%. The difference of 5.2% between the WREN and the present recurrent allocation represents a large amount of funding (approximately \$1.9 million). Equalisation for this area would need to occur incrementally, as the capacity to increase services is limited by access to staff and infrastructure and the limitations of the annual Regional budget allocation. The provision of Regional equalisation funds to this area commenced in 2002-03 and will continue over a number of years.
- The WREN percentage for Melton is 5.9% and the current allocation of recurrent funding to the area is 4.7% of the WMR HACC budget, which represents approximately \$440,000 in funding. Melton has an increasing population, so it is important to increase the growth allocation to this area to ensure that HACC resources keep pace with the population demand.
- Wyndham is marginally under resourced compared to the other local government areas within the Region, when the WREN percentage allocation is compared to the current allocation of funds. The WREN indicates that Wyndham should receive about 10.2% of the Regional growth budget. However the allocation is presently 10% so this represents an under allocation of approximately \$73,000. It is proposed that the total growth allocation will be addressed incrementally, as with the other areas within the Region.
- Funds equalisation through HACC growth funding for 2003-04 is recommended for the Brimbank, Melton and Wyndham local government areas.

5.3.2. Recommended expansion of activities – Priority 1

Following the data analysis and conclusions described in Section 3 and 4, the Region recommends the following activities for expansion.

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

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The following tables show a summary of the expansion in activities for 2003-06.

Table 5.2.a: Recommended expansion of activities (all Priorities), 2003-04

Activities	Units	\$
Home Care	10169	248,530
Personal Care	13201	368,836
Property Maintenance	704	25,027
Allied Health	1916	137,511
Nursing	5600	352,016
Delivered Meals	14000	17,220
ACM	-	218,350
SSR Training	-	8,000
SSR HACC Response Services	-	22,500

Table 5.2.b: Recommended expansion of activities (all Priorities), 2004-05

Activities	Units	\$
Home Care	7074	177,182
Personal Care	13346	382,230
Property Maintenance	522	19,019
Allied Health	2553	187,811
Nursing	4406	283,900
Delivered Meals	29785	37,551
ACM	-	100,515
SSR Training	-	3,000
SSR HACC Response Service	-	22,500

Table 5.2.c: Recommended expansion of activities (all Priorities), 2005-06

Activities	Units	\$
Home Care	5664	145,412
Personal Care	18463	542,001
Property Maintenance	578	21,586
Allied Health	3236	244,007
Nursing	4274	282,279
Delivered Meals	75567	97,653
ACM	-	26,617
SSR Training	-	4,000
SSR HACC Response Service	-	22,500

5.3.5. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Home Care (hours)	Personal Care (hours)	Property Maintenance (hours)	Allied Health (hours)	Nursing (hours)	Delivered Meals (meals)	Assessment & Care Management \$	Service System Resourcing \$
Brimbank	Brimbank City Council	Direct						14000	\$65,024.49	
Brimbank	MECWA Community Care	Direct	5249	5800					\$45,000	
Hobsons Bay	Hobsons Bay City Council	Direct		2219					\$8,085.75	
Maribyrnong	Maribyrnong City Council	Direct	1044	915					\$18,776.00	
Melton	Melton Shire Council	Direct	631	600					\$21,703.86	
Moonee Valley	Moonee Valley City Council	Direct	1518	1719	704				\$3,746.71	
Wyndham	Wyndham City Council	Direct	1727	1948					\$56,013.21	
Brimbank	RDNS	Direct					1996			
Hobsons Bay	RDNS	Direct					958			
Maribyrnong	RDNS	Direct					1170			
Melton	Djerriwarrah Health Service	Direct				350	886			
Moonee Valley	RDNS	Direct					590			
Brimbank	ISIS Primary Care	Direct				1046				
Moonee Valley	Doutta Galla Community Health Service	Direct				520				
Hobsons Bay	Western Region Health Centre	Direct								
Moonee Valley	Western Region Health Centre	Direct								
Region-wide	Council on the Ageing (SSR training)	Direct								\$8,000
Region-wide	(HACC Response)	Direct								\$22,500
Total Allocated			10169	13201	704	1916	5600	14000	\$218,350	\$30,500

Stakeholders indicated a 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.

5.4.1.1 Regional overview

A WMR Primary Care Partnership project, *Western Metropolitan Region Culturally and Linguistically Diverse Aged Care Strategic Plan 2003 – 2008* was undertaken during 2003 by Katherine Wositzky from Katherine Wositzky Social Research. Regional and local demography of the CALD elderly was sourced from the ABS census 2001. A further data set describing the CALD elderly population has been provided from ABS Census 2001 data in Appendix C. The figures and percentages in the two data sets are slightly different due to different methodology in using the data. However, the overall inferences are the same in both data sets. Therefore, as the regional data has been widely disseminated in the Region and is being used by agencies, the Region has elected to use this data in this plan. The Region has elected to use this data in this plan.

Based on country of birth, 44% of the 65+ population in WMR are people from a CALD background (ABS Census 2001). This has increased by 28% from the previous census in 1996. For the 70+ CALD population it is even more significant, with a 64% increase recorded since the 1996 Census.

CALD communities are experiencing disadvantage in accessing HACC services due to a range of issues that have been documented. These include: language barriers, poor intake or referral experiences, lack of knowledge of services available and lack of culturally sensitive service provision. Currently, people from CALD backgrounds are under-represented in HACC basic services including, Home Care, Personal Care and Delivered Meals.

In WMR the Ethnic Services Network (ESN) is the major regional forum representing ethnic social support services. The ESN is a mechanism for informing consultation around allocation of growth HACC funds for the CALD and mainstream sector, based on the needs of local communities and services, gaps in service provision and local priorities. The regional office also consults the Aged Services Network in the planning and development of funding priorities.

5.4.1.2 HACC funded ethno-specific agencies

Currently WMR funds 23 agencies to provide culturally appropriate social support and volunteer coordination services to CALD communities within the Region.

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The following table shows the agencies and communities funded.

