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Analysis of Demand for Local
Government 'In-Home' HACCC
Services in the Western
Metropolitan Region

Final Report

**Funded by the Department of Human Services-
Western Metropolitan Region**

January 2001

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 - Aged and Disability managers from the WMR Local Governments
 - Assessment officers from these Councils
 - Referring Agency staff
 - Council staff responsible for data recording and reporting
- Council staff who generated numerous reports

Executive Summary

Background

Home and Community Care (HACC) is a national cost-shared program between Commonwealth and State and Territory governments. Auspice agency contributions and user fees add to the overall funds available for the delivery of services (Department of Human Services, 1998b). In Victoria, unlike other States/Territories, local government contributions comprise a significant proportion of the available HACC funds. In the Western Metropolitan Region, these contributions range from 32%-50% of Council HACC budgets.

The "Analysis of Demand for Local Government 'In-Home' HACC Services in the Western Metropolitan Region" arose through the "Spirit of Co-operation", an alliance between the Department of Human Services and the seven Local Government Authorities (LGAs) in the Western Metropolitan Region (WMR) of Melbourne. It was commissioned by the Department of Human Services (DHS) and managed by a steering committee comprised of representatives from the "Spirit of Co-operation" group. In this forum there had been discussion centred on a number of issues that highlighted the lack of available data about demand for HACC services in the WMR. These issues related to anecdotal evidence suggesting that demand for HACC services in the region had increased and was leading to lower levels of service provision compared to other regions of Victoria. Other issues related to inconsistencies in the interpretation of assessed need across the region and the residual effects of Compulsory Competitive Tendering on service structures. The National Ageing Research Institute was commissioned to conduct the project.

Prior to the commencement of the project, the steering committee and researchers agreed on the primary purpose, aims and scope of the project and defined the research questions to be answered.

The aims of the project were to:

- Gain an understanding of the level of demand for HACC services, including unmet demand, in the WMR
- Identify factors contributing to unmet demand
- Develop strategies to assist Councils deal with demand issues
- Recommend a consistent method of data collection, including definitions of low/medium/high needs, for all WMR Councils to enable accurate measurement of service demand and service delivery. It was stated that such a framework could also be used in any future prospective study of HACC service demand, should the opportunity for this type of research arise.

The research questions to be addressed were:

1. What is the population profile of those currently receiving Local Government "in-home" HACC services in the WMR:
 - Age/gender/carer status etc
 - Cultural/linguistic background

- Socio-economic status
 - Level of need (eg low/medium/high)
 - Types of Council and other services received
2. How does this population profile data (research question 1) compare with other available data (other metro, national etc)?
 3. What demand management strategies do WMR Councils currently employ?
 4. What is the impact of the level of demand for HACC services at the individual client, organisational, and service system levels?

Methodology

To address the key research questions, this project combined descriptive information from service providers with analysis of population and routinely collected service provision data. Consultations and interviews were conducted with representatives of the Local Government in-home HACC services and key referring agencies. A consultation was conducted with LGA staff responsible for data management and report production to identify usual practice and common issues. The Aged and Disability managers from each Local Government were approached to participate in telephone interviews. Two assessment officers from each of the Councils were also interviewed in person at their workplace. Interviews with key referring agencies were conducted on the telephone with representatives from an Aged Care Assessment Service, the Royal District Nursing Service, a Post Acute Care Facilitation Unit, case management and brokerage services, hospital discharge planning, community health centres, ethnic community centres and respite co-ordination services. The key aim of these interviews with different groups was to understand factors influencing demand, the impact of the perceived unmet/increased demand on the service system, organisations and individuals trying to access services, and demand management strategies.

To supplement this information, reports were also generated from each Council's database to develop a demographic profile of in-home Local Government HACC services taking into consideration; age, gender, client need, carer status, cultural/linguistic background and some socio-economic indicators. Reports were also generated that investigated the number of clients accessing services and the level of service use. Where possible this data was collected by priority ratings allocated to clients. Analysis was conducted using summary statistics.

Issues with Data Collection

A number of important issues arose through the data collection process. In summary, these were:

- Three different software databases were used across the region with varying capabilities of both the programs and the way in which they were used.
- Inconsistent data categories between LGAs making comparison over time and between services difficult.
- Large amounts of 'not recorded' or missing data.
- Different approaches to terminating client records leading to differences in the number of registered clients.

This created limitations when developing a demographic profile of clients, both for each LGA and for comparison between LGAs.

Profile of the WMR

The Western Metropolitan Region of Melbourne has a diversity of socio-economic backgrounds, ethnicity, population density and age. Its high proportion of people from a non-English speaking background (NESB) and lower socio-economic status, distinguish it from other regions in metropolitan Melbourne. Population projections are consistent with state population trends, with the number and proportion of people over 85 years of age predicted to steadily increase. There are seven LGAs in the region: Brimbank, Hobsons Bay, Maribyrnong, Melbourne, Melton, Moonee Valley and Wyndham. These LGAs differ from each other. Melton and Wyndham are characterised by a low population density, higher socio-economic status than the Victorian average and a younger population. Life expectancies for males in Maribyrnong, Melbourne and Hobsons Bay are significantly lower than the Victorian average. Brimbank has the largest total population while Moonee Valley has the largest population over 70 years of age.

HACC target population projections, based on the Relative Resource Equity Formula (RREF), suggest that Moonee Valley's target will remain stable while Brimbank's is likely to steadily increase to 2006 when it will have the largest HACC target population in the region. Melton has the smallest population, however, the number of people over 70 years of age is expected to almost double between 1996 and 2005 and the target population is also set to rise significantly. The Relative Resource Equity Formula (RREF, on which regional allocations for HACC funding are based), however, receives criticism as it does not account for regional differences in ethnicity and socio-economic disadvantage – both of which impact on costs and demands for public services. A project to review the RREF commissioned by the DHS-Victoria, to be completed by March 2001, aims to address some of these shortcomings.

Key Findings

Demand Management Strategies

The research found that in general there was a very high demand on services and that a number of demand management strategies were evident across the region. Generally, a combination of strategies were used including:

- Prioritising clients as high/medium/low priority. Six of the seven Councils applied priority criteria with the aim of allocating a priority of high, medium or low to all clients. There was a variety of tools and approaches used across the region with four Councils adopting a score based approach to determine priority.
- Rationing services. Two Councils had managed demand by reducing the level of home care available to each individual, but still providing some service to a large number of individuals.
- Waiting lists for home care, personal care and respite were operating in two Councils. Another Council had a waiting list for home maintenance services and one used short-term waiting lists during periods of excessive demand.
- Limiting service promotion. Most assessors reported that promotion of Council services was not active due to the already high demand for services. The major

concern was that promotion had the potential to raise expectations that were unlikely to be met.

- Increasing HACC funding through Council contributions. There was some evidence to suggest that the ability for some Councils to meet demand more effectively than others related to the level of Council contributions in the budget for HACC services. For example, at one Council this approach was applied to avoid waiting lists and minimise the need for stringent priority criteria. It was highlighted through consultations that Councils may be unable to sustain their current levels of contribution.
- Another approach that may have contributed to demand management included the substitution of available HACC and other services. For example, the high level of home maintenance provision at one Council may allow a one off or infrequent service to link low needs people with the service system despite not gaining access to other more regular services. Use of local shopping delivery services in another LGA was also described as an approach to freeing up home care hours to enable more people to access services.

Service Provision

Anecdotal evidence suggests that demand for services in the region has substantially increased over recent years. The reference group was interested in identifying any changes over time in the patterns of service demand using routinely collected service provision data. Data were retrieved from existing databases for a four-week period in May 1996, 1998 and 2000. However, due to the Department of Human Services undertaking significant changes in categorising service types during these years, most of the data for 1996 could not be reported. The service provision data was analysed, together with information from key informant interviews to develop a picture of demand issues across the region. Key points from the review of service provision were:

- Reports from assessors suggested that there had been a gradual increase in referrals over the last few years.
- There was a lack of appropriate data on the number of new referrals, the number of people who were refused services and the number of people who were provided access to services. Therefore, limited quantitative evidence to support the perceptions of staff was available.
- For most LGAs the number of clients receiving home care and the average hours of home care they received dropped slightly from 1998 to 2000. Most LGAs provided an average of one hour per week of home care, per client. The City of Melbourne was the only exception, providing clients on average almost 2 hours per week. One to two hours per week of home care is consistent with the level identified in the HACC User Characteristics Survey (Department of Health and Aged Care, 1998) and the recent HACC Status Report (Howe, 2000).
- Personal care also tended to be provided for one hour per week with the exception of Melbourne that provided approximately 4 hours of personal care a week. One hour per week is less than the HACC User Characteristics Survey that indicated Victorian clients averaged almost 2 hours of personal care a week (Department of Health and Aged Care, 1998). It is important to note that the user survey includes all HACC services such as the Royal District Nursing Service (RDNS) and it is likely that the time difference may be attributed largely to time provided by WMR RDNS services

and other providers of personal care whose data were not included in this Local Government study. However, the level identified for WMR LGA HACC was also lower than that provided by a number of the Councils represented in the HACC Status Report (Howe, 2000). The interface between Local Government and other personal care providers in the region needs further exploration before firm conclusions about unmet demand in this area can be made.

- Respite care was provided to a very small number of clients. Excluding children with disabilities, respite was provided to approximately 1-3% of the number of clients receiving home care in any one Council.
- Respite was the major type of service provided to families with children with disabilities. The average hours of home care, personal care and/or respite care for these clients was higher than that of the general HACC client population.
- Meal provision levels were consistent across the region.
- Moonee Valley provided home maintenance to almost four times the number of clients than the other Councils. Although their HACC target population is large they were still providing services to a higher proportion of their population than the other LGAs. In the absence of benchmarks for levels of service delivery, no implications for this difference can be drawn.
- A comparison of the hours Brimbank and Wyndham provided for different levels of priority suggests Brimbank provide a higher amount of home care to those assessed as high priority than medium and low. Wyndham, however, provides a similar level to all three priority levels. For personal care, however, clients assessed as medium priority at both Councils were averaging more hours than those assessed as either high or low priority. (These Councils were compared as they were able to provide accurate and comparable data on level of priority.) This illustrates that although Councils frequently use priority categories to determine who gets a service and when it can be provided, it does not necessarily link to service provision levels.
- Average hours of service provision per HACC target population individual, using population numbers from the RREF, indicates that Melbourne provides the highest level of home care followed by Maribyrnong and then Moonee Valley. Melbourne provides four times the amount of personal care per HACC target individual than the other Councils, but provides a lower level of home maintenance and delivered meals. As a comparison with the HACC User data and the HACC Status Report, the WMR is generally providing services below or at level with the rest of the state.

Client Profile

Data retrieved from LGA client databases indicated that between 10-40% of clients do not have basic demographic and health status data recorded. It is expected, however, that many of these clients would be accessing home maintenance and food services where assessment processes are often less 'formal' and information collected about clients is often kept to a minimum. However, the data for these clients is important for developing a profile of HACC users and for understanding who is gaining access to these services. The following analyses were made using available data:

- There was an under-representation of clients from NESB in relation to their proportion of the total population and population over 70 years.
- Approximately 20% of clients were under the age of 65.

- Between 60% and 70% of clients were female, reflecting the overall lower life expectancies of males.
- There was a high proportion of clients across the Councils with a primary disability relating to circulatory or muscular conditions.
- The proportion of clients with multiple disabilities was highest in Hobsons Bay and appears to be increasing in this LGA.
- Approximately 80% of clients are on a full or part pension. This is consistent with other HACC client profiles.
- The majority of clients lived in houses with the second largest number of clients living in flats. The only exception to this was in Melbourne where a higher proportion of clients resided in flats, as would be expected in the inner city.

“Level of confusion”, “availability of informal support” and “proficiency of English” all had a high proportion of ‘not recorded’ data. This requires further investigation and has implications for developing individual care plans and planning for service delivery. All of these factors have significant impact on ability to maintain independence and access services and are important indicators of need.

Contextual Factors in the WMR influencing demand for Local Government HACC

Apart from the demand on the HACC program overall and the perceived inadequate levels of funding for existing services, the main factors contributing to the demand for LGA in-home HACC services in the WMR identified by interviewees were:

- An ageing population.
- High proportion of people from a NESB (Proportion of people who speak English poorly is greater in the 65+ population than in the general population).
- Low socio-economic status of region reduces the ability of clients to pay for private services. Also associated with lower life expectancies and poorer health.
- Early Discharge Practices at acute hospitals in the region.
- Reports of increasing demand for other Aged and Disability services (eg. RDNS).
- Changes in purchaser/provider arrangements increases complexities in an already fragmented system.

The apparent disparity between State/Commonwealth HACC funding and the level of demand on the HACC program overall was an underlying theme throughout the interviews, and consultations with Aged and Disability Managers.

Impact of increased demand

Analysis of research data, including interview data, identified that increased service demand impacts at a number of levels (individual, organisational and service system).

Individual level

- Service providers reported that they had limited ability to provide HACC services at a time when prevention of deterioration may be possible (evidenced by waiting lists and refusing services to those assessed as low priority). There is growing opinion

that this may result in higher levels of individual need or a requirement for increased services in the short to medium term rather than the medium to long term.

- Clients with high service needs who are eligible and on the waiting list for care packages providing case management and brokerage services cannot be fully supported with the levels of care available from Local Government HACC services.
- High demand for services reduces the flexibility and responsiveness of services. This is likely to put greater demand on informal carers.
- A number of specific groups were identified through the interviews as not having their needs met in relation to in-home HACC services. These groups were:
 - Adults with disabilities (particularly in the 16-64 year age group).
 - People with neuro/cognitive disabilities including Acquired Brain Injury (ABI).
 - People from NESBs.
 - Adults and families who require a flexible and responsive service.
- Increased client dissatisfaction regarding low levels of service was reported by Council staff (often relating to past experiences of Council services when services were sometimes provided at higher levels).

Organisational level

- Evidence suggested that high demand for services impacted on assessment and administrative staff. This can affect staff turnover and continuity for clients. Time pressures on staff were also evident, with tasks such as data collection and recording regarded as a much lower priority than direct care. This led to poor recording of demographic data reducing the ability to use this information to guide service planning and development.
- Reduction of home care hours and the subsequent impact on direct care staff also requires consideration, but was beyond the scope of this project.

Service system level

- The high demand for Local Government in-home HACC services appeared to be paralleled by high demand for other services (such as RDNS). In turn high demand on other services appeared to impact on demand for Local Government services in the region. This interrelationship is complex and results in apparent stress throughout the system.
- Local Governments are struggling to provide set 'Maintenance of Effort' hours for Linkages clients.
- High demand tends to force service providers into a reactive rather than proactive mindset, and leaves little scope for flexibility in service provision.

Other issues that may impact on demand included the fragmentation of the service system described by a number of individuals interviewed. The increasingly large number of organisations and service activities was identified by some as a major factor increasing the costs of infrastructure and the likelihood of duplication of assessment, which may also reduce people's ability to navigate the service system and access appropriate services. Primary Care Partnerships (PCPs) are being developed in an effort to address these issues. There were

varying levels of optimism among service providers about the extent to which PCPs will be able to reduce fragmentation in the system.