Funded Agency Name	Communities
Association of Ukrainians in Victoria	Ukrainians
Australian Croatian Community Services	Croatian
Australian Greek Welfare Society Ltd	Greek
Australian Polish Community Services Inc	Polish
Australian Romanian Community Welfare, Health & Services Association of Victoria Inc.	Romanian
Australian Vietnamese Women's Welfare Association	Vietnamese
Co As It Italian Assistance Association	Italian
Federation of Spanish Speaking Senior Citizens Centre Vic.	Spanish Speaking
Filipino Community Council of Victoria Inc	Filipino
Finnish Friendly Visiting Service	Finnish
Gateway Social Support Options Inc	Vietnamese
Horn of Africa Senior Women's Program Inc	Horn of Africa Senior Women's Program Inc
Macedonian Community Welfare Association Inc.	Macedonian
Maltese Community Council of Victoria Inc.	Maltese
Migrant Resource Centre, North West Region Inc.	German, Lao Elderly, Coptic Elderly, Horn of Africa Men's Group, Indian, Sri Lankan, Turkish
Russian Ethnic Representative Council of Victoria	Russian
Serbian Social Services and Support Inc	Serbian
Sokol Melbourne Inc.	Czechoslovakian
Spanish Latin American Welfare Centre (CELAS)	Spanish Latin America
Victorian Arabic Social Services Inc	Arabic
Victorian Elderly Chinese Welfare Society Inc	Chinese
Vietnamese Community in Australia/Victoria Chapter Inc.	Vietnamese
Yarramar Aged Care Services - Gwennap Home for Aged	Vietnamese

WMR based ethno-specific agencies are not funded to deliver HACC basic services, such as Home Care, Delivered Meals, Property Maintenance etc.

5.4.1.3 Current initiatives within WMR

WMR has commissioned the following projects to inform CALD HACC development in the Region:

- CALD Aged Care Strategic Plan 2003 – 2008 (CALD Report) to develop a five year plan which will focus on primary care services supporting elderly people of CALD backgrounds to remain living at home. Although the project is planned for completion in late June 2003, this project has provided useful information and has identified a range of issues (managed by Moonee-Valley/ Melbourne PCP).

- Improving the Focus on CALD Needs in Initial Contact & Initial Needs Identification project, December 2002 (managed by Moonee-Valley/Melbourne PCP).
- HACC Cultural Planning Tool. All of the agencies in the WMR that receive HACC funding (approximately 69 agencies) have developed HACC Cultural Plans for their services, which outline strategies and actions to be taken, to meet the needs of people from CALD backgrounds.
- The National Ageing Research Institute (NARI) reports on (1) *Demand for HACC services in the WMR* and the (2) *HACC Strategic Plan for the WMR 2000 -2005*, have been major works in the Region researching HACC service provision. These reports highlighted the under-usage of HACC services by people of CALD backgrounds and also the disadvantage and special needs of elderly people of CALD backgrounds. (HACC Strategic Plan for the WMR 2000–2005, NARI 2001).

At a regional level Primary Care Partnerships' attention to people aged 65+ of CALD backgrounds has been inclusive throughout all of the service coordination projects. In addition, some specific projects focusing on CALD issues concerning delivery of services to people of CALD backgrounds have been completed or are currently being implemented.

5.4.1.4 Key issues in service provision

Regional projects have documented the difficulties experienced by CALD groups in accessing HACC services due to language barriers. Gaps in CALD sensitive best practice have also been identified by a number of mainstream services (CALD Aged Care Strategic Plan 2003-08). There is a need to develop and maintain the skills associated with cultural competency, especially at the assessment stage. This is particularly the case for mainstream HACC agencies that are funded for this activity. (Improving the Focus on CALD Needs in Initial Contact & Initial Needs Identification Project Dec. 2002).

Many staff who are sole workers, or who work in smaller agencies, find it difficult to balance the needs of service provision against initial contact, DHS accountability requirements, agency management requirements and culturally appropriate and responsive client referral. In addition, the training and networking requirements of the HACC role are often sacrificed in the interests of meeting client needs.

Through the Culturally Equitable Gateways strategy, DHS has acknowledged the difficulty of small agencies in being able to work beyond their own agency practice. Additional funding will be made available to support agencies to work with other agencies to effect broader system change that might assist better practice and enhance access to HACC Basic services by the CALD community.

Elderly people of CALD backgrounds, especially from new and emerging communities, may lack knowledge of services, and not know or understand how to access the service system. Many consumers have a preference for and use ethno specific services as a point of contact for entry into the broader service system, because of common language and social networks. Issues of access through other services are impacted by isolation due to language, community fragmentation and limited social networks.

A need for practical resource sharing has become evident through consultations with the ethno-specific sector agencies and local government. This partnership building could include sharing agreed processes, practices and protocols and conducting regular agency displays and exhibitions. These strategies can work towards supporting an improved knowledge of client need and client pathways to support the development of more appropriate service provision for CALD clients.

5.4.1.5 The CALD community in WMR

The diversity of countries of birth and languages in the WMR spans 135 countries and 80 languages spoken at home. This diversity includes some better-established communities, language groups and new and emerging communities. People from these communities have varied cultural, linguistic, educational and social backgrounds.

Data Limitations WMR CALD Aged Care Strategic Plan 2003-08.

Accuracy of service use data is also dependent on the consistency of service providers in completing cultural identity information on their clients. Major improvements have been made in this area however some data collections are still incomplete. The discussion about CALD has referred to:

- the number of people born in a non-English speaking country
- the number of people within the LGA who speak a language other than English

Table 5.3 below, based on numbers of people born in a non English speaking country, shows that elderly people of CALD backgrounds are represented within all the local government areas in the Region. The highest numbers (2001) can be found in: Brimbank (65%), Moonee Valley (41%), Maribyrnong (40%), and Hobsons Bay (37%).

The ten most recorded languages (other than English) spoken at home in each local government area are outlined in Table 5.4.

Table 5.3 COB of 65+ BY LGA FOR 2001 & 1996

LGA	65+ NESCOB 1996	% TOTAL 65+ POP 1996	% OF WMR 65+ CALD POP 1996	65+ NESCOB 2001	% TOTAL 65+ POP 2001	% OF WMR 65+ CALD POP 2001
Brimbank	7201	65%	34%	9779	65%	35%
Moonee Valley	5278	37%	25%	6435	41%	24%
Maribyrnong	3059	34%	15%	3419	40%	13%
Hobsons Bay	2953	33%	14%	3942	37%	15%
Wyndham	1224	31%	6%	1739	32%	6%
Melbourne	1063	22%	5%	1095	27%	4%
Melton	351	20%	2%	693	27%	3%
WMR	21129	39%	100%	27102	44%	100%

Source: ABS 2001 census

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Table 5.4: 2001 Census: Top 10 languages spoken at home by people aged 65+ in WMR (by place of usual residence)

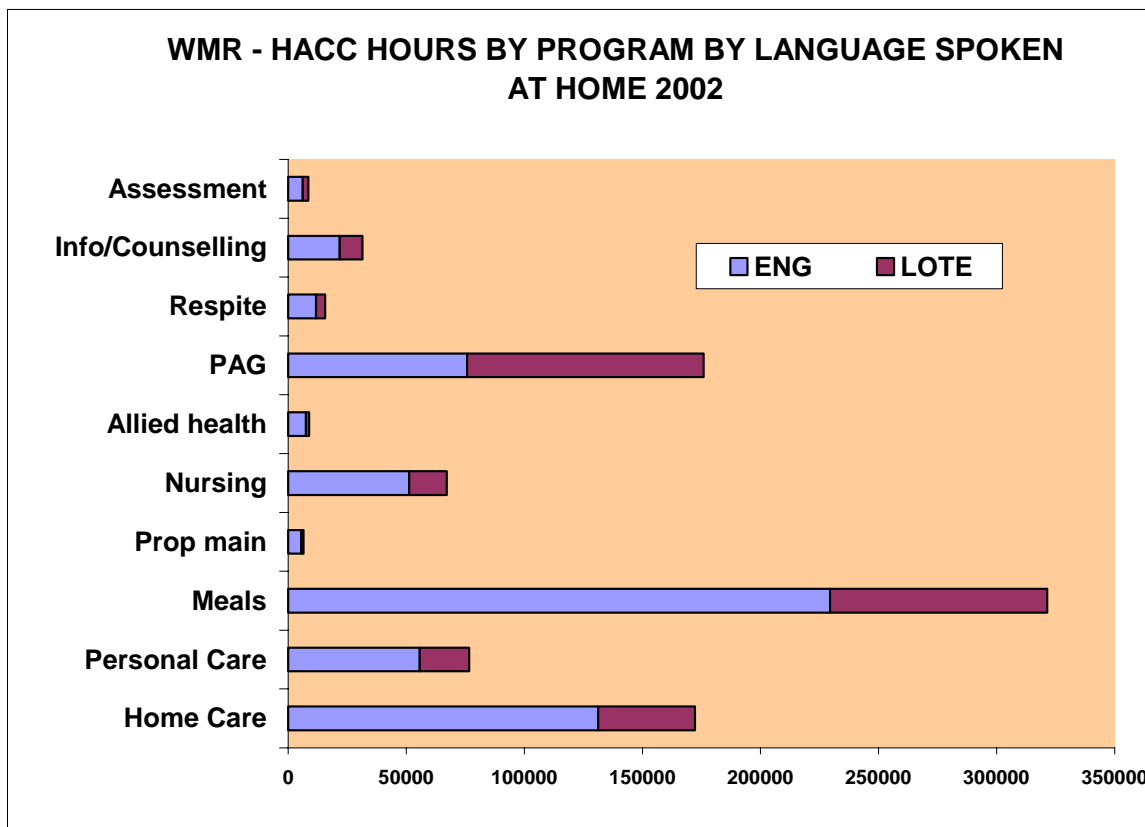
Language	Brimbank	Hobsons Bay	Maribyrnong	Melbourne	Melton	Moonee Valley	Wyndham	Total
English	4,849	6,383	4,643	2,228	1,817	8,687	3,553	32,160
Italian	1,507	1,074	772	263	77	3,048	689	7,430
Greek	1,055	459	500	66	30	637	99	2,846
Maltese	1,445	421	83	27	73	298	89	2,436
Chinese (ALL)	348	114	309	251	30	424	47	1,523
Vietnamese	581	69	457	33	3	176	24	1,343
Polish	708	210	180	22	28	140	48	1,336
Croatian	609	163	133	18	40	164	35	1,162
German	471	195	66	33	42	166	73	1,046
Macedonian	383	114	139	5	12	35	60	748
Ukrainian	291	69	59	6	6	150	10	591
Other	2,689	1,271	1,257	1,181	420	1,725	740	9,283
Total	14,936	10,542	8,598	4,133	2,578	15,650	5,467	61,904

Source: ABS 2001 Census.

5.4.1.6 Current service provision in the WMR

The MDS data (2002) indicates that the CALD elderly population are under-represented in HACC basic services broadly across the Region. The following chart shows the level of hours of HACC service activity provided by Language Other than English (LOTE) spoken at home across WMR.

Figure 5.1 WMR – HACC Hours by program by language spoken at home 2002



Source: HACC MDS 2002 (CALD Report)

* Please note that info/counselling refers to counselling, support, information and advocacy: This assistance type covers a number of supportive services to help clients and carers deal with their situation. It includes one-on-one counselling, advice, and information.

This clearly indicates that there is an under utilisation of core HACC services by the CALD communities with the exception of Planned Activity Groups (PAGs). A breakdown of this information by local government area level is provided in Appendix G.

5.4.1.7 Local government area breakdown of HACC usage

At a local government area level, there are a number of factors that influence greater proportional representation of people from a culturally and linguistically diverse background in HACC services. Some reasons include agencies being more successful in providing culturally responsive services, whilst other services are utilised more because greater numbers of CALD clients reside closer to the service outlet.

Table 5.5 shows the comparison between the percentage of people that speak a language other than English in each local government area and the percentage of

HACC clients that speak a language other than English. This indicates that clients from a CALD background are most under-represented in terms of service usage in the local government areas of Brimbank, Hobsons Bay and Melton.

Table 5.5 Comparisons of HACC clients 65+ who speak LOTE at home by LGAs

LGA	% LOTE HACC clients	% LOTE Pop
Brimbank	48%	65%
Hobsons Bay	17%	36%
Maribyrnong	22%	41%
Melbourne	32%	30%
Melton	7%	22%
Moonee Valley	27%	45%
Wyndham	19%	29%
WMR	27%	43%

Source: HACC MDS 2002 (CALD Report)

5.4.1.8 Established CALD communities

A number of the more established communities such as post war migrants are now ageing and may be requiring HACC services. Issues for these communities include: deteriorating health, reverting back to language of origin (due to ageing and dementia) and decreasing traditional family caring models. It is well documented that HACC activities act as preventative measures to assist people to maintain good physical, mental health and social links as their capacity to access the community independently and maintain their own home decreases.