Recommendations

A number of recommendations that arose through this project are described in the conclusion of the report. Broadly, the recommendations are:

- That prioritisation tools/assessment tools are further developed to introduce greater consistency across the region. An initial step would be to convene a working group to examine the issue, and to consider the appropriateness and feasibility of standardisation of such a tool. This working group would need to work closely with Primary Care Partnerships (PCPs) and include representation of all PCP groups across the region. The philosophies underlying the different approaches to assessment and prioritisation would need to be addressed.
- That a review of maintenance of effort agreements is undertaken in the WMR.
- That Councils initiate a review of the practices of separating or integrating the assessment and service provision functions, and the impacts this will have on demand and service management. Councils have varying views on this issue and a review would need to draw upon any existing research.
- To improve data recording. The quality of data routinely available with which to identify and track patterns of demand limited this project. Key areas that need to be addressed include;
 - appropriate levels of administrative support (or assessment officer time where they are responsible for recording);
 - staff training particularly to reduce levels of 'not recorded' data and to improve quality overall;
 - review of termination practices of client records;
 - development of a consistent system for recording people who are referred but not offered services.

Consistency in the collection of routine data items should improve with the implementation of the HACC Minimum Data Set (MDS). However, a number of key variables needed to monitor demand are not part of the MDS. Adequate funding is necessary to ensure there are adequate staff to pursue these goals and to implement the MDS and other DHS reporting requirements.

- That Councils consider other options for effective and strategic use of assessment officer time to ensure that reviews are completed routinely. This could involve exploration of technology that may reduce replication of reporting by assessment staff, eg use of laptops during assessments.
- That further research is undertaken to investigate changing demand and the impact of demand on individual clients, and on people who are not accessing services. This research would be greatly enhanced by implementing the recommendations in this report.

It was evident that Councils were experiencing pressure to meet demands for service as indicated by the use of waiting lists, low service ceiling levels, systematic reductions in client

service hours, and increased (though potentially unsustainable) contributions of funds from Councils. Data from other regions on provision of services is limited. Data that is available shows that most WMR Councils provide similar levels of service as other LGAs and HACC providers. However, there are no set service delivery benchmarks to determine whether particular levels are appropriate or adequate. It is also important to note that the differences between Councils within the region arose because of different levels of demand and different capacity of individual LGAs to respond to demand. The researchers draw no implications for reductions in funding to individual Councils where the data show a greater capacity to respond at a higher level of service provision. Some of the resource/funding implications that this research project has revealed will be addressed where possible in the HACC strategic planning process due for completion in April 2001.

Empirical, quantitative evidence to support the view that demand for services in the region has increased, or is higher than other regions, was limited, as the available data were not appropriate to measure changes in demand over time. However, a number of areas in which data collection could be improved were identified. The project used a developmental approach to the research which stimulated discussion and consideration of the types of data that need to be available to measure demand more effectively in the future, and provides information to assist the "Spirit of Co-operation" forum with future developmental activities.

1. Introduction

The delivery of in-home services to the aged and people with disabilities has been a growing trend in Australia and overseas for many years. This shift from residential care towards community care for older people in Australia, following overseas trends, has been well documented (Gibson 1998). The Home and Community Care (HACC) Program, established in 1985, had as its main aim to provide a comprehensive and integrated range of support services for frail aged and other people with a disability and their carers, thereby preventing premature or inappropriate admission to long-term residential care. HACC is a national cost-shared program between Commonwealth and State/Territory governments. Auspice agency contributions and user fees add to the overall funds available for the delivery of services (Department of Human Services 1998b). In Victoria, unlike other States/Territories, local government contributions comprise a significant proportion of the available HACC funds. Whilst the proportion of Council funding to HACC services is agreed in the Victorian State policy as 20%, Councils generally report funding at much higher proportions.

Concerns about the expected increase in demand for HACC services have been the subject of much debate in the aged care and disability sectors in recent times. In particular, researchers, policy-makers and service providers have highlighted the need for a well-resourced and responsive service system to meet the expected increase in the demand for community care. The responses have included a focus on improving assessment systems and service coordination (Lincoln Gerontology Centre 1998), targeting (National Ageing Research Institute and Bundoora Extended Care 1999), and data collection (Data Reform Working Group 2000), all of which contribute to an improvement in HACC services. However, the diversity of the HACC target population combined with a complex system of service providers, presents a challenging task to the achievement of equity of service access. Focussing attention on regional issues makes an important contribution to the achievement of national aims.

1.1 Why Study Demand for HACC Services in the WMR?

The debate about allocation of resources in HACC tends to centre on the tension between broad coverage – giving at least some services to large numbers of people, and narrow coverage - targeting high levels of service to those with high or complex needs. In the report on targeting in HACC (National Ageing Research Institute and Bundoora Extended Care 1999), attention was drawn to the possibility of discouraging people by denying them access to basic levels of services when narrow targeting strategies are adopted. However, denying basic levels of service to people may also reduce the opportunity to prevent deterioration in health and ability to manage at home. Unmet need is potentially a lost opportunity to provide people with the reassurance that care will be available when it is needed, which may motivate them to mobilise their own supports so that they may continue to live in the community. It is important that government funding bodies have a detailed understanding of the extent and nature of unmet need in the region, to provide a sound basis for decisions about resource allocation strategies.

Locally initiated research can contribute to the range of data necessary for some significant policy and service development initiatives. At a more immediate level, it can assist the local service providers to develop an understanding of the resourcing levels and service responses

needed. This can contribute to the development of a consistent approach to service delivery by heightening the awareness of the key providers of areas of inconsistency.

The idea for this project arose in the "Spirit of Co-operation", an alliance between the Department of Human Services and the seven Local Government Authorities (LGAs) in the Western Metropolitan Region (WMR) of Melbourne. In this forum, there had been discussion centred on a number of issues that highlighted the lack of available data about demand for HACC services in the WMR. These issues, which led to the development of the brief for this project, can be summarised as follows:

1. Anecdotal evidence suggested that demand for HACC services had increased, but no consistent information had been collected for the WMR to build up a regional picture of service demand and service usage.
2. Anecdotal evidence suggested that clients living in other regions of Victoria received more service for commensurate need and that there were significant differences in equity of service access within the WMR.
3. There were perceived differences in the interpretation of assessed need across the 7 LGAs with implications for service access and provision.
4. There were concerns that the current resource allocation framework did not adequately take into account factors such as socio-economic indicators, health indicators, and cultural and linguistic diversity indicators.
5. There were concerns about the impact of Compulsory Competitive Tendering and the resulting changes in service structure in the WMR. However, there was no evaluative data to draw upon to assist service providers in further development of their service structures.

This project, titled "Analysis of Demand for Local Government 'In-Home' HACC Services in the Western Metropolitan Region", was conducted by the National Ageing Research Institute. It was commissioned by the Department of Human Services (DHS) and managed by a steering committee comprised of representatives from the "Spirit of Co-operation" group. Those represented on the steering committee were DHS, City of Moonee Valley and City of Hobsons Bay. Prior to the commencement of the project, the steering committee and researchers agreed on the primary purpose, aims and scope of the project and defined the research questions to be answered. This document reports on the conduct and findings of the research project. Some of the comparisons of service provision data showed marked differences between LGAs. The differences arise because of different levels of demand and different capacities of individual LGAs to respond to demand. It was beyond the scope of this project to determine optimum or best practice levels of service provision for individuals, specific target groups or local areas. Further research needs to be conducted to assess the implications of these differences. The researchers draw no implications for reductions in funding to individual Councils where the data shows a greater capacity to respond at a higher level of service provision.

1.2 Project Purpose, Aims, Scope and Research Questions

Purpose of the Research Project	<p>The stated purpose of this project was to develop a picture of demand and user profile of in-home HACC services delivered by local government in the Western region of Melbourne. It was expected that this information would be important for consideration during the WMR five-year strategic planning process to be conducted during late 2000 and early 2001.</p>
Project Aims	<p>The aims of the project were to:</p> <ul style="list-style-type: none"> • Gain an understanding of the level of demand for HACC services, including unmet demand, in the WMR • Identify factors contributing to unmet demand • Develop strategies to assist Councils deal with demand issues • Recommend a consistent method of data collection, including definitions of low/medium/high needs, for all WMR Councils to enable accurate measurement of service demand and service delivery. It was stated that such a framework could also be used in any future prospective study of HACC service demand, should the opportunity for this type of research arise.
Project Scope	<p>The project focussed on the “in-home” HACC services provided by local governments in the WMR:</p> <ul style="list-style-type: none"> • Home care • Personal care • In-home respite • Property maintenance • Delivered meals <p>It did not encompass out-home-services, or services provided by other organisations.</p>
Research Questions	<ol style="list-style-type: none"> 1. What is the population profile of those currently receiving Local Government “in-home” HACC services in the WMR: <ul style="list-style-type: none"> • Age/gender/carer status etc • Cultural/linguistic background • Socio-economic measures • Level of need (eg low/medium/high) • Types of Council and other services received 2. How does the population profile data (research question 1) compare with other available data (other metro, national etc)? 3. What demand management strategies do WMR Councils currently employ? 4. What is the impact of the level of demand for HACC services at the individual client, organisational, and service system levels?

1.3 Demographic features of the WMR

The Western Metropolitan Region (WMR) is composed of seven LGAs; City of Brimbank, City of Hobsons Bay, City of Maribyrnong, City of Melbourne, Shire of Melton, City of Moonee Valley and City of Wyndham. According to the most recent census collection in 1996, Brimbank had the largest population, followed by Moonee Valley, with Melton having the smallest (Department of Infrastructure, Victoria, 1997)

Table 1: Population Characteristics of the Western Metropolitan Region

	Total population 1996 census	Population 70+ (% of total population)	% change in 70+ Population from 1996-2005	% 70+ NESB	Index of Relative Socio-Economic Disadvantage (IRSED)
Brimbank	149131	6982 (4.7)	↑59.8	62.7	946.4
Hobsons Bay	74166	5920 (8.0)	↑30.9	33.3	979.5
Maribyrnong	59031	6270 (10.6)	↑10.1	33.9	887.7
Melbourne	48560	3272 (6.7)	↓15.3	46.7	1035.4
Melton	39167	1124 (2.9)	↑93.8	17.8	1008.5
Moonee Valley	104849	9759 (9.3)	↑21.2	33.6	1011.8
Wyndham	73901	2564 (3.5)	↑53.9	31.7	1024.9
Total WMR	548805	35891 (6.5)	↑29.6		984.9

Source: WMR DHS data based on 1996 census data & Western Metropolitan Region, 1998

Table 1 shows Moonee Valley has the largest number of people over 70 years of age accounting for 9.3% of the total population. Maribyrnong and Hobsons Bay also had a high proportion of their population over 70. Population projections for 2005 suggest that all WMR LGAs, except Melbourne, will have an increase in their total number of people over 70 years of age. This increase will be most significant in Melton where their population over 70 years will almost double. Although it will still have the smallest population over 70, this dramatic change is likely to impact on the availability of services in this area. The expected increase at Brimbank where their population base is already comparatively large is also likely to add significant pressure on HACC services.

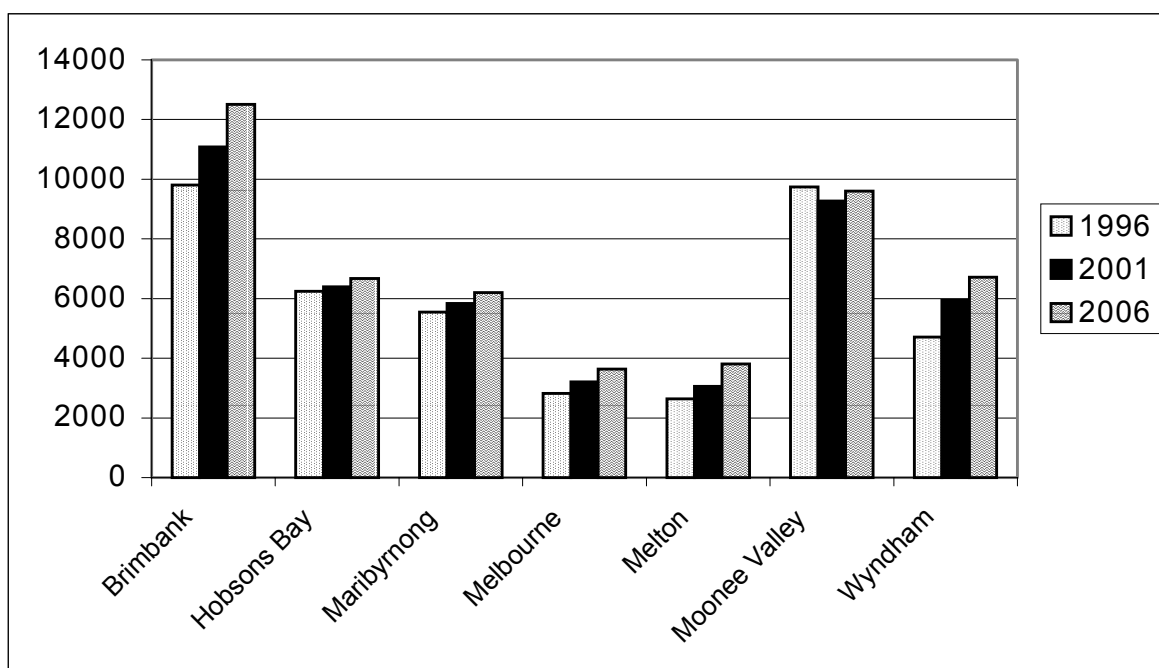
Table 1 also shows the diverse cultural mix of the WMR. Brimbank has the largest proportion of people over 70 years who speak a language other than English at home, followed by Melbourne, with Melton having the lowest proportion. The proportion of people from a NESB in the WMR is much higher than that of the total Victorian population, with only 20.2% speaking a language other than English at home, and 26.1% in the total Melbourne Metropolitan region (Department of Infrastructure Victoria 1997).

The Index of Relative Socio-Economic Disadvantage (IRSED) provides an indication of socio-economic status relative to other areas of Australia with a lower score indicating greater disadvantage. It is a useful measure, as it not only accounts for income, but other important factors such as education levels. The national average is 1000 with Victoria's average generally higher. Brimbank, Hobsons Bay and Maribyrnong rank below the national average. When considering the population over 70, Melbourne has the lowest proportion of people

earning less than \$10,000 per annum (52%), followed by Moonee Valley and Wyndham (63%). Maribyrnong and Brimbank have the highest proportion with 75% of the aged population earning less than \$10,000 (Western Metropolitan Region 1998).

The Relative Resource Equity Formula (RREF) aims to rank different LGAs' HACC target population as an indication of the need for services and the funding necessary to maintain these services. Although the RREF is about to be reviewed, it defines its target population as a sum of the people with moderate, severe or profound disability and those over 85 years of age (Department of Human Services 2000b). For rural LGAs, weighting is added to account for disadvantages created by isolation. In the WMR, Melton and Wyndham receive a rural weighting, although projections of the RREF suggest that in 2006 Wyndham will no longer receive this rural weighting. Figure 1 shows the target populations based on the RREF for 1996 as well as projections for 2001 and 2006 based on 1996 data.

Figure 1: HACC Target Population for 1996 and projections for 2001 and 2006 including the Rural Weighting based on the Relative Resource Equity Formula



Source: Western Metropolitan Region, 1998.

NB: The rural factor weighting applies to Melton and Wyndham in 1996 and 2001 and Melton only in 2006.