5.4.1.9 New and emerging communities

There is limited projected and current data on the numbers, location, languages spoken and English proficiency of smaller and newly arrived communities in WMR. Information about new emerging communities and their potential HACC needs can be sourced from the Department of Immigration Multicultural and Indigenous Affairs (DIMIA) and through anecdotal evidence provided by agencies.

We do know that WMR continues to receive significant numbers of new arrivals settling in Australia under various immigration programs such as: family reunion and refugee and special humanitarian programs. Refugee and humanitarian migrants differ from other migrants in several respects. These migrants are likely to have suffered trauma and in many cases torture. They are also unlikely to be proficient in English; together these issues compound their capacity to access mainstream HACC services when they require them.

According to DIMIA settlement data between 01/01/1998 and 28/02/2003, a total of 339 people over the age of 65 settled in WMR. 37% of these people (126) were to settle in Brimbank (see Table 5.6).

Table 5.6 Number of migrants settling in WMR (01/01/1998 – 28/02/2003)

LGA	UNDER 65 YEARS	65 YEARS +	65+ AS % OF ARRIVALS IN LGA	TOTAL
Brimbank	4,483	126	2.7	4,609
Hobsons Bay	2,982	26	0.8	3,008
Maribyrnong	2,460	60	2.3	2,520
Melbourne	2,306	41	1.7	2,347
Moonee Valley	1,372	41	2.9	1,413
Melton	938	22	2.3	960
Wyndham	578	23	3.8	601
TOTAL	15,119	339	2.1	15,458

Source: DIMIA Settlement Database

Consideration needs to be given as to how these communities gain knowledge of and are linked into the HACC service system if and when they need access to HACC services.

5.4.2 Conclusions

The Region has a large CALD population that continues to increase. The profile of the Region's diverse population is not reflected in HACC service provision data. Lack of culturally appropriate services, lack of knowledge of available services and language barriers, attribute to the underutilisation of these basic HACC services. For ageing CALD communities, issues such as reverting to their language of origin and loss of traditional caring models compound the issue of access.

It is acknowledged that ethno-specific agencies perform an essential role in assisting CALD clients to access mainstream services. In the next three years the WMR HACC service system needs to be resourced to undertake a range of critical functions with the aim of enhancing the development of links and partnerships between ethno-specific agencies and mainstream services and to support agencies to reduce barriers to HACC services for people from a CALD background.

Recommendations for 2003-06 build on the capacity and strengths within agencies to enable a range of critical functions to be undertaken.

5.4.3 Project recommendations

The recommended projects for 2003-06 are:

5.4.3.1 Current CALD Equity and Access Position extension (additional recurrent funding 2003-04)

The recurrently funded HACC Equity and Access position plays an important role in supporting the Ethnic Services Network, developing regional ethno-specific policies, supporting agencies and providing an advocacy role in relation to the accessibility of HACC and Aged Care services for ethnic communities. Additional funding of \$10,000 is recommended to extend the capacity of this position.

5.4.3.2 CALD Community Development Officer (new fixed term recurrent position 2003-06)

The WMR CALD Community Development Officer will work with key stakeholders in WMR to identify priorities toward ensuring equitable access to HACC services for CALD clients within the HACC eligible target group. It will achieve this goal by

facilitating and strengthening the relationships and knowledge within the service system.

The work of the Community Development Officer will be supported and guided by a Steering Committee of key stakeholders.

Work will occur initially within a specific catchment area. Models developed will be incrementally implemented across the Region.

The position will work with existing networks, relevant equity & access support positions and be guided by Regional projects/reports and Cross Regional and Statewide CALD initiatives.

During consultations the sector indicated a preference for this position to be placed within DHS, WMR.

5.4.3.3 Emerging Communities Community Development Officer (new fixed term recurrent position 2004-07)

It is recommended that this position would work with new and emerging communities within WMR who may need HACC services but are not aware how to access them. This position will review the HACC basic needs of these new and growing communities. Within this project, support will be provided to establish links to facilitate access to social support and HACC basic services.

5.4.4. Allocation process, 2003-04

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

Catchment	Name of Agency	Allocation Method	Service System Resourcing \$
Regional	Dept. of Human Services, Western Metropolitan Region.	Direct	70,000
Regional	Migrant Resource Centre North West	Direct	10,000

Stakeholders generally agreed with the focus of proposals, however a concern that work of the role was too broad was expressed and that clearer objectives and parameters needed to be articulated. This will be addressed through the direction of a steering committee and development of a position work plan.

5.5. Priority 3

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

5.5.1. Introduction

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

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

5.5.2. ATSI statewide directions for service development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5.3. ATSI sector

5.5.3.1 Demographics of the ATSI Community

The *ABS Experimental Estimates of Indigenous Population (a) 30 June 2001* suggest that the ATSI population in Victoria is 27,928 people or 0.6% of the total population. ABS Population Projections indicate that the ATSI population in Victoria will increase by 48% between 1996 and 2006 (Effective Change, 2003).

The ABS and DHS recognise that the ATSI population identified through the 5-yearly *Census of Population and Housing* is an underestimate of between 50 and 100%, suggesting that the actual ATSI population in Victoria is between 41,892 (0.87% of the total population) and 55,856 (1.2% of the total population) (Effective Change, 2003).

The table below shows ATSI population data for local government areas within Victoria that have ATSI populations of over 100 people. All seven WMR local government areas are represented here.

Table 5.7: Number (over 100) and Percentage of ATSI People in Local Government Areas Studied for the Victorian ATSI HACC Needs Analysis Project

Local Government Area	Total Number of ATSI People	% of total Population
BSW		
Glenelg	274	1.35%
Southern Grampians	101	0.58%
Grampians		
Horsham	198	1.1%
North Grampians	110	0.8%
Hume		
Delatite	191	0.91%
Moira	254	0.94%
Mitchell	299	1.17%
Greater Shepparton	1,601	2.75%
Wangaratta	153	0.57%
Wodonga	333	1.03%
Loddon Mallee		
Campaspe	644	1.77%
Gannawarra	141	1.17%
Greater Bendigo	939	1.04%
Macedon Ranges	132	0.35%
Mildura	1,188	2.4%
Mt Alexander	103	0.6%
Swan Hill	935	4.4%
Western Region		
Brimbank	543	0.32
Hobsons Bay	298	0.35
Maribyrnong	286	0.46
Melbourne	193	0.37
Melton	327	0.61
Moonee Valley	310	0.28
Wyndham	601	0.68

Source: *ABS Experimental Estimates (a) 2001*
(Effective Change, 2003)

5.5.3.2 Regional overview of the ATSI Community

Figure 5.2 shows the ATSI population in WMR by local government area. Table 4 provides a visual comparison by showing the total WMR population by local government area.

Figure 5.2: WMR ATSI population: ABS Experimental Estimates (a) 2001

Indigenous Status | Indigenous | Sex | (All)

WMR ATSI Population: ABS Experimental Estimates (a) 2001

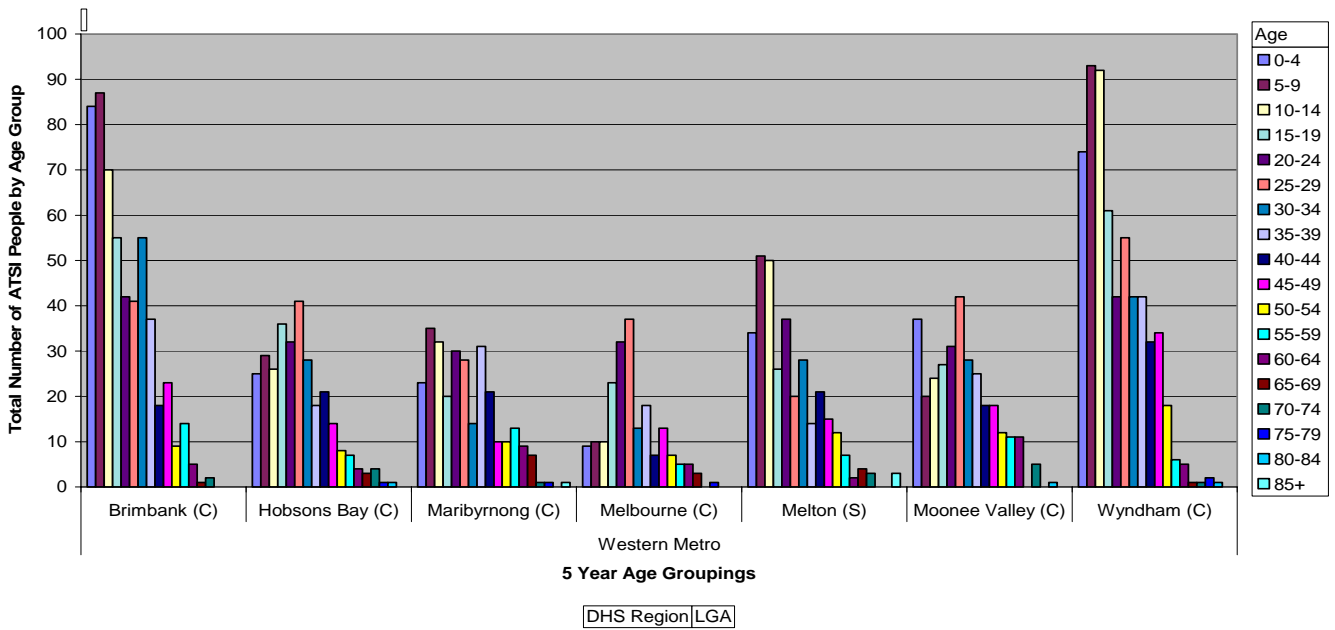
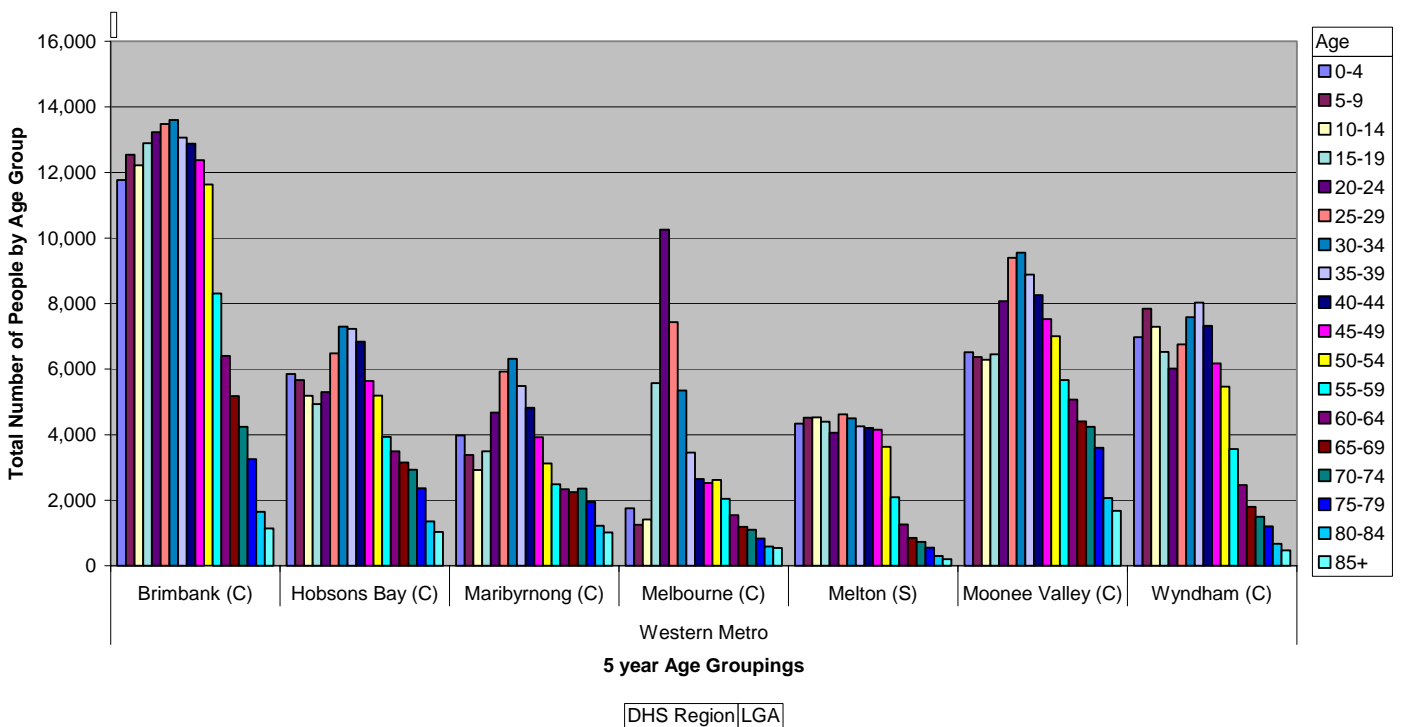