Figure 1 shows that in 1996 Moonee Valley and Brimbank had the largest HACC target populations, consistent with their larger general population and proportion of people over 70 years of age. RREF projections reflect the general population projections with an increase from 1996 to 2006. This increase appears most significant in Brimbank while Moonee Valley drops between 1996 and 2001 and slightly increases again between 2001 and 2006. Despite the drop in the number of people over 70 from 1996 to 2005, Melbourne's target population also increases. This may indicate a larger growth in younger people with disabilities. As argued in a strategic review of aged care services in Hobsons Bay (Gecko Solutions 1998), direct population based funding does not take into account socio-economic and cultural disadvantages within a region. Also, as Gibson points out, using age as a measure of need does not take account of lower life expectancies related to poorer health status (Gibson, 2000).

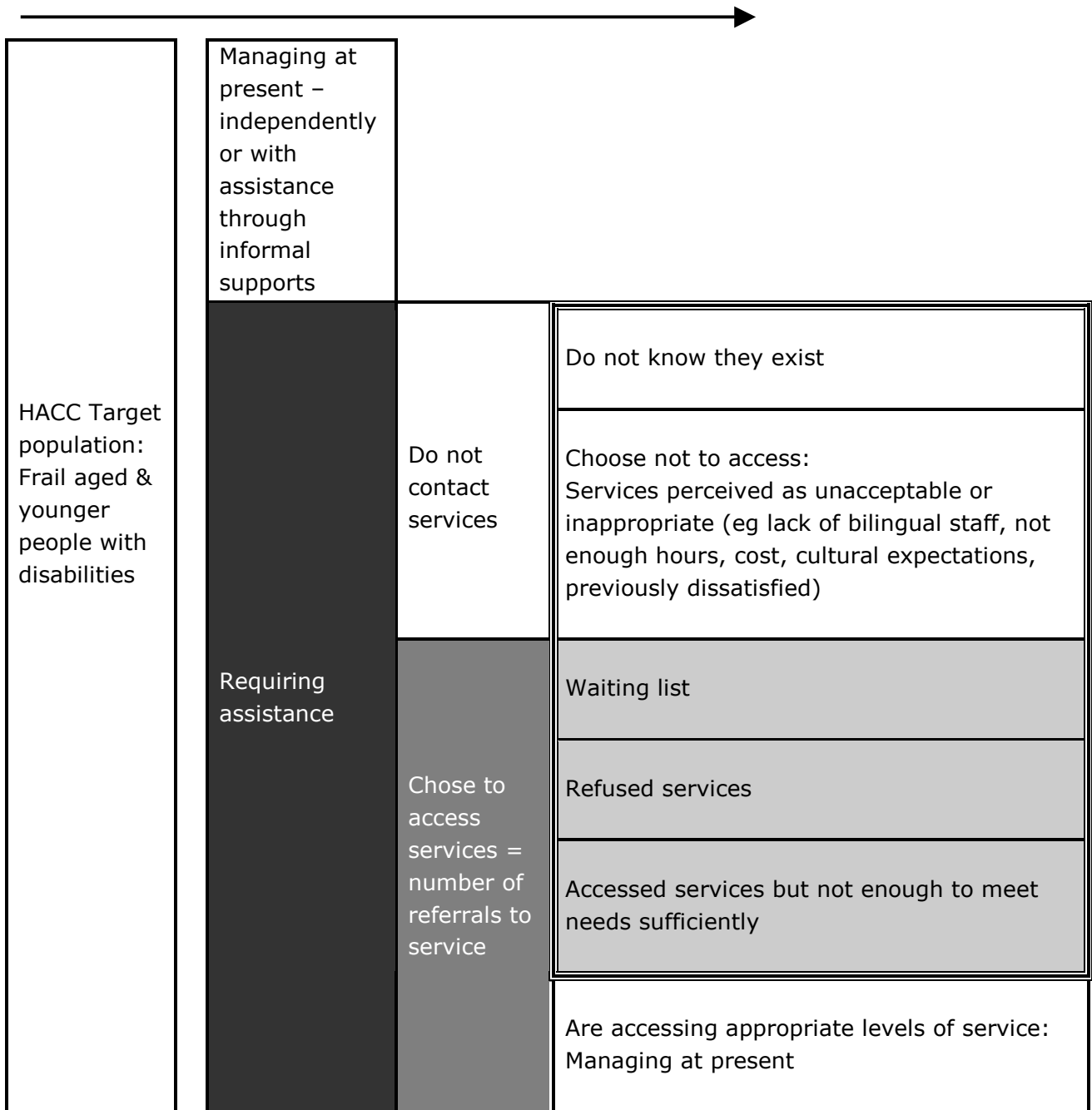
In the WMR, males in Brimbank, Melton, Moonee Valley and Wyndham and females in all seven LGAs have a life expectancy similar to the state average. Males in Maribyrnong, Melbourne and Hobsons Bay, however, have a lower life expectancy than the average for all Victorian males. Maribyrnong males have the third lowest life expectancy in the state (Department of Human Services 1999c). The Victorian Burden of Disease study (Department of Human Services 1999c) also found that males in Brimbank, Hobsons Bay, Maribyrnong and Melbourne and females in Maribyrnong had a significantly higher number of Years Life Lost (YLL- an indication of mortality) from all causes than for the average of Victoria.

In summary, the WMR has LGAs that are disadvantaged in comparison to metropolitan Melbourne as a whole and Victoria in terms of socio-economic, cultural, health status and life expectancies. Although these characteristics differ across the LGAs within the region, estimation of the HACC target population based on a simple population based RREF would appear to disadvantage large parts of the region. This is a theme clearly articulated by the local government Aged and Disability Managers in the Region. As one Aged and Disability Manager said, "a review of the RREF is needed urgently to ensure that there is a needs-based proportioning of the HACC budget. The Western Region is clearly disadvantaged."

1.4 Unmet demand – real or perceived?

A common perception amongst service providers in the aged and disability community care sector is that demand for HACC services has increased significantly, leading to increasing levels of unmet demand for services. In the WMR it was noted that no consistent fields of information had been collected by service providers to enable service planners to build a picture of service demand and service usage across the Region. Whilst there had been a strong perception of unmet need, there had been a lack of collated measurement of demand or quantification of unmet demand within individual LGAs and consequently at a Regional level. The following diagram attempts to illustrate the relationship between need for services, demand, unmet demand and the specific areas on which this project focuses.

Figure 2: The relationship between need and demand within the HACC target population



Note: the proportions for each category do not attempt to represent the real proportions that exist in the population.

Key:

Need

Unmet need

Demand for services

Unmet demand for services

2. Methodology

2.1 Consultations and Interviews

A number of consultations and interviews were conducted with key staff working within Local Government "in-home" HACC services as well as a number of key referring agencies.

2.1.1 Consultations with data staff from each LGA

A group forum, of representatives from each participating LGA, was held during the early stages of the project to discuss issues pertaining to data entry and report generation. Managers of each service were asked to nominate a staff member who was experienced using their software database and able to participate in the group. This person would then be responsible for generating reports about the client demographic profile and service use later in the project. For some LGAs this staff member had an administrative role and for others the Aged and Disability Manager attended. The consultation was held at the City of Moonee Valley offices. The forum enabled the project to be introduced to those who would be generating reports. It also enabled the importance of collecting this data to be emphasised and for LGA staff to report on the capabilities and limitations of the different databases in use by the different LGAs. In addition, it provided an opportunity for staff from each LGA to meet and discuss issues of data collection and reporting.

2.1.2 Interviews with LGA Assessment Officers

Interviews were conducted with two assessment officers at each of the seven LGAs. As most of the LGAs had only two or three assessors, this sample of fourteen represented the majority of assessors within Local Government in the WMR. A set of questions was developed and covered the following topics:

- referral processes, assessment and service delivery
- service promotion
- assessors perspective on service access and equity
- assessment documentation and information pathways
- approaches used to prioritise clients
- process and frequency of reviews.

Questions were open-ended and assessors were encouraged to introduce other topics that they felt were relevant to the issue of demand for services. Interviews were conducted with individual assessors at each assessor's workplace. The interviews took between thirty to sixty minutes. All gave permission to have the interview tape-recorded to ensure information could be accurately reported. The interviewer also took notes during each interview. Tapes were later transcribed for analysis.

2.1.3 Interviews with Key Referring Agencies

To develop a comprehensive picture of demand and LGAs ability to meet people's needs, it was important that people external to Local Government were asked about their perceptions of Local Government services. Twelve telephone interviews were conducted with staff from key

agencies that referred to LGAs in the WMR. Agencies were chosen to represent a broad range of services and included; ACAS, Community Health Centres, Linkages services, RDNS, Ethno-specific services, carer respite services and a post acute care service (See Appendix 1 for a full list of the participating agencies). A Migrant Resource Centre declined to participate because they had limited contact with LGA services, (but suggested other appropriate organisations). The interviews covered topics about ability to access LGA services and whether there were differences between Councils. Staff were also asked about how they managed demand for their own services and whether they had any suggestions about improving management of demand for Local Government services. Although the range of services interviewed was broad, the coverage of each service was somewhat limited as interviews were held with only one staff member from each service. However, there was considerable consistency in the interview data in relation to service provision of individual LGAs. The information from these interviews also appeared to match information collected from LGA staff in relation to meeting demand for services.

2.1.4 Interviews with LGA Aged and Disability Service Managers

Towards the conclusion of the project, brief telephone interviews were conducted with the Aged and Disability Manager from each of the seven LGAs in the WMR. The purpose of these interviews was to gather further information about:

- Primary Care Partnerships
- Implementation of the HACC Minimum Data Set
- Arrangements to provide Maintenance of Effort hours for clients receiving care packages
- Client fees policy
- Funding arrangements
- Staff/team structure
- General comments about demand and future service provision

2.2 *Service use and demographic data*

A number of reports were obtained from the databases at each participating LGA to complement the interview data and to provide statistical evidence of the level of service provision and the demographic profile of those accessing services.

After the group forum with LGA staff, the project team developed a series of data questions. Each question was presented in table format so staff could more clearly see what was being requested. The question format and content was pilot tested in one LGA and minor modifications made prior to circulation to all seven LGAs. Reports covered referral data, service provision and demographic data for three different time periods. The referral data considered source of referral and number of referrals between 1st February and 31st May for 1996, 1998 and 2000. A four month period was used as it was expected that the number of referrals received in a one month period would be too small to make generalisations. For the service provision and demographic data a four week period was used for the same three years (6th May – 2nd June, 1996; 4th – 31st May 1998; 1st – 28th May 2000). The month of May was chosen as a period in which there were few public holidays or school holidays that may influence the provision of services due to limited availability of staff. The service provision data looked at hours and numbers of clients receiving home care, personal care, respite care,

food services and home maintenance/modification. Demographic data was collected for the same time periods and included:

- Age
- Gender
- Country of birth
- Language spoken at home
- Proficiency of English
- Level of confusion
- Primary disability
- Multiple disabilities
- Housing type
- Income type
- Availability of an informal carer

Staff were also requested to send the parameter file listing from their database. This list translates all the codes that appear on reports.

Additional statistical data was obtained from other project reports, and reports produced by the Australian Bureau of Statistics. This data enabled comparisons to be drawn between the profile of clients accessing "in-home" HACC services and that of the general population. This approach was endorsed in the *"Targeting Best Practice"* report developed through the Municipal Association of Victoria in 1998 (Prideaux 1998). This report recommended comparing client user demographics with general population demographics as one indication of equity of access to LGA HACC services. One data source commonly referred to in the present project is; *"Maximising the Potential: An Aged Care Data Profile and Analysis of the Western Metropolitan Region, 1997"* (Western Metropolitan Region 1998). Another source commonly used was a summary of 1996 census data: *"Victoria in Fact: 1996 Census Statistics for Victoria's Local Government Areas"* (Department of Infrastructure, Victoria 1997). Levels of service provision were compared with figures from the most recently published *"HACC User Characteristics Data Collection"* that has information on provision of HACC services for all regions across Victoria for November 1997 (Department of Health and Aged Care 1998). This report is somewhat limited as it only includes a 10-20% sample of the client group. Service provision data was also compared with the recent *"HACC Status Report for Victorian Local Government"*, produced by the Municipal Association of Victoria (Howe 2000). This report provides data on service provision for a sample of 22 rural and metropolitan Local Government HACC service providers in Victoria.

Data reports obtained from each LGA software database enabled some comparisons to be drawn on the amount of service clients were receiving. Combining these data with information obtained from LGA Aged and Disability managers and assessors as well as from key referring agencies added depth to the analysis. Using descriptions from assessors about how priority and level of service provision is determined helps explain different levels of service provision between Councils. It was also anticipated that combining the different sources of information would help to develop a picture of demand and identify procedures that have been used to manage demand.

The methodology used in this project enabled verification of data and information. For example, information regarding guidelines and practices gained through interviews with assessors was confirmed through interviews with their managers as well as statistical data and information from other referring agencies. When difficulties were encountered with interpreting data, those who generated the reports could be re-contacted and ambiguous data clarified. This process enabled the researchers to develop a better understanding of the software and its ability to generate appropriate reports. It also provided those who generated the reports an opportunity to learn more about the program and how to improve the quality of reports produced.

3. Issues arising from Data collection

After reports were obtained from most of the LGAs, a number of difficulties in interpreting the data were identified. Some of these difficulties arose from misinterpretation of requirements, and others through different applications and coding used within software databases. Further difficulties arose for the LGA that used a different software program to the other LGAs. It was decided that the best approach to overcoming these difficulties was for a research officer to visit each Council to discuss the reports and where necessary run some reports again. One of the greatest difficulties faced by the project officer was determining the different service types and levels, as these differed from one LGA to another and from one year to another. Contact was made with the producer of Sharikat Khoo (HACC software program) on a number of occasions to clarify issues and to ensure that HACC clients were not being double counted in reports if they were receiving more than one service. Although many difficulties were overcome, a number could not be overcome due to data entry procedures and database limitations. These limitations are discussed in more detail throughout this report.

3.1 Software Databases

At the beginning of the study six of the Councils were using the software database "Sharikat Khoo", whilst the Shire of Melton used "HACCPAC". During the course of the study, the City of Melbourne changed from using Sharikat Khoo to using "Care Manager". This program was suitable for this LGA as service provision had been tendered out to a for-profit organisation and the Council was responsible for the assessment process only. This program is not able to produce rosters and would, therefore, be unsuitable for the other Councils in the region. Aged and Disability Managers reported some dissatisfaction with the commonly used HACC software, and one Council had recently put to tender the provision of an appropriate alternative software program.

3.2 Inconsistent categories and data entry

Although variables for different demographic data are pre-set in Sharikat Khoo, each Council is able to manipulate the codes within each variable. The original set-up provides a basic list of variables but sometimes these codes do not meet the needs of individual LGAs. For example, a client may speak a language at home that is not included in the basic list of languages; the LGA can then add this code onto the database. This leads to variations in codes between Councils, thus limiting the ability to compare demographic data between LGAs. Different prioritising procedures also limit the ability to compare clients from different LGAs with the same coded priority level. The implementation of the HACC Minimum Data Set aims to eliminate these inconsistencies for demographic data but it is unlikely that all data will be consistent within the next two years. Comparisons are also limited when data for a large proportion of clients has not been recorded. Different LGAs and different assessors will vary in their diligence at entering demographic data. Entering demographic data that does not appear relevant to service delivery may become the lowest priority in assessors' tight schedules when weighed up with other tasks such as completing assessments and organising commencement of services for clients.

3.3 New Modules

Over recent years there have been many changes in data requirements for DHS. These changes have led to many changes in software databases and in the set-up of modules within Sharikat Khoo. Modules are used to group clients together under different service types. In the past, the DHS requested a separation between "general services" (home care, personal care and respite care) and "specific services" (home care, personal care and respite care provided for families who have a child/children with a disability). This separation is no longer required and instead home care, personal care and respite are to be shown individually with specific care clients added into the appropriate type of care. For the purposes of this report, few comparisons between 1996 data and 2000 data have been made due to the changes in categories used. The new "output purchasing" report also provides useful summaries of clients and hours provided by service type. This report, however, was not introduced until after 1996 and again limits the ability to use 1996 data to track changes in service provision over recent years.

More recently, an assessment module has been developed to record all clients referred to Local Government HACC services who receive an assessment regardless of whether they gain access to a service. This has the potential of providing a useful measure of people who request services and may be eligible (although a low priority) but do not receive services due to high demand for the service. Unfortunately, at this point it appears that this information, although recorded, cannot be generated in a report that summarises the number of clients assessed who receive services and the number who do not. A list of terminated clients can be generated within the module and will include all clients assessed and refused service (a termination date is generally recorded if they are refused services). It will, however, also include all client records terminated for other reasons including "client moving into other care" or "becoming deceased".

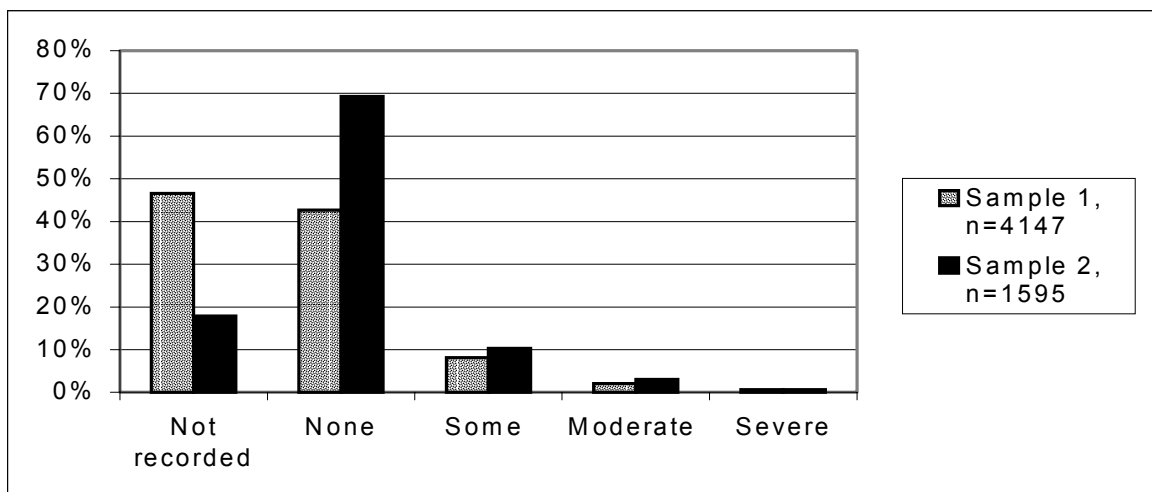
3.4 Defining "Active Clients"

To help describe the data it is important to acknowledge the difference between "active clients" and clients who have accessed the service in a given period. In this project, the researchers looked at a four-week period. The number of clients who accessed a service in the four weeks may be considerably less than the number of active clients. To increase understanding of the data, the reasons for these discrepancies need to be considered. One reason for the discrepancy is that clients who are temporarily suspended (for reasons such as being in hospital) will not receive any services within that period but will still be counted as an active client. Clients who have cancelled the service but have never had their records terminated will also be counted as active despite receiving no services. For this project the demographic data has been collected for the "active" client population while the service provision data only includes clients who received services in the relevant four-week period. The following case example will describe the limitations to using only those who accessed services to describe the demographic profile.

3.4.1 A Case Example

A case example is included to illustrate some of the difficulties encountered when trying to interpret the data. This example demonstrates the impact of considering "active clients" rather than "clients who received services" as the unit of measure. It highlights how the use of different approaches can make it difficult to compare data between Councils.

Figure 3: Level of confusion for clients during a 4-week period in May 2000.



Sample 1 includes all clients who are listed under home care, personal care, respite care, food services and home maintenance.

Sample 2 includes all clients who received home care, personal care and respite during the 4 week period in May 2000.

Figure 3 shows level of confusion for clients for the same four-week period in 2000 and the same Council but a different report and a different range of services. Sample 1 shows level of confusion for all “active” clients for home care, personal care, respite care, food services and home maintenance clients and has a total of 4147 clients. Sample 2 reports only clients who received a service during the four-week period. This type of report, however, cannot be generated to include home maintenance or food services clients. The discrepancy of 2552 clients arises for a number of reasons that can be determined by examining a number of other reports and speaking to data entry staff. Although the obvious difference is due to the exclusion of home maintenance and food service clients this could lead to a false conclusion that 2552 clients receive either food services or home maintenance. When looking at actual service provision, only 201 clients received home maintenance and 668 received food services. Another report, however, indicates that there are 2978 “active” home maintenance clients and 830 “active” food services clients. The main difference in home maintenance clients between 201 who received services and 2978 who are listed, can be attributed to the termination procedures for these clients’ records. Instead of terminating a client’s record after they receive this service, they are kept “active” on the system in case they need to use the service again in the future.

Despite the limitations to using Sample 1, it has been used to describe demographic data in this project, as it is the only way home maintenance and food services clients can be included. It does, however, increase the proportion of “not recorded” client demographic data, perhaps indicating that these fields are not as regularly recorded in the home maintenance and/or food services modules. It may be recorded on the CIARR or other assessment forms but this has little value when trying to generate summary statistics of the total client profile. Although these limitations exist, these reports provide some useful data on the demographic profile of people who contact the service and have an assessment completed. It does, therefore, provide a description of who is gaining access to Local Government “in-home” HACC services. For service provision information it is illogical to consider the number of active clients and the hours of care provided, as this would not indicate the level of service for those actually receiving services.

4. Demand management strategies currently employed

This section is based on interview data from assessment officers, LGA Aged and Disability Managers, and representatives from other key referring agencies. It explores the different approaches used by Councils to manage demand for their services.

4.1 *Priority of Access Guidelines*

With the high demand for services, the need to prioritise clients to determine who will access services has become an increasing concern for assessors. Priority of access approaches varied between Councils, with three different approaches noted. The most commonly used method for prioritising clients is a score based tool. The other approaches are less rigid and rely to a greater extent on professional judgement. Each of these approaches is described in greater detail below with a case study incorporated to highlight some of the potential inconsistencies that can be obtained with different scoring tools.

4.1.1 Descriptive approaches to determine high/medium/low needs

Brimbank and Wyndham used a descriptive or categorical approach. Areas of need for the target group/s are identified in guidelines, and a typical profile of clients in each of the priority categories is described, paying attention to key areas of need. A summary of descriptions used for each category by these two Councils is included in Appendix 2.

One advantage of the descriptive approach over the scored approach is that there appears to be greater scope for employing clinical judgement. Disadvantages of this approach include the potential for less objectivity than when a score based system is employed and that descriptions may not always “fit” every person. For example, someone assessed at Wyndham may fit into the “medium” priority because they have a low level of frailty in the absence of informal supports. The medium priority also suggests, however, that all medium priority clients will have some informal support. Score based approaches can permit more flexibility in acknowledging that clients vary on all dimensions of need. Comments from assessors suggest satisfaction with the approach and acceptance that not everyone will “fit” into categories:

“Yes, we have a set of guidelines, but there are always exceptions to the rule. Sometimes we need to make a professional judgement.” (Brimbank assessor).

“We haven’t had to deny anyone service because of the priorities... We are about to change our priority ratings to include people at risk. They are just at 1, 2, 3 at the moment so we are going to add an at risk category that although they are at that stage at the moment they are at risk if something changes of moving up to the next priority” (Wyndham assessor).

4.1.2 Broad guidelines with clinical judgement

Maribyrnong used a system that had priority categories for respite care and specific home care (low, medium and high) but not for other services. The Council’s targeting policy states that each client will be assessed in accordance with level of dependency and outcomes expected. Each level of dependency will have upper level time limits / service limits. In this way, targeting occurs according to both need and outcome expected. For clients receiving two or

more services, the benefits of additional services should be considered to determine whether they will make a difference. (Implies rationing resources amongst a larger number of service users).

“Because we don’t have that sort of system, we don’t assess you as needing 15 hours per week but give you two - we don’t do that. We... come to an agreement with a client... For new clients we would not go very far above the current maximum but we may do that on a short term basis. We are meeting their needs as far as we can... I think that there are some clients that we can’t provide adequate [services for]- ones that need fairly regular monitoring - we probably can’t provide as much as we should.” (Maribyrrnong)

The advantages for this approach are the same as for the method used at Wyndham and Brimbank. However, it could allow for greater subjectivity and inconsistency between assessors.

4.1.3 Score based approaches

The most common approach, used by Hobsons Bay, Melbourne, Melton and Moonee Valley, was a score based system. Score based approaches to assessment involved the use of an assessment tool containing a number of items covering areas that have previously been identified as important. Clients are rated (usually on a 5-point scale) according to their level of need or risk in each area. An overall score is obtained by summing the scores for each individual item. The scores obtained can then be classified as falling into several broad categories, for example high, medium and low priority. The benefits of this approach include:

- Information on client need, in a broad range of areas previously identified as important, can be taken into account.
- Priority decisions can sometimes be based on more objective criteria than is possible when assessment decisions are based solely on clinical judgement.

There are a number of disadvantages in using score based systems, especially when the assessment tool has not been empirically validated, as is the case with the assessment tools currently in use. A score based approach assumes that equal weighting can be given to each item assessed in determining priority, when in fact the relative importance of each item in determining priority has not been established by empirical studies. Certain combinations of risk factors (for example loss of vision, and home hazards) may constitute greater risk than other combinations of risk factors, but a simple score based approach does not take this into account. To address these limitations, assessment staff from each Council report that they use their own clinical judgement in combination with assessment tools in reaching decisions about relative priority. An Aged and Disability Manager pointed out that all priority tools should be used as guidelines only, and not used prescriptively, as the assessor needs the flexibility to make the final decision based on all factors at play in each individual case. Stewart et al also argued that a more structured approach to assessment should not be a substitute for professional judgement (Stewart, Challis et al. 1999). Rather, it may help to alleviate some of the issues identified such as lack of consistency, and the subjectivity of the descriptive approaches.

Assessors also preferred the score based approach, as it appeared to appease clients about the small hours of service provision. According to assessors, when clients were shown that they were allocated hours according to an “objective” scale they seemed to understand differences and be more satisfied with the outcome. Assessors reported that scores seemed to reflect

their own “gut feelings” about what priority someone should be and that the system was a way of validating their assessment and increasing objectivity as much as possible:

“It’s very useful because we don’t have enough services to go round so you really need a system like that. It’s a bit limiting ... each situation is unique. If we had the flexibility to ... give the services people need rather than trying to get them to fit. Sometimes there are unique situations where we extend services they need, in light of bad budget and not enough services to go round, it takes pressure off the assessment officer to have something that sets in place the criteria” (Hobsons Bay assessor)

“I think they need to do a lot more on that [priority tool]. I feel that some questions could be changed to make it easier for all of us to understand. It helps us determine client needs, what they are and whether the client needs personal care or HACC service” (Melbourne assessor)

“It makes it easier when you have to tell somebody that *‘you are not eligible – but you are not scoring very high which means that you may need to go on to a waiting list’*. It also makes it easier for us to take on those people who are really on high needs and be able to supply them with services.” (Melton assessor)

“I think the one (priority tool) we use now is really good... The new method is good and flexible. It covers the carers as well.” (Moonee Valley assessor)

HACC National Service Standards suggest ten indicators of the vulnerability of HACC service users when determining relative need (as indicated by an asterisk in the table below). Melton and Hobsons Bay developed their tool together and thus have identical categories indicating some consistency across the region in prioritising processes. Melbourne and Moonee Valley explicitly take account of level of income in determining priority. Moonee Valley based their assessment tool on a set of criteria which are different from, but overlap to a certain extent with ‘The National Service Standards’ vulnerability indicators. Areas that are not covered include sensory capacities and the capacity of the household to support the service user. Areas covered that are unique to the Moonee Valley instrument are nutritional status, willingness to accept current services, and client commitment to stay in own home.

Table 2: Priority tools: categories included

	Melbourne – 10 items	Hobsons Bay and Melton – 10 items	Moonee Valley – 15 items
Isolation *	✓	✓	✓
Physical capacity *	✓	✓	✓
Mobility *	✓	✓	x – overlaps with physical health above
Cognitive and emotional capacities / perceived memory function *	✓	✓	✓
Sensory capacities *	✓	✓	x
Carer Issues *	x – overlaps with “household capacity” below	✓	✓
Communication *	x – overlaps with risk of neglect abuse below	✓	✓
Physical environment *	✓	✓	✓
Capacity of household / availability of support *	✓	✓	x
Risk abuse / neglect *	✓	✓	✓
Household income / financial situation	✓	x	✓
Supports required / available	✓	x	✓
Willingness to accept current services / increased assistance	x	x	✓
Commitment to stay at home	x	x	✓
Nutritional status	x	x	✓

For a more detailed version of Table 2 refer to Appendix 3 for a description of the range of scoring options.

4.1.3.1 Examining the consistency between tools: A Case Study

The following case study describes an example of a couple who could be referred to a WMR Local Government HACC service. After the case description, a score is shown that indicates the likely outcome of an assessment at the four Councils that use a prioritising tool.

Mr and Mrs S are living in their home of 10 years since their migration to Australia from Poland. Both speak very little English as Polish is their preferred language. Mrs S has poor balance as a result of a stroke she had a couple of months earlier. She was recently hospitalised as a result of a fall and has regular visits from the RDNS to dress a wound. Mrs S also has a podiatrist come to cut her toenails every six weeks. Her mobility is declining and she is vision impaired. She uses a walking frame to ambulate and requires assistance from Mr S to perform personal care tasks. After her fall, their bathroom was fitted with rails and a bath seat. These minor renovations have provided a safe environment. Mr S is able to complete shopping, prepare meals and perform other household chores but is feeling stressed and worn out and needs assistance with his 24-hour caring role. They are both resistant to her moving into residential care and despite the stress, Mr S is prepared to provide care to keep her at home. They are, however, happy to accept community services. They receive the full pension.

Priority Outcomes	Hobsons Bay & Melton	Melbourne	Moonee Valley
Mrs S assessed score	25	31	30
Very high	41+	45-50	N/A
High	29-40	26-40	33-45
Medium/moderate	21-28	16-25	21-33
Low	0-20	0-15	0-21

Table 2 shows that Mrs S would be assessed as a moderate or medium level priority at Hobsons Bay, Melton, and Moonee Valley, but a high priority at Melbourne. This indicates that there is the potential to be assessed as a different priority at different Council services. It should be noted, however, that this case study was *developed to emphasise that one client can receive different priorities* at different Councils. A different case study that was examined produced a consistent assessment of "medium priority" across the four Councils. Other case studies may show one of the other Councils to be inconsistent to the others.

It should be noted that regardless of assessed priority, service provision would tend to vary between Councils due to different policy guidelines and resources. However, it is an important first step in improving equity of access to have a tool that can be applied consistently across the region. Once this has been developed, the comparison and analysis of service provision across LGAs for varying levels of need and urgency, will have relevance and meaning.