Figure 5.3: WMR population: ABS Experimental Estimates (a) 2001

Indigenous Status | (All) | Sex | (All)

WMR Population: ABS Experimental Estimates (a) 2001



The ATSI population data in Figure 5.2 shows the number of ATSI people living within each local government area based on the Australian Bureau of Statistics Experimental Estimates 2001. As Australian Bureau of Statistics figures are said to under estimate the number of ATSI people by 50% to 100%, this would suggest that the total ATSI population for WMR is between 3,837 and 5,116 people (Effective Change, 2003).

Within WMR the largest populations of ATSI people live within the local government areas of Brimbank (543) and Wyndham (601). The local government areas of Wyndham (0.66%), Melton (0.61%) and Maribyrnong (0.46%), have the largest percentages of ATSI people as a proportion of their total populations (refer to Figure 5.2).

Data for WMR shows that the ATSI population are a young population. Over half of the ATSI population is under 25 years of age. The age structure for the community is largely a product of high birth rates and relatively low life expectancies among ATSI people (Effective Change, 2003).

5.5.3.2 Service provision within WMR

Currently in the WMR there are 13 ATSI people accessing HACC basic services. There is one Planned Activity Group session funded in the WMR for ATSI people. This session runs one day per week and is provided by Aboriginal Community Elders Service (ACES). It has 6-12 regular participants.

The Aboriginal Community Elders Service is located within the Northern Metropolitan DHS Region of Melbourne. The WMR has no ATSI specific health service organisation.

In 2002 a group of ATSI and other community members formed to develop a business plan for a ATSI specific service in the WMR to provide access to drug and alcohol services, children's services, community health, HACC and a number of other health based services. This group will have a key role in establishing this new organisation by January 2004. The agency will operate from the Maribyrnong local government area and service the whole of the WMR. It is hoped that this ATSI specific service site will provide and promote access to health services for the ATSI communities in the WMR. The service site has been named the Indigenous Gathering Place.

5.5.3.3 Planning for ATSI HACC services in WMR

In the past an adequate profile of HACC eligible ATSI population in the WMR has not existed. In 2001-02 Statewide consultations with Koori groups identified that a WMR needs analysis should be implemented as a priority to identify the needs of frail aged and people with a disability from the ATSI community living in the WMR. The aim of the needs analysis was to:

- Map the ATSI population in the WMR
- Identify access and equity issues for the ATSI populations in the WMR
- Determine current HACC service provision in the WMR
- Identify needs of the ATSI community in the WMR.

A consultant was employed to carry out a project within the WMR as well as five other DHS Regions. A Statewide steering committee was established to oversee the six projects. Membership included:

- DHS regional staff representatives
- Members of the VICACD
- DHS Central Office staff representatives
- Non DHS regional steering committee member.

In addition to the Statewide Steering Committee, a WMR Steering Committee was also formed to oversee the development of the WMR Needs Analysis project. Membership included:

- Community Health Representative
- Koori HACC Metropolitan Liaison Officer
- Koori Specific Agencies
- DHS staff representatives including planning and HACC staff
- Indigenous Gathering Place Representatives
- Local Government representative.

The WMR Koori HACC Needs Analysis Project

The project findings reported that there are approximately 959 ATSI people in the HACC target group (the HACC target for the Koori community is defined as 50yrs+) within the WMR. It is expected that this will increase by approximately 100% over the next 20 years. The findings of this project have been incorporated into a three-year plan for the development and implementation of Koori HACC services in the WMR.

The largest populations of HACC eligible ATSI people are situated within the local government areas of Wyndham, Maribyrnong, Moonee Valley and Brimbank (Effective Change, 2003).

MDS and quarterly output collection data on service usage collected by agencies shows that currently there are 13 ATSI people from the WMR accessing HACC services (Effective Change, 2003). This represents a significant under utilisation of HACC services by this community.

WMR Aboriginal Services Plan

The Aboriginal Services Plan is a region-wide plan that includes a whole of DHS response to meeting the needs of the ATSI community in the WMR. (Please note that the WMR Koori HACC Needs Analysis partly informed the development of this plan).

Issues related to accessing HACC services for the ATSI community.

The Koori HACC Needs Analysis project highlighted that the usage of HACC services by the ATSI community within the WMR was low. One of the key reasons for low usage of HACC services is the issue of access. It has been well documented that ATSI people are reluctant to use mainstream services. Barriers identified include:

- Distance (for those living in rural and regional areas) and lack of access to transport
- Lack of access to general practitioners
- Lack of access to culturally appropriate services

- Distrust of services due to past experiences with services and institutions
- Lack of private health insurance and general economic disadvantage.

Other barriers that were identified by the ATSI communities to accessing HACC services included:

- Past experiences of racism or inappropriate responses from mainstream agencies
- Fear of mainstream services
- Systematic barriers such as waiting times and service delivery models
- Cost (there is a perception in the ATSI community that mainstream agencies charge fees and Koori agencies do not)
- Strong preference for ATSI workers particularly for in home services i.e. Home Care.

(Effective Change, 2003)

Issues to be considered when providing HACC services to the ATSI community.

The Koori HACC Needs Analysis project identified the following issues that need to be considered when providing and planning HACC services within the WMR:

- ATSI people need HACC services at a younger age and are more likely to require higher levels of service than the non-ATSI population, due to premature ageing and poor health status
- There will be a continual increase in the number and percentage of ATSI people entering the HACC target group and requiring HACC services
- Disease prevention and management are important components of meeting the needs of ATSI people in the HACC target group
- The number and location of ATSI people in the HACC target group (and their needs) needs to be better understood by HACC funded agencies
- Cultural and access issues cannot be ignored in the planning and delivery of HACC services to ATSI people. The vast majority of ATSI people choose to access HACC through Koori agencies, and often do not regard mainstream as an appropriate alternative. Those ATSI people wanting to access services through mainstream often face systemic and other barriers
- The distribution of ATSI people including very small pockets in rural and regional locations indicates that innovative approaches and service models are required to effectively meet their needs
- Within the ATSI community the needs of the individual are not regarded as separate from, or in isolation to, the needs of the family. HACC assessment and services must take into account the needs of the family.