4.1.4 Prioritisation: Summary of Issues

In summary, prioritising approaches and tools used across the region are inconsistent. More specifically:

- Different emphases is placed on the level of professional judgement across Councils
- Scoring tools in use have not been empirically validated
- There has been limited collaboration within the region to develop a consistent approach to prioritising

These issues are common throughout the community care sector. Similar studies of assessment tools overseas reveal high variability, low comparability and low capacity to generate standardised information (Stewart, Challis et al. 1999). Whilst some work has been done in Victoria to develop an assessment tool relevant for a number of aged care providers at

a local level (Mann 1998), more detailed research on this issue is recommended. The Primary Care Partnership development occurring in the WMR relating to 'Better Access to Services' will be a useful vehicle to look at common assessment processes for HACC and other primary care services in the region. However, the issue of consistent prioritisation between Councils also needs to be addressed. A useful first step would be to establish a representative working group to consider the potential to develop a tool for assessment and prioritisation to be applied by each LGA, and develop a plan for achieving this goal. Such a working group could discuss the different methods of assessment identified in this project and agree on a key set of elements. Detailed consideration of the philosophies underlying the different approaches to assessment and prioritisation would also need to be included. A comprehensive trial and evaluation of a new tool may also be an achievable goal in the medium term.

4.2 Rationing and Service Distribution (coverage)

Most LGAs were managing increased demand by maintaining coverage and reducing the amount of service allocated to individual clients. The extent of the cutback in hours varied considerably between Councils and for Brimbank and Melton this spreading of services had occurred in conjunction with the introduction of waiting lists for low needs clients:

"Priority 3 (low) were cut down to 2 hours per fortnight, priority 2 clients (medium) were cut to 2-3 hours per week, priority 1 clients [high] were not cut down but we have been asked to review them to bring them down a few hours" (Brimbank assessor).

Wyndham and Maribyrnong managed increased demands through "thinly spreading" services:

"What we are doing is slicing the cake thinner and that has its own problems. Most people who are eligible get some services, maybe not as much as they like, in some cases not as much as they need" (Maribyrnong assessor).

"What we have tried to do is spread the service a lot thinner. A couple of years ago they went through and changed most people from a weekly service to a fortnightly service and this has given us extra funds to be able to step in if someone is in crisis to increase their home care or if they are post-discharge and they haven't been picked up by PACFU." (Wyndham Assessor).

This practice enabled most eligible people to access at least minimal levels of service. For those with lower needs, receiving fortnightly home care may be what enables them to continue to manage at home. The impact for high priority clients who have had services reduced, however, requires further investigation. At both Councils, this "thinning of service" required a reduction in hours for many clients. Wyndham assessors reported that a recent increase in the number of Community Aged Care Packages (CACP) had increased their ability to provide service. There were, however, 7-10 people on a waiting list for CACPs who in the meantime relied on Council services for the care required to remain at home. Some assessors were dissatisfied with the extraordinarily high level of care that CACP clients received. Their dissatisfaction stemmed from the fact that while the few who were able to access a package received a high level of service, those who had similarly high needs but were on a waiting list had to manage with the bare minimum. One assessor commented that care packages were a "Rolls Royce" service and that the gap between them and Council services was rapidly widening.

Assessors at Hobsons Bay were able to allocate a maximum of 3 hours service per week for high priority clients. Those who already accessed services were not able to increase their

hours, regardless of changing circumstances. "If anybody is already getting service and asks for more, unless they are in real dire straits we are not providing anyone with extra service, we are only giving new people new service" (Hobsons Bay assessor). This practice aimed to stretch out resources so that newly referred high needs clients could access at least some services. Those with lower needs were unable to access services and were advised to contact the Council again if their circumstances deteriorated. This created much frustration for assessors who reported that needs based assessments were not possible:

"We try really hard to assess people on need rather than on what we can give them. But at the same time it is a bit pointless really because we always go out there knowing what we can give people. So you ... find all the information and discover all the people's needs, but at the same time you don't want to raise their expectations, spend a long time with them, and say I know you need all this stuff but actually I am only going to give you (once) a fortnight. So I think you do end up moving away from the needs based assessment which is a real shame... That's all my social work training was built on; seeing people as individuals and looking at their needs and then trying best to meet that, which is what we still do, but you can't avoid going out there knowing already what you can give people." (Hobsons Bay assessor)

Assessors believed that the lack of preventative services led to clients who initially required a low level of support, to require a much higher level of support in only a brief time period:

"Really, we don't do any preventative service any more....we don't really give people anything unless they really need it. It's a bit sad... You end up refusing service to people...you give them your card and say come back to us and not long afterwards you get these people coming back again because they can't manage or something has happened to them... Maybe if you had given them that preventative service they could have carried on at that level for longer." (Hobsons Bay assessor)

Moonee Valley assessors also reported a tightening of services and an inability to provide care for some clients who would have received services in the past, for example, new mothers:

"When I started home help young women could get help if they had a baby and now that's low priority. Back then services were provided for young mums but now it's provided for the aged. There's a lot of older people that need a lot of assistance."

At most times, however, they were able to offer services to most eligible people on a short term basis at the least:

"There are some on the lower end - we try generally not to refuse them... We have to look at our services and demands...Don't deny any services, get them over that period... We can generally meet people's needs. We are starting to get to that stage of budget restraint... People are realising they don't have to go into a nursing home"

Despite this, assessors at Moonee Valley reported that when there was an influx in referrals a small number of people would be put on a waiting list until "things settled down". This suggested that they were providing the maximum level of services, and if referrals continued to increase without the equivalent funding, the ability to provide service would become limited.

4.3 Waiting Lists

The previous section described how some service providers chose to ration services across a larger client base as a strategy for managing demand. This had the advantage of allowing a

larger number of people to access services and to improve the potential to prevent deterioration for those with lower needs. However, some Councils using this strategy were still unable to provide services to the large number of people requesting them. Melton and Brimbank had started a waiting list as a means of managing this demand. Hobsons Bay, however, reported that they preferred not to use a waiting list as it gave people a false sense that they may be able to access services in the future, when in reality they would only receive service if their priority rating changed. Rather than rely on waiting lists to indicate level of demand, they encouraged clients to formalise complaints to relevant authorities as a way of increasing pressure for increased funding and raising awareness of the situation facing the service and individual clients. Despite this, Hobsons Bay did use a waiting list for home maintenance services. Moonee Valley also used them on a temporary basis to cope with influxes of referrals in peak times.

Clients assessed as a low priority at Melton and Brimbank were placed on a waiting list. Brimbank had also stopped providing service for new clients who were assessed as a medium priority. This began in January 2000 when the service was tendered and the assessment process was separated from service provision.

"[Clients are] advised they are going on a waiting list and if their situation changes [they] need to notify the Council because there is no time for review... People are now put on waiting lists but they're people that we've seen. There was a period of unrest in the unit and people may have been put on waiting lists without a visit because of lack of staff." (Brimbank assessor).

Although approximately 400 people were on the waiting list, assessors commented that many of these people were no longer waiting as they no longer needed services, having accessed services elsewhere (perhaps through family) or had moved into residential care. This provides some indication of the potential impact of not providing low-medium needs clients with support.

Melton had a much smaller waiting list with approximately 50 people. As opposed to rationing services widely, Melton chose to fulfil the needs of higher need clients at the cost of lower priority clients:

"People of high priority are getting what they need at the cost of the lower priority...People on high level should be on packages, but because there is not enough packages they seem to be building up at the top" (Melton assessor).

This waiting list was initiated about 18 months ago when demand for services increased rapidly and a second assessment officer was recruited.

"Melton has a waiting list - but really they have closed their books. A waiting list implies that when someone who is getting services dies or goes into other care, they are replaced by someone on the waiting list" (Referring agency).

A number of agencies, however, also commented that recently there had been some improvements in the availability of services at Melton; "Although there are still restrictions, the new financial year has seen some improvement - getting at least some services." Another agency respondent had "noticed some improvement in the last 3-4 months, don't always get a flat "no" from Brimbank or Melton."

Although Maribyrnong attempted to meet demand through rationing services, there was also some expectations that this could not be maintained. It was noted by an assessor that eventually a waiting list would be necessary: "It's getting harder and harder because the dollars are getting less and less – last year we were heading towards waiting lists because there's only so far you can cut the bone. Unless we get more money and if it increases we will probably [start] a waiting list".

Waiting lists were identified by key referring agencies as a difficulty; "Waiting lists are a problem- especially at Melton and Brimbank" (CareConnect). It is unclear whether the difficulty experienced was due to the management of the waiting list or the reality that demand for services had led to the need for a waiting list.

4.4 Service Promotion

Almost all assessors reported that their Council was not active in promoting Council HACC services due to the demand for services. They commented that it was futile informing people about these services when they often were not going to be able access them. Although assessors indicated that this was a poor practice, they indicated they had little alternative, as they did not want to give people false hope of receiving services. Assessors at Brimbank, Hobsons Bay and Melton made the following comments:

"We don't have very many brochures. Although it is a bit sad to say, we are probably better off not doing that because the demand is high enough as it is, so we would be creating a demand that we could not meet... I think people should have access to the information but there is a fine line between telling people about things and raising expectations that we cannot meet."

"We have printed information for our clients and translated into twelve community languages which is available to everybody ... We have information available if requested. We don't advertise in the local paper ... We have good information available to those who ask for it".

"Due to the waiting list the Council doesn't do a lot of advertising. Even though there is a waiting list, advertising of services is still needed to ensure that all members of the community are aware of services."

Melbourne Council, however, was able to actively promote their service:

"We have functions and have a lot of forums to let people know of the service. There is a project that is going on with Ministry of Housing targeting those people... every year we have festivals so we advertise quite a bit. I suppose we could send pamphlets to let them know the service is around. We haven't done that" (Melbourne assessor).

Most assessors reported that new clients heard of the services by "word of mouth" through friends and neighbours accessing services, or through other health professionals and agencies:

It was also stated that many people didn't know specifically about HACC services but when they needed help they generally went to the Council for advice and were then referred on. There was also a perception that people trusted the Council and that they would be there to help when needed;

"I think sometimes people just phone the Council because they don't know what [else] to do... they don't have any concept of what HACC services are at all. Lots of people hear via if they have been in hospital or GPs making referrals." (Hobsons Bay assessor)

Assessors reported that once someone became a client they were provided with ample information regarding the service, their rights and responsibilities, as well as grievance procedures:

“Whenever we do an assessment we leave information of the services available. From this, people contact us whereby they are given comprehensive information” (Moonee Valley assessor).

“When we go out we generally give the client a magnet with our phone number on it... Also have Statement of rights and responsibilities, Service Charter... Home Care task list – we leave this in the client’s home and we tick off what the carers need to do. If they are going to receive meals we leave recommendations of the foods they should have” (Moonee Valley assessor).

Interestingly, referring agencies in general, continued to promote the existence of Council services:

“We will always tell clients about the services Councils can provide. If we receive a referral from ACAS and no referral to Council has been made, I will ask the client if I can make a referral to Council. We then do a joint assessment to work out with Council assessors what each of us can provide. This happens with most Councils. However, some clients don’t want Council services because of the fees associated.” (CarerLinks)

Most assessors stated that the Council had some information translated into languages other than English that were common in their community, however, most believed that there was not enough information and not enough languages covered:

“We make sure our literature is up there but we don’t have a lot that is translated into other languages. I have been using the Department of Human Services... generic HACC literature. We are looking... at translating our own information - then you have got a problem that the elderly from non-English speaking backgrounds can’t read in their own language. That’s often why we target the local newspaper so that English speaking relatives let them know about the services. We target the local doctors because people from Non-English Speaking Backgrounds attend their doctor frequently, so we have targeted them and made them aware of our services.” (Wyndham assessor)

They also reported that people from NESBs were not accessing the service in proportion to how many were living in the community:

“I am sure there is a higher proportion of those people within the Council who would be eligible than actually use the services. And we find that people who do get referred quite often are eligible and we offer them service and they cancel or refuse” (Hobsons Bay assessor).

Assessors indicated that the main reason for this was that many families felt it was their responsibility to look after their relatives. The other main reason cited was the language barrier and that older people of NESB were not confident about having someone who they couldn’t communicate with in their home. Although most Councils had some carers who spoke languages other than English, it was stated that this would not be well known:

“There is a reluctance for Vietnamese to use services because they like to look after their own as much as they can... Feel intimidated by English speaking people. Don’t realise interpreters can be used, perhaps a little bit of pride” (Brimbank assessor).

“A lot of people from ethnic backgrounds seem not to want to pay for the service or they find the service is unsuitable. Although we do try to get workers who are from the same ethnic background and speak the same language... I think people just have a different concept about what the service is about. And if you don't speak the same language it seems like a huge bureaucracy that you have to go through all the procedures and its probably quite hard to do” (Hobsons Bay assessor).

Referring agencies also raised this theme. One representative commented about the differences between ethnic populations that had a large number of people and strong networks and those with only very few people who tended to be more isolated and less likely to link up with these networks. Some of these people were becoming more isolated as they spoke dialects that were uncommon and sometimes not used in their own families. “More formalised ethnic groups with senior citizens tend to know more about services, it's the minority ethnic groups – older people speak older dialects – their grandchildren don't” (ISIS Primary Care).

4.5 Client Reviews

Wyndham and Maribyrnong had undertaken a systematic review of clients over the past 12-18 months with the aim of reducing most clients' home care down (generally from weekly to fortnightly and 2 to 1.5 hours) to allow more people, or people with higher needs, to access limited services:

“For the last two years we've gone on a concerted effort to reduce them (clients) back from weekly to fortnightly, most of them are happy with that. I always go in with the idea we need to share what we have, and generally at the end of the day they are quite happy with that” (Maribyrnong assessor).

A study conducted in two Melbourne metropolitan LGA HACC services provided some evidence that reducing services through reviewing needs can provide better outcomes for clients than simply cutting all services for low service users (Lindeman 1997). The method of prioritising described by Maribyrnong reflects the findings of this 1997 study. Unfortunately, time pressures on assessment officers in the WMR meant that routine review for low needs clients rarely occurred. Rather, most clients were reviewed as a result of a change in circumstances. Generally changed circumstances became evident at a hospital visit or via a report from a Council carer, clients or their family.

Most Councils had protocols to routinely review clients. For some Councils these time frames were: 3 months for high needs, 6 months for medium needs and 12 months for low. Others aimed to assess all clients within a 12-month period. Almost all assessors reported that these goals were not feasible and that it was difficult simply keeping up with new referrals and requested reviews:

“We are behind with doing that [reviews]. What happens most of the time is we get requests for reviews either from the home care office...or the workers that go and see the clients will refer them back because they are concerned about something... or the clients refer themselves or their family members. So we end up doing a lot more of those than annual reviews. Obviously when you go out and see a client you have got a review date in there and that's how we keep track of what we should be doing” (Hobsons Bay).

“[Reviews] should be every 6 months, but with 300 clients at 19 hours per week (part time assessor) it's really difficult. In reality review occurs (every) 12 months. People will generally ring if there are problems and if they are not coping.” (Melbourne assessor)

"If there are people who are far more vulnerable we do assessments probably every six months. Unfortunately that really hasn't happened over the past 2 or 3 years due to lack of resources. I was the only one doing all the assessments and reviews and you'd be kept doing assessments and follow up and there was no time to do reviews. The ones that were done were more your crises reviews – people would come in and say I've just had a fall, just come out of hospital ... we would go out and do those reviews. Regular reviews just weren't happening." (Melton assessor).

An assessor from Wyndham stated that they received approximately 40 new referrals and 20 requests for reviews per month. Simply keeping up with these reviews was difficult and routine reviews become the lowest priority. Often these routine reviews consisted of a phone call - thus missing out on vital information about the client's home environment and family interactions. Some Councils had monitoring forms that direct care staff were responsible for completing. One assessor reported that relying on home carers for requests for review was a poor practice as it placed unfair responsibility on these staff who may not have the skills to identify important changes in circumstances. As many Councils had also split service provision from assessment, assessors reported having less contact with direct care staff to discuss the needs of individual clients:

"We review as needed. The home care workers are given a monitoring schedule... They will report back when there are changes but they will also report back how people are doing every 6 or 12 months. We would like to get to see everybody about every two years but its not possible, what we tend to do is review people when there are changes. If we don't review them we refer them on to ACAS to review. It's those people that sit in the background that nothing has happened to them. You don't get around to seeing them." (Wyndham assessor)

This assessor also described the problems with completing reviews over the telephone and relying on home care staff to feedback on changes.

"The home visit is so much more than just talking to the client - its about getting an idea of what their relationship is with their family. You can't always do that over the phone...- I guess you hope the home care worker will pick up on some of that. Then often they don't have a lot of training or experience to pick up on that and they don't feel that that is their role."

Unfortunately, this method of reviewing clients means that high priority clients are more regularly reviewed than lower priority clients and where increases in service is required it is not picked up. Low priority clients, who have not been identified as requiring an increase in services, do not receive a routine review due to time pressures on assessment staff. Clients who may be able to have services reduced, therefore, are also not picked up through the current review process. This method of targeting services to better manage demand was also identified by a referring agency; "better and more regular reviews and reassessment" is required. One Aged and Disability manager argued, however, that reviews more frequently identify an increased need for services rather than the option to reduce services. At present there is insufficient evidence on the effectiveness and outcomes of reviews and reassessments to provide information to adequately assist service planners/managers and assessors to determine the best mechanisms, frequency etc of reviews and reassessments. However, some research evidence suggests that an increased emphasis on on-going reassessment, along with greater use of shorter periods of service where appropriate, would lead to a greater turnover of clients than presently exists (Turvey and Fine 1996). These practices may lead to greater efficiencies in the use of assessment resources and may help service providers to manage service demand.

4.6 Increasing HACC funding through Council contributions

Another demand management strategy reported is increasing the HACC budget through the Council's own contributions. In the WMR, LGA contributions to HACC ranged from 32% to 50% in individual Councils, although there were variations in how funding contributions were calculated. This may become a less effective demand management strategy as Councils are trying to better manage expenditure. In Moonee Valley, the Council had increased budget contributions over the previous two years, a strategy which was regarded as unsustainable: "Council has done this to avoid a budget blow-out as we struggle to meet demand. We wanted to avoid stringent waiting lists and tighter prioritisation criteria." Some referring agencies perceive that there is significant variation in the levels of Councils' contributions: "Some Councils put more [funding] into community services than others... Some don't put in enough" (referring agency assessor). The view was expressed by an LGA manager, however, that many agencies would have little knowledge of how local government HACC services are funded.

At one Council a waiting list was introduced as a method of meeting specifications within budget. Prior to Compulsory Competitive Tendering (CCT), however, this Council would have provided the service regardless of budget overruns.

4.7 Different Use of Available In-home HACC Services

In addition to spreading services thinner, demand management strategies can also include different use of available services. Ideally, assessment officers should be able to be flexible about the services offered by their own organisation without feeling unduly constrained by the model of service delivery in place. For example, offering one-off or infrequent services, may also be a valid demand management strategy (such as home maintenance or spring cleaning depending on the person's most immediate needs). This practice can be used to ensure that people with lower needs have some link to the service system, even though they are ineligible to receive ongoing in-home support because of their needs relative to others in the target group. Other strategies could be to offer a service regularly but less frequently (eg monthly). For example, one respondent from a major referring agency noted that some clients would benefit greatly from having occasional assistance with laundry and shopping, but that this is not always covered by Council services (some do not offer occasional assistance of this type). Another referring agency reported that families of children with a disability sometimes have emergency respite needs, or need to change their usual service requirements at short notice, but that Councils are mostly unable to respond to these emergency situations. For this client group, their needs can remain unmet if their LGA has little flexibility in responding to emergency situations.

The possibility of health promotion interventions or preventative strategies as common outcomes of needs assessments undertaken by Councils may also emerge as a means of managing demand. Whilst not a theme emerging through the interviews, this direction is clearly highlighted by government for future development (Department of Human Services 2000a) and is a strategy that is discussed in more detail later in this report.

There may also be potential for Councils to use available services differently through investigating the options available in the community. For example:

“We have reduced the shopping by getting every supermarket in the area, their name, when they deliver, how much it costs. That was an expensive service for us. Cutting down on shopping has given more hours for other services” (Maribyrnong assessor).

5. Provision of Services

This section provides some information to begin to evaluate the evidence of demand for 'in-home' HACC services. New referrals received by LGAs are discussed as is the service provision levels of each LGA "in-home" HACC service. In relation to new referrals, qualitative data points to a general increase in demand for services. In relation to service provision, it was found that there was a generally low level of service provided to clients regardless of the level of need or priority of the client, or of the nature of the service (eg personal care, respite or home care). The City of Melbourne appears to provide a higher level of service to home care, personal care and respite care clients than other Councils indicating a better ability to meet service demands in that area. Some interesting comparisons between the HACC User Characteristics data, the HACC Status Report and the WMR are also made in this section.

5.1 Number of new referrals and referral sources

Only limited information was obtained relating to new referrals and the source of these referrals. Most Councils had recently added another module to their software programs that allowed a record to be kept of incoming referrals and referral sources. Unfortunately, the ability to generate summary reports that only produce data on "in-home" HACC services was not possible as data often included referrals for all LGA HACC services including centre-based and full cost recovery services. Some information on the number of new clients entered on the database within a specified time period for "in-home" HACC services was developed and has been included in Appendices 5 and 6. This data, however, only shows the clients who were assessed and received a service and does not indicate those who were referred but were not able to access services due to screening and prioritising processes.

The data that were obtained shows the main referral source varied across the region, however, some trends were evident. Most referrals are made by those in the informal network of the person requiring services or by the person themselves. Hospital and GP referrals were also a high proportion of the referral source for those who were accessing services. These referral sources also reflected those reported by assessment officers:

"There's quite a lot of self referring, referring through friends, neighbours, and family other than that from ACATs, from RDNS, sometimes through doctors, often from hospitals, particularly from Western General, occasionally from housing services" (Maribyrnong assessor).

Assessment officers also reported an increase in the number of new referrals as well as an increase in level of need of existing clients. Often an increase in number of referrals was related to practices of another agency or an increasing demand for other services.

"It's been creeping up on us – there are quite a few new ones [referrals] but there is also increasing levels of need for established clients. We also have in the last couple of years taken on a lot of personal care work which RDNS used to do - that accounts for a lot of hours – RDNS have had a similar sharp increase in demand. They no longer do straight personal care - they refer that onto us" (Maribyrnong assessor).

"A lot of hospitals ring up making referrals - possibly because people are going home earlier from hospitals and need these services" (Hobsons Bay assessor).

These comments suggest that there is an overall increase in demand on the service system, however, as discussed, there was a lack of quantitative data to support this observation.

5.1.1 Improving data collection on demand

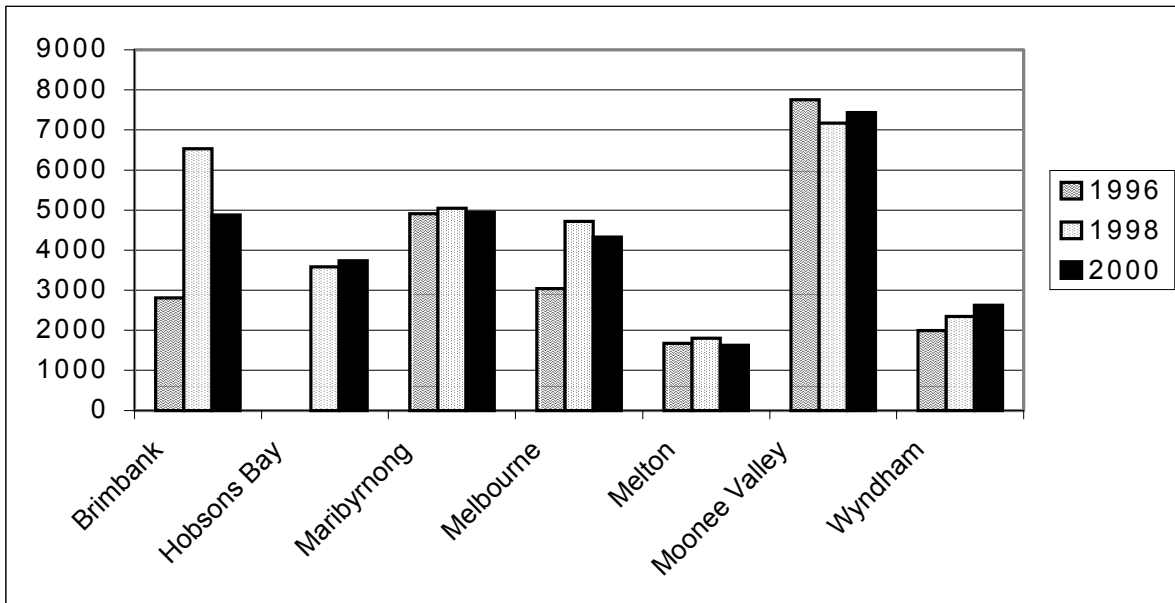
The new assessment module used by those who use the Sharikat Khoo program enables data to be recorded on people who are referred to the service but who may not receive services due to prioritising processes used within each Council. To determine whether the module provides a means of understanding unmet demand a number of issues will need to be explored. At present, clients who do not access services have their record terminated. This does not mean that the data is completely lost but it does mean that these clients will not come up on demographic reports. A terminated client list can be generated but will include clients who received services who had their records terminated for other reasons, such as moving out of the area or moving into residential care.

A variable needs to be added to the module (if it does not already exist) stating whether clients were admitted on to the service, with only two response categories; 'yes' and 'no'. This should enable reports to be generated that compare clients who did get services to those who didn't. A number of demographic and health status reports could be generated to investigate why clients do not get access to services. Preferably, the module would contain categories that match up with the priority tool used including the total score that was determined during assessment (particularly useful if a consistent tool is used across the region). These reports could be compared across the region to investigate whether clients denied service at one Council have higher needs, or higher dependency, than those denied service at another Council. Perhaps these reports could be generated once every three months. After these reports had been generated, clients who did not access services could have their records terminated to ensure they are not included in other client profiles. The capability of the assessment module to perform these actions needs to be investigated and Councils not using Sharikat Khoo also need to investigate the possibility of generating this data.

5.2 Service Provision

Figure 4 shows the total hours of service provided for home care personal care, respite care and home maintenance for a 4-week period in May.

Figure 4: Total hours of care provided for home care, personal care, respite care and home maintenance in 4 week period

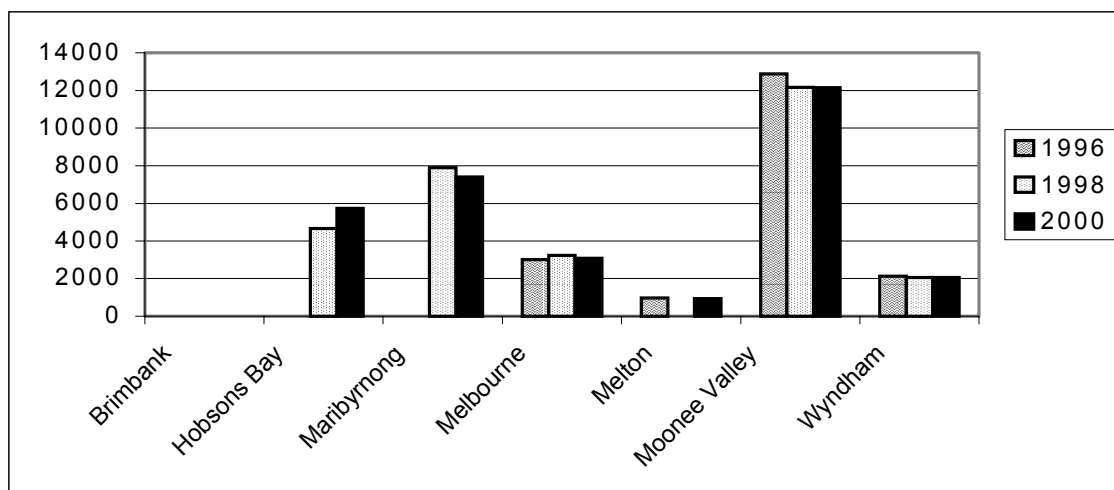


Home maintenance is included as number of jobs for Hobsons Bay. Hours for Brimbank and Moonee Valley do not include home maintenance in 1996.

Figure 4 shows that Moonee Valley provides the largest total hours of “in-home” services, despite a small decrease in hours from 1996 to 2000. This high number of hours is consistent with the estimations of the HACC target population that shows Moonee Valley has a comparatively higher target population than the other LGAs, with the exception of Brimbank. Wyndham has steadily increased hours while Hobsons Bay, Maribyrnong and Melton have maintained a similar amount of service. Brimbank and Melbourne increased hours from 1996 to 1998 but have dropped back in 2000, but still provide a higher number of hours than in 1996.

Figure 5 also shows that Moonee Valley provides a far larger number of meals than the other Councils. Unfortunately, no data on meal provision were available for Brimbank, due to the use of a manual system.

Figure 5: Total Number of delivered meals provided during a 4-week period in May



Melton and Wyndham data obtained through manual records for the total month of May. Melton data for 1998 was irretrievable.

The following sections provide details of different service activities in relation to the number of clients receiving that service. It should be noted that Linkages 'maintenance of effort' hours have generally not been included due to inconsistencies in recording these clients separately from other full cost recovery service provision to Linkages clients. It should be noted that the numbers of clients receiving maintenance of effort hours are less than one hundred for all LGAs. The maintenance of effort hours set by each Council are indicated in the section that considers impact on the service system.

5.2.1 Home Care

Table 3 shows the number of clients and the hours of home care they received during four weeks in May 1998 and 2000. Due to inconsistencies and lack of availability of data for 1996 it has been excluded from all figures relating home care personal care and respite. The figures shown in brackets relate to clients receiving specific services - "in-home" services for younger people with a disability. Please note that these figures are for home care services only (unless stated otherwise in the notes to the table). The numbers are not extracted from the general client figures but are additional clients and hours.

Some LGAs split their home care into different levels relating to different tasks and different staff pay rates. These different levels may not be mutually exclusive and therefore to simply add up the clients under each level may lead to double counting some clients. For this reason, Table 3 shows a possible range of client numbers for Brimbank and Maribyrnong. For the hours per client two averages have been calculated. The first uses the smallest number of clients possible and the second uses the largest number of clients.