(Effective Change, 2003)

Health and Well being of the ATSI Community statewide and in WMR

Available evidence suggests that ATSI people suffer a greater burden of disease than the rest of the population. The poor health and well being of the ATSI communities has been well documented and indicates that the ATSI community have a higher likelihood of need for HACC services.

Research shows health issues prominent in the ATSI community are:

- Illnesses such as diabetes, cardiac disease, cancer and obesity
- Disabilities including acquired brain injury often related to substance abuse
- mental health issues.

Other issues that may be experienced by members of the ATSI community are:

- Stolen Generation Issues
- Cultural and family disconnectedness
- Family violence
- Isolation and depression
- Frailty
- Carer issues (relating to caring of family members taking priority over having health issues investigated or diagnosed).
(Effective Change, 2003)

Socio-Economic Status of the ATSI Community

Victoria's ATSI population tend to live in urban areas, either in Melbourne or major regional centres. Their living arrangements are distinctive: ATSI people are less likely to own their own homes than non-Indigenous Australians (Effective Change, 2003) ATSI people are much more likely to live in large household groups and one-parent families.

ATSI households tend to have much lower incomes. The 1996 census data reported that nearly 50% of ATSI households had incomes of less than \$600 per week, compared with 42% of non-ATSI households (Effective Change, 2003).

5.5.3.4 Strategy to support HACC ATSI services in the WMR

Population data and projections indicate that the number of ATSI people entering the HACC target group will increase by more than 50% between 1996 and 2006 and continue to grow exponentially over the next 20 years, from 960 to approximately 1,920 by 2006, (Effective Change, 2003).

The objective of Priority 3 of the three-year Ministerial Priorities for HACC services (2003-06) is to "Increase the quality and quantity of HACC services for the ATSI community".

A planning workshop was conducted with key stakeholders in the WMR (April 2003) to confirm the findings, conclusions and recommendations of the WMR Koori HACC Needs Analysis project and consider actions required to implement the recommendations.

The complexity of issues that the findings identified and key stakeholders confirmed included:

- Low level of awareness within the ATSI community about the HACC program and what services it provides
- Low service usage
- Strong preference within the ATSI community for services to be delivered by a Koori specific agency.

(Effective Change, 2003)

It was agreed during the planning workshop that the goal over the next 3-5 years is to work towards a full range of HACC services for the ATSI community underpinned by the following principles:

1. Locally delivered services
2. An ATSI specific service site, which provides a point of entry to HACC services located in the WMR
3. Partnerships between the local Indigenous Gathering Place (ATSI specific service planned for the WMR), other ATSI agencies, mainstream providers and DHS.

(Effective Change, 2003)

The Indigenous Gathering Place was identified as the agency that will become the key access point to HACC services for the ATSI community. As the Indigenous Gathering Place will be a newly established agency, it was agreed at the planning workshops that it will be important to develop partnerships and links with current HACC service providers in order to support the agency's administrative infrastructure to comply with the mandatory HACC reporting requirements and the implementation of quality systems.

The HACC Training and Advisory Committee has also agreed that over the next three years there will be a commitment to providing ATSI specific training to support ATSI staff and provide education about the ATSI community to mainstream agencies.

5.5.4. Expansion of services

Over the next three years, the planning and development of HACC services for the ATSI community will need to consider the following;

- the increasing ATSI HACC target population
- the poor health and well being status of the ATSI community
- the limited community awareness of services available
- service providers limited awareness of the ATSI community in the WMR and their needs
- current low service usage by the ATSI community.

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

Based on the data analysis in this Section the following activities have been recommended for expansion.

Table 5.8 WMR Koori HACC three year strategy

Year one 2003-04	Year two 2004-05	Year three 2005-06
Establish a key access point to HACC for eligible ATSI people within the WMR. A Koori specific Assessment and Care Management position is recommended within the WMR to support provision of information about services available and access to HACC services for ATSI people living in the WMR. Budget available approximately \$80,000.00 recurrent.	Recurrently funded -----> -----> ----->	Recurrently funded -----> -----> ----->
	Extension of Koori specific Planned Activity Group services within the WMR. Planned expansion of two days per week. Budget available approximately \$70,000.00 recurrent.	Recurrently funded -----> ----->
		Expansion of gateways to mainstream services for HACC eligible ATSI people living in the WMR or Koori specific HACC activity expansion for WMR. This will be based on community needs identified in 2003-04 and 2004-05 through the Assessment and Care Management Officer position and partnerships with other agencies. Budget available approximately \$70,000.00 recurrent.

5.5.6. Allocation process, 2003-04

The funding allocations recommended below are in accordance with DHS' *Purchasing and Funding e-guide*. The Indigenous Gathering Place was identified as the agency that will become the key access point to HACC services for the ATSI community in WMR. As the Indigenous Gathering Place is a newly established agency it was agreed at the planning workshops by representatives from the Indigenous Gathering Place, community members and the Maribyrnong City Council that Maribyrnong City Council would auspice the funds for the ATSI Assessment and Care Management position. It was agreed that this position would be based at the Indigenous Gathering Place. Maribyrnong City Council have agreed to provide professional support to this position and in supporting the Indigenous Gathering Place with their administrative infrastructure in order to comply with mandatory HACC reporting requirements and the implementation of quality systems.

Catchment	Name of Agency	Allocation Method	Assessment & Care Management \$
Regional	Western Suburbs Indigenous Gathering Place	Direct	80,000

5.6. Impact of Priorities 1-3 Recommendations

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.