Table 3: Home care clients, hours and average hours per client for a 4 week period in May 1998 and 2000

	Year	Clients (Specific Service- SS)	Hours (SS)	Av. hrs per client for 4-weeks (SS)
Brimbank	1998	828-885 (37)	4554.35 (316.5)	5.5-5.2 (8.6)
	2000	756-774 (41)	3285.9 (306.7)	4.4-4.3 (7.5)
Hobsons Bay	1998	759 (18)	2934.5 (106.8)	3.9 (5.9)
	2000	791 (21)	2948.75 (102.5)	3.7 (4.9)
Maribyrnong	1998	973-1073	4863.65	5-4.5
	2000	931-971	3828.29	4.1-3.9
Melbourne	1998	458 (N/A)	3511 (264*)	7.7
	2000	351 (N/A)	2514 (276*)	7.2
Melton	1998	214 (7)	993 (33.3)	4.6 (4.8)
	2000	199 (5)	905.75 (29)	4.6 (5.8)
Moonee Valley	1998	639-1616* (73*)	5920.75* (729.2*)	9.3-3.7* (10*)
	2000	1096-1567 (7)	5418.5 (25)	4.9-3.5 (3.6)
Wyndham	1998	427 (24)	2063.5 (169)	4.8 (7)
	2000	510 (12)	1796.25 (84.5)	3.5 (7)

*shows figures for home care, personal care and respite combined

Maribyrnong does not include home care for younger people with disabilities in specific services.

Table 3 shows that Melbourne provides, on average, a much higher rate of home care than the other LGAs with an average of over 7 hours per 4 weeks, or almost 2 hours per week. Most of the other Councils provide around 1 hour per week on average, although it is difficult to rank Moonee Valley due to the large range of possible clients and hours per client. Between 1998 and 2000 there were many changes in the number of clients and hours of home care provided. Interestingly, most LGAs are servicing fewer home care clients in 2000 than in 1998 with the exception of Hobsons Bay and Wyndham who had increases of 4% and 19% respectively. Despite the increase in number of clients in Wyndham the number of hours provided dropped by 13%, resulting in a drop in average hours per client in a 4 week period from 4.8 hours in 1998 to 3.5 hours in 2000. This change was described by assessment officers as an attempt to spread services. As a Maribyrnong assessor indicated, home care provision is provided at a minimal level that aims to maintain a household but does not always meet clients' expectations:

"Certainly everybody is getting a little less than they would like but then cleanliness is a personal thing, some people are happy with once a month or once a week, some would like it cleaned every day. What we do is maintain a level of cleanliness or hygiene that isn't fantastic but it maintains that household" (Maribyrnong assessor).

The data shown in Table 3 can be compared with the HACC User Characteristics Data Collection (Department of Health and Aged Care 1998). For the month of November 1997, this 10-20% sample of the HACC client group was receiving 4.8 hours in the WMR and 4.3 hours in all of Victoria. The WMR provided more hours than the other three Metropolitan regions that provided between 3.5 and 3.8 hours per client during this one-month period. In 2000, only Melbourne and Melton provided more than the Victorian average for November 1997, with Brimbank very close to the average. Table 3 also shows figures that were similar to those reported in the HACC Status Report (Howe 2000). This report showed that for the 14 LGAs included in the study, clients tended to receive between 1-2 hours per week home care.

Families who have a child with a disability are, on average, receiving a higher amount of home care than older clients. It is important to note that for 1998, Moonee Valley and Melbourne did not have home care for younger people with disabilities separate from respite and personal care. This would explain the apparent drop in hours at Moonee Valley from 10 hours in 1998 to only 3.6 hours in 2000 (although still slightly higher than for older home care clients).

5.2.2 Personal Care

Table 4 indicates the number of clients receiving personal care for 1998 and 2000.

Table 4: Number of clients receiving personal care by general and specific services

	General		Specific Services	
	1998	2000	1998	2000
Brimbank	56	56	21	14
Hobsons Bay	53	80	4	33
Maribyrnong	N/A	92	NA	NA
Melbourne	58	78	NA	NA
Melton	31	27	4	5
Moonee Valley level 2 (medium)	NA	123	NA	4
Moonee Valley level 3 (high)	NA	38	NA	3
Wyndham	34*	59	**	4

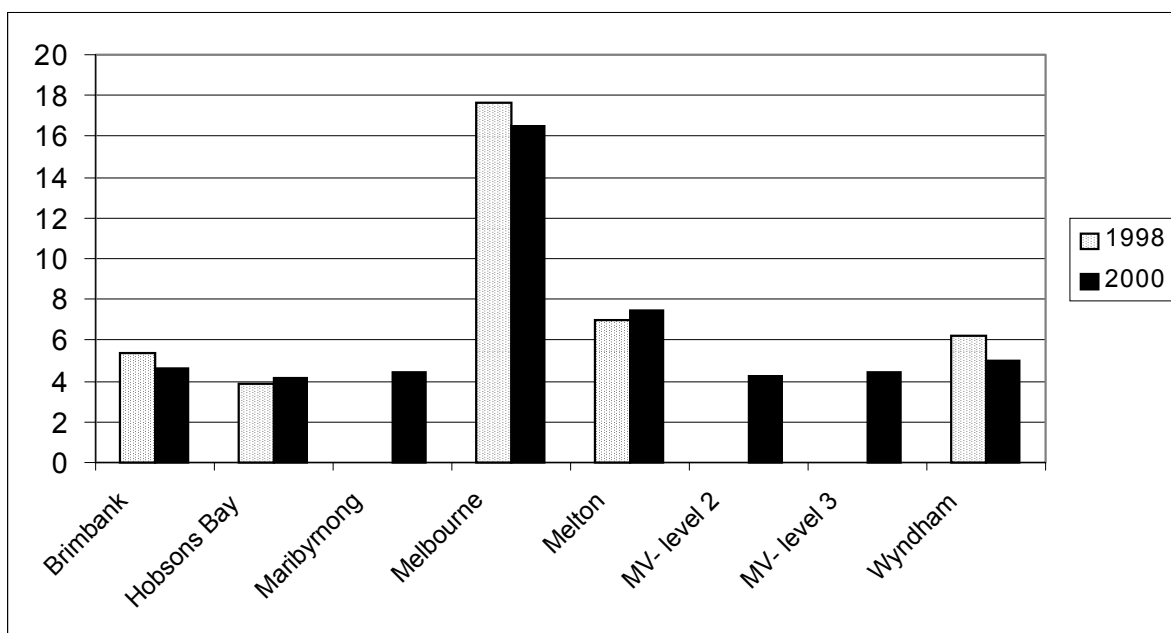
*Please note that in 1998, respite is included with personal care for Wyndham.

**Included under respite as hours are combined.

Table 4 shows that there is a higher number of 'general' clients receiving personal care services than younger people with disabilities. Very few children are receiving services under personal care. They may, however, be receiving this type of care during respite hours. For those who had data available for 1998 and 2000 there had been a large increase in the number of clients with the exception of Brimbank who maintained the same number of clients.

Figure 6 shows the average number of personal care hours per client for 1998 (where available) and 2000. Note that specific care clients have not been shown in this figure.

Figure 6: Average hours per client for personal care during a 4-week period in May (does not include specific care)



NB: In 1998 Maribyrnong and Moonee Valley personal care hours were included with home care and respite. Moonee Valley used two levels of personal care that appears to overlap in the data. Therefore, the total number of clients, or hours per client cannot be identified. Wyndham has respite included with personal care perhaps explaining the higher hours per client for 1998 than 2000. Wyndham staff reported that from 1998-2000 there had been an increase in hours of personal care provided to each client.

Again, Melbourne stands out as providing a higher level of service on average for each client with over 16 hours over 4 weeks or about 4 hours per week. Most of the other Councils were providing closer to 4 hours over 4 weeks - an average of about one hour per week. As most personal care involves assistance with showering, one hour a week would equate to about one, at the most 2, showers a week. Due to limitations of the databases used it was not possible to produce reports on the involvement of other service providers involved with clients care. Due to infrequent client reviews and updating of records, it is unlikely that any data recorded on the database would be an accurate reflection of current service use from other agencies. This level of personal care matches assessors description of what they usually allocate; "The general maximum for personal care is two showers per week but some people get three" (Maribyrnong assessor). At Hobsons Bay high priority clients only receive:

"three hours a week... and that could be a combination of cleaning, personal care, assistance with shopping, paying bills - it's nothing. If they need two showers per week and it takes three quarters of an hour and they score very high then that leaves them with an hour and a half a week and if they have incontinence it would be nice to have a shower [more often]" (Hobsons Bay assessor).

Although the number of personal care clients had increased between 1998 and 2000 there were only minor changes in the average hours received by personal care clients. Brimbank and Melbourne dropped slightly in 2000 while Hobsons Bay and Melton provided slightly more personal care hours per client. Although Wyndham also appears to drop this decrease is more likely to be explained by the fact that respite care hours were combined with personal care in 1998 but not 2000. Overall, it appears that the increase in number of clients has not had a

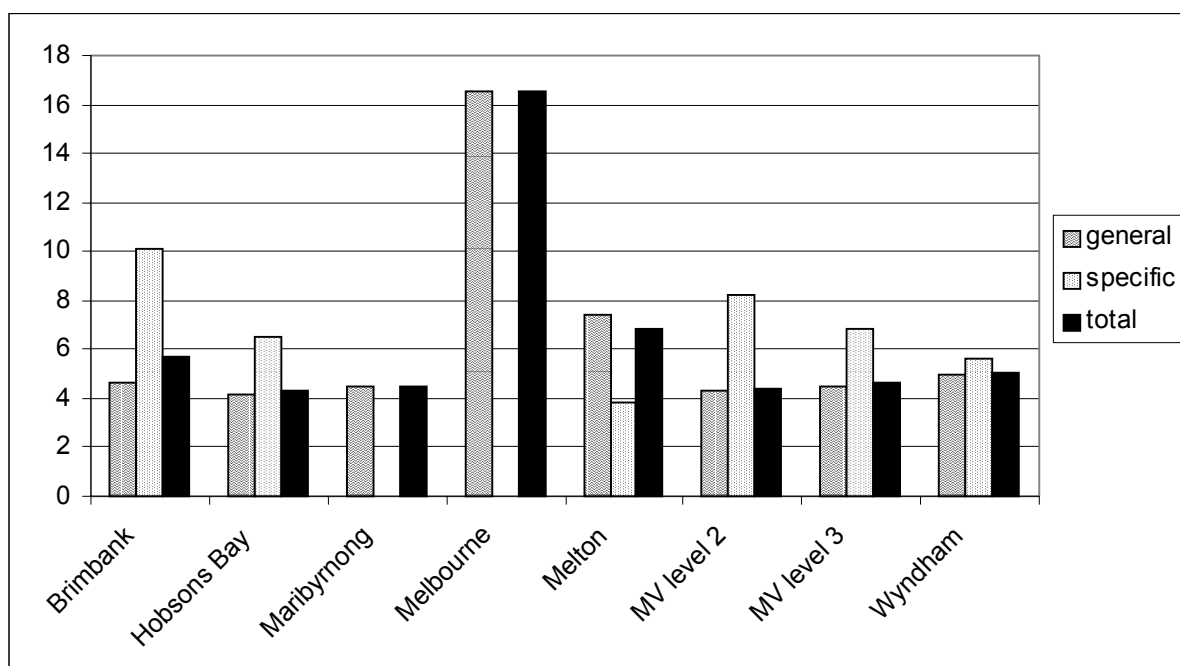
significant impact on the provision of hours for each client. How long Councils can maintain this increasing number of clients, however, is not known and is an area of concern for future provision of services.

Data from the HACC User Characteristics Data Collection (Department of Health and Aged Care 1998) shows that in November 1997 Victorian personal care clients were averaging 7.3 hours of personal care for the month while those in the WMR were averaging 13.5 hours. As for home care, the WMR's average service provision was also higher than other metropolitan regions that provided between 7 and 8.2 hours over the month. It is important to note that figures from the HACC User Characteristics will also include personal care provided by RDNS and other HACC funded services. As the RDNS receives a significant proportion of the HACC funding for personal care, the ability to compare Council personal care provision with these figures is limited. It is also possible that the 10-20% HACC User sample size provides a poor estimate of the amount of service being provided to Local Government HACC clients.

Data from the HACC Status Report may provide a better comparison to the data from the present study as both are collected from local government services. The HACC Status Report indicates that most personal care clients from the metropolitan Local Governments received between 1 and 3.5 hours per week with three of these seven Councils providing more than 2 hours a week (Howe 2000). Clients in rural and provincial centres received a similar amount with the exception of high priority clients who tended to receive more than their metropolitan counterparts. Although clients were averaging a similar amount of personal care in the Western Region as other LGAs in Victoria, the total amount of service provision appears small. Assistance from informal carers and use of other personal care services such as RDNS, however, also need to be considered to determine the appropriateness of this amount of personal care.

Figure 7 shows the same data for general personal care for 2000, together with specific care clients and an overall service average.

Figure 7: Average hours per client for personal care during a 4 week period in May 2000



NB: Melbourne had no data shown for personal care for specific care clients as the number of clients had not been determined. It is known that for this period in May 2000, specific care clients received a total of 276 hours of care for respite, personal and home care.

For all of the LGAs shown, only Melton and Maribyrnong provided a lower level of personal care for children with disabilities than for older people. Maribyrnong shows no hours for specific care as they only provide a respite service for these clients. Within this respite, however, clients may be receiving some assistance with personal care tasks. Brimbank provides twice as many hours for specific care clients than older clients for the four-week period shown. The differences between older clients receiving personal care and younger people with disabilities highlights some of the limitations of combining all “personal care” clients, as has been requested by DHS in recent years. Considering an overall average of hours per client does not take into account the different needs and level of service for older people in comparison to families with children with disabilities.

5.2.3 Respite Care

Table 5 indicates the number of clients receiving respite care services for 1998 and 2000. Despite the significantly higher number of older people accessing local government in-home HACC services, the table shows that more younger people are accessing respite services.

Table 5: Number of clients receiving respite care by general and specific services

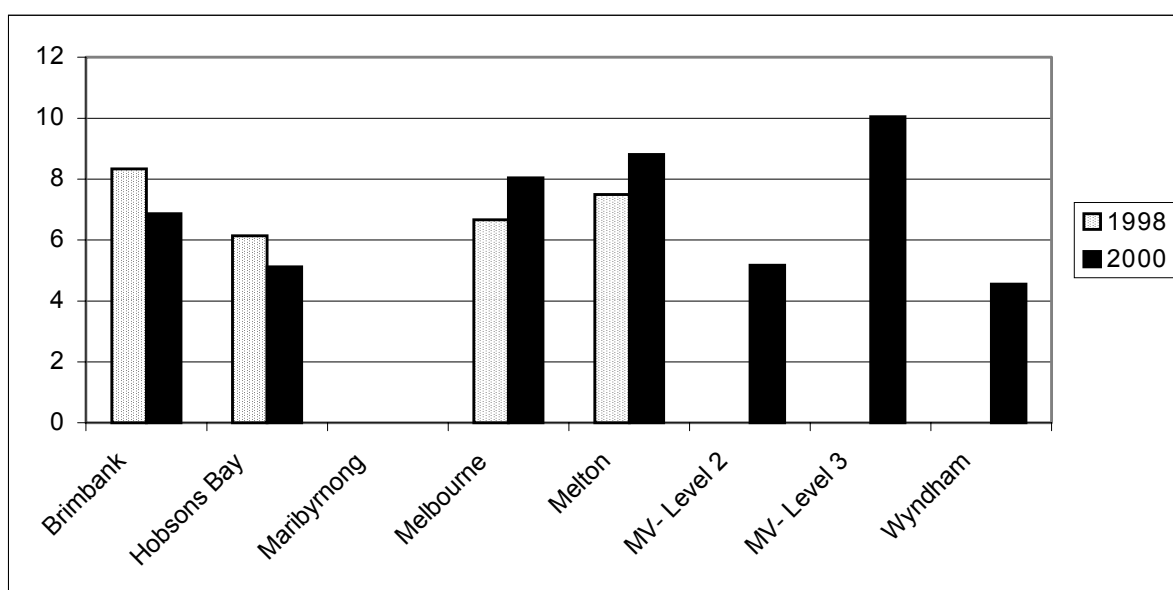
	General		Specific Services	
	1998	2000	1998	2000
Brimbank	19	18	73	68
Hobsons Bay	7	6	38	41
Maribyrnong	NA	NA	38	36
Melbourne	18	25	NA	NA
Melton	7	2	36	37
Moonee Valley level 2 (medium)	NA	17	NA	4
Moonee Valley level 3 (high)	NA	9	NA	52
Wyndham	NA*	9	33**	41

*1998 data for Wyndham general respite is combined with personal care

**1998 data for Wyndham specific services respite also includes personal care.

In contrast to the personal care data, there does not appear to be an increase in respite care clients between 1998 and 2000. Despite a relatively small client population, Melbourne is providing respite to a larger number of older clients than the other Councils. Hours per older respite care client are shown in Figure 8.