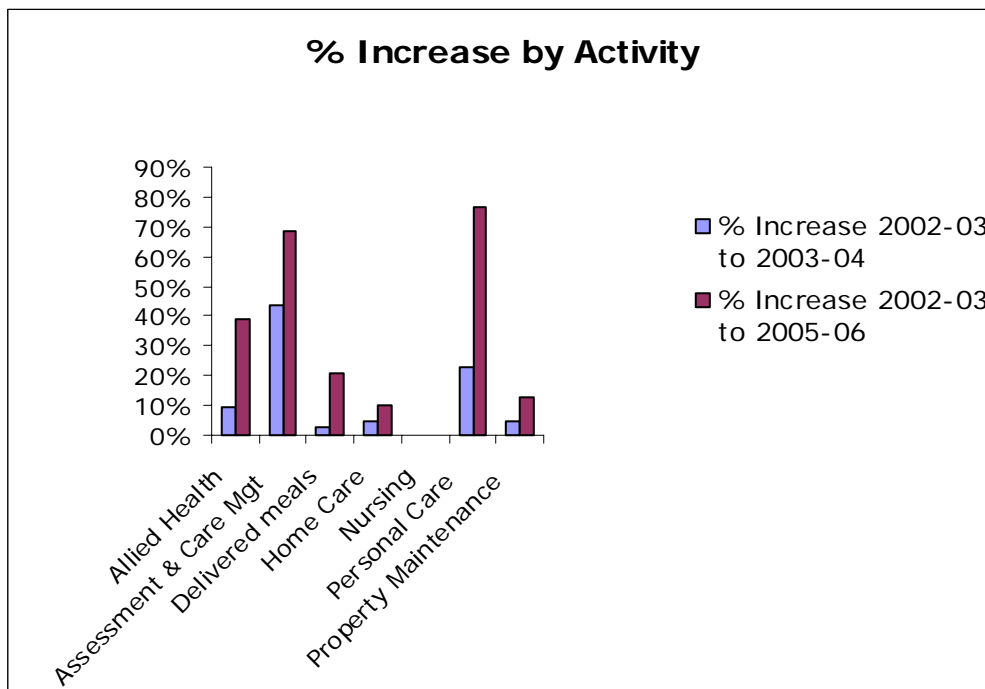


Figure 5.4 Percentage increase of Priority 1 activities, 2003-04 and 2003-06

The table and the graph below provide a summary of the impact of the distribution of growth funding for 2003-06 in each local government area. The first bar shows the recurrent base budget 1 July 2003 (excluding consolidation funds). The second bar shows the recommended recurrent base budget at 1 July 2006 (including consolidation funds) and reflects funding allocations as recommended in this Regional Plan. The third bar shows the WREN population share by local government area for 2005-06; and indicates proposed progress towards redressing HACC funds inequity between local government areas.

Table 5.9: 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
Brimbank	\$8,707,153	23.7%	28.9%	\$10,597,919	25.4%	29.0%
Hobsons Bay	\$6,160,532	16.8%	15.4%	\$6,598,428	15.8%	15.1%
Maribyrnong	\$5,703,232	15.5%	14.5%	\$6,158,561	14.8%	14.1%
Melbourne	\$2,889,741	7.9%	4.9%	\$3,176,473	7.6%	4.9%
Melton	\$1,735,839	4.7%	5.9%	\$2,206,204	5.3%	6.5%
Moonee Valley	\$7,864,743	21.4%	20.2%	\$8,728,412	21.0%	19.7%
Wyndham	\$3,655,216	10.0%	10.2%	\$4,190,543	10.1%	10.7%
Total	\$36,716,457	100.0%	100.0%	\$41,656,539	100.0%	100.0%

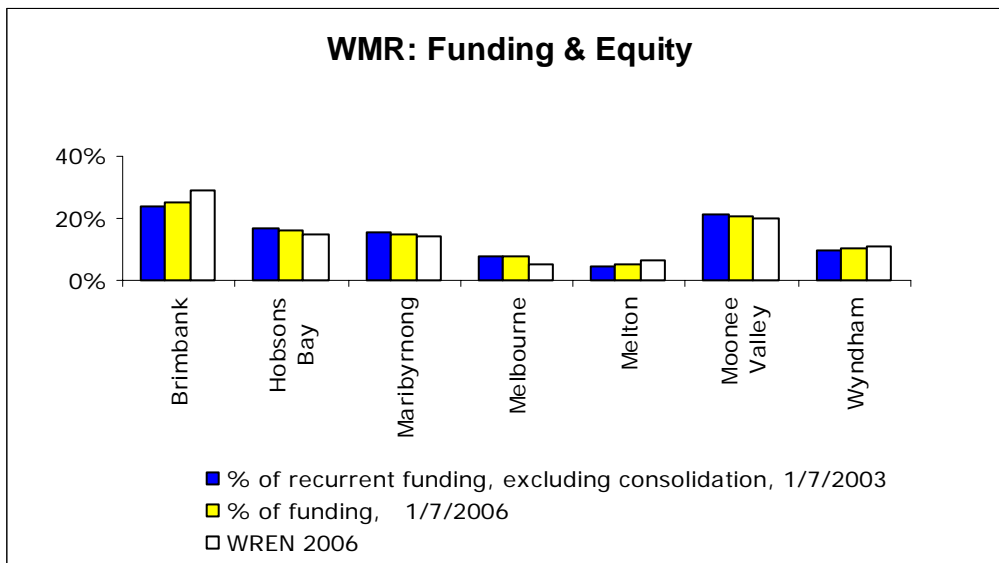


Figure 5.5: Recurrent funding 1 July 2003 and 1 July 2006, compared to equity

Section 6 – Non-recurrent funding

6.1. Introduction

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

6.2. Regional development initiatives

The WMR will allocate \$30,000 in 2003-2004 for a service development initiative that will look at furthering the substantive work that has occurred in the Western Metropolitan Region with the implementation of Service Coordination.

Purpose:

This project aims to look at the Care Planning component of service coordination tool templates which encompasses the Service Coordination Plan.

Aims:

- To determine the role of the keyworker.
- Develop an understanding between agencies on how a keyworker is nominated and what their core skills encompass.
- Practices, Protocols, Processes and Systems around how care plans are developed with consumers/carers and service providers.
- How consumers and carers can be involved in decision making around the service coordination plan to ensure privacy requirements are met in multidisciplinary care planning.
- Agreement on how collaboration with GPs and service providers will occur.
- Develop Practices, Processes, Protocols and Systems around review schedules, initiation of reassessment and providing feedback to referral agencies.

6.3. Minor capital discretionary funding

Up to 15% of the Regional Minor Capital allocation may be reserved for discretionary purposes.