Figure 8: Average hours per client for respite during a 4-week period in May (does not include specific care)



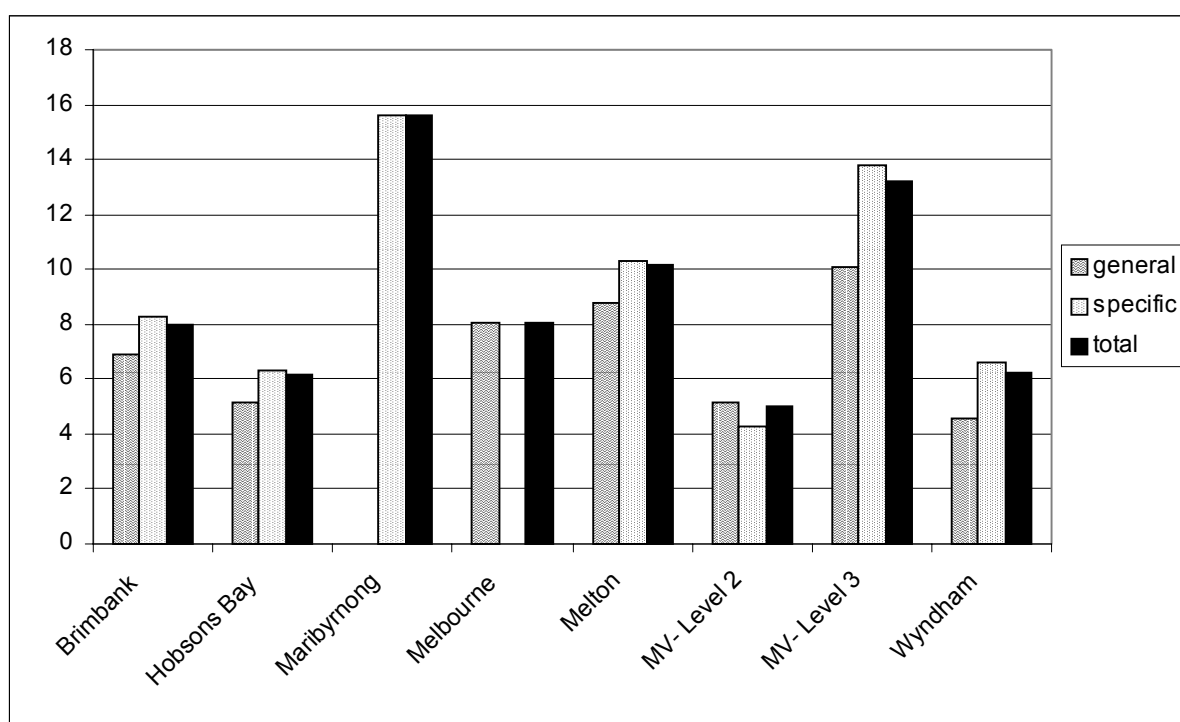
NB: Maribyrnong mostly provides respite hours to children with disabilities and is shown in Figure 9. General respite hours were very small and appeared unreliable. In 1998 Moonee Valley included home care, personal care and respite care together. In 2000 Moonee Valley separated clients into 2 separate levels with level 2 (medium priority) having 17 clients and level 3 (high priority) with 9. Wyndham respite for 1998 is combined with personal care.

The respite hours provided by each LGA was relatively consistent. For Moonee Valley clients, being classified as level 3 (high priority) was likely to result in a much higher level of service provision than being classified as level 2 (medium priority). Only Melton, Melbourne and Level 3 Moonee Valley clients received an average of 8 hours of respite for the 4-week period in 2000, equivalent to about 2 hours per week. Clients at Hobsons Bay, Moonee Valley (level 2) and Wyndham received about 5 hours over 4 weeks during 2000, just over an hour a week. This is well under the HACC User Characteristics Data Collection for November 1997 where

clients across Victoria were receiving on average 11.6 hours a month. While the WMR was providing 7.2 hours for the 10-20% sample, other metropolitan areas were providing between 11.2 and 15 hours on average (Department of Health and Aged Care 1998). Data from the HACC Status Report, however, also shows a trend for the participating LGAs to provide about two hours a week respite care. However, five of the fourteen LGAs in this study were providing, on average, more than two hours a week respite (Howe 2000).

Once again there does not appear to be any significant trends of reduction or expansion of hours per client from 1998 to 2000. Brimbank had most consistently provided less hours per client for personal care, respite and home care while Melbourne has decreased hours for personal care and home care but increased them for respite care. Melton had increased respite hours and personal care hours per client from 1998 to 2000 whilst home care stayed the same.

Figure 9: Average hours per client for respite for a 4 week period in May 2000



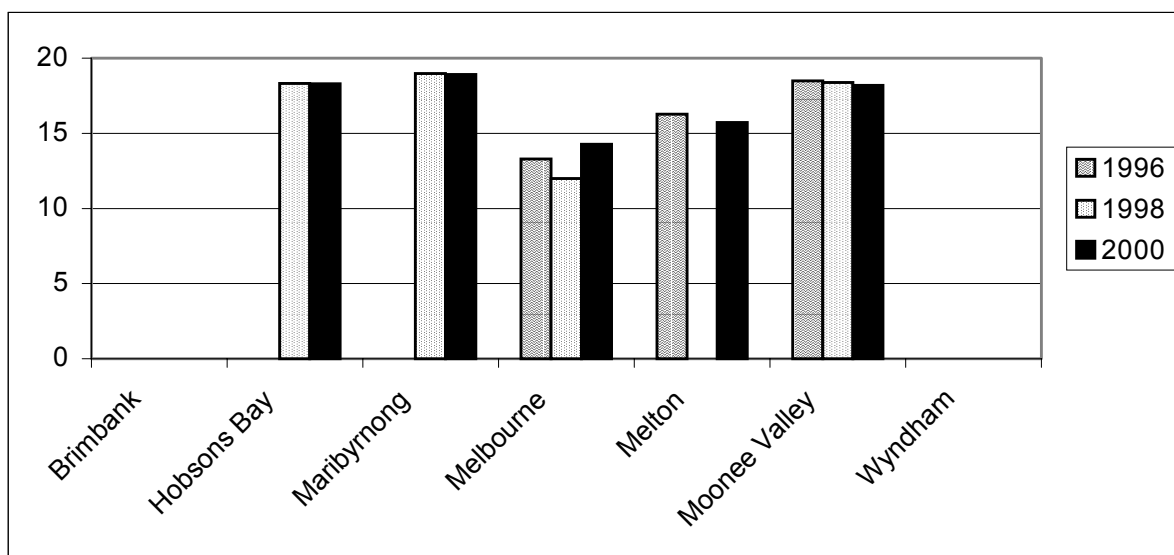
NB: Melbourne had no data shown for respite for specific care clients as the number of clients had not been determined. It is known that for this period in May 2000, specific care clients received a total of 276 hours of care for respite, personal and home care.

Generally, specific care clients received, on average, a larger number of respite hours than other clients. Maribyrnong provided most of its respite care to younger people with disabilities. These clients also received on average a larger number of hours than clients from the other LGAs. Moonee Valley (for level 3 clients), Brimbank, Hobsons Bay, Melton and Wyndham all provided, on average, a larger number of respite hours for younger people than older people receiving respite. The difference at Moonee Valley between level 2 (medium priority) and 3 (high priority) provision of respite is quite substantial with level 3 specific care clients receiving, on average, an additional 10 hours service over the 4-week period than level 2 specific respite clients. It should be noted that there was a much larger number of level 3 specific care clients than level 2 (52 compared to 4).

5.2.4 Food Services

Food services data was less routinely recorded on a computerised database with 3 Councils still using a manual system and Hobsons Bay moving to a computerised system after 1996. Two of the Councils using this method, however, were able to provide some data on number of clients receiving meals and the number of meals delivered.

Figure 10: Average number of Meals delivered per client during a 4 week period in May



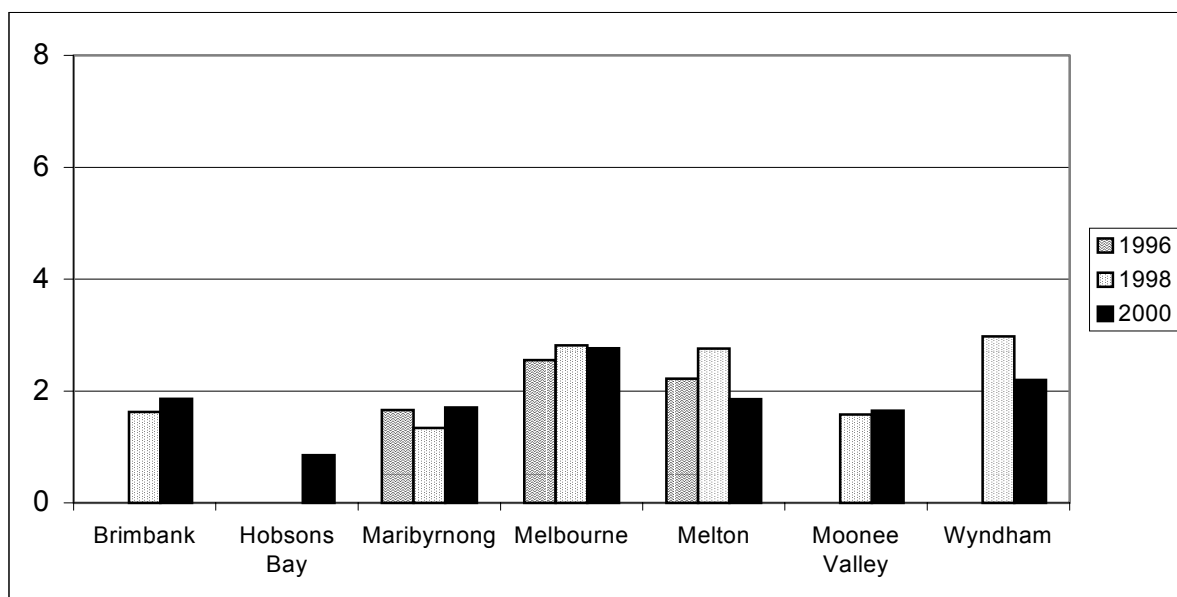
NB: Brimbank was unable to provide this information due to the food services systems being run manually. Wyndham was able to extract total number of meals provided during the month but was not able to provide number of clients who received these meals. Melton has a manual system for this service but was able to provide monthly summaries for 1996 and 2000. Data for 1998, however, could not be located.

Figure 10 shows that most LGAs delivered a similar number of meals per food service client. Unlike the previous services described, Melbourne provided the smallest number of home delivered meals. Most of the Councils provided a consistent number of meals across 1996 to 2000. An average of 16 meals over the four-week period would equate to 4 meals per week. The November 1997 HACC User Characteristics survey showed that across Victoria the average number of meals per client was 13.7 and for the WMR 11.9. The Western region average was below other metropolitan regions that averaged between 16.7 and 18.4.

5.2.5 Home Maintenance

Data on home maintenance is difficult to analyse due to the nature of the service and because recording procedures have changed within LGAs over the last 5 years. Some LGAs entered this data on Sharikat Khoo only in the last few years. Other LGAs were only able to provide total number of jobs completed while others provided number of hours. Where possible hours was the unit of measure used. It is also of less relevance to look at average hours per month as this type of service is commonly provided as a one-off, as needed, service, such as changing smoke detector batteries or building a ramp that may require 2 staff working for up to five days.

Figure 11: Average hours of Home maintenance received per client during 4 weeks in May



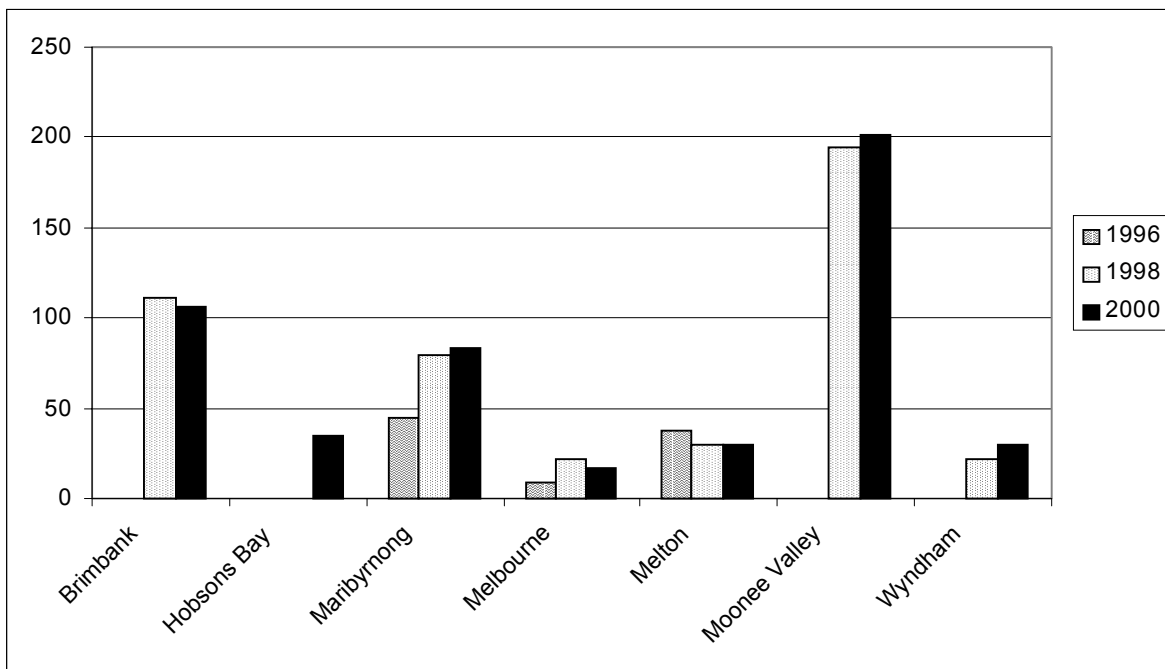
NB: Hobsons Bay has number of jobs as the unit of measurement. Staff from Hobsons Bay indicated that this figure appears to underestimate the number of jobs and clients as the module is new and may be used inconsistently.

The HACC User Characteristics data for November 1997 (Department of Health and Aged Care 1998) show that on average home maintenance clients received 2.7 hours per month. The WMR data from this central DHS collection for this service is surprising as it shows an average of 10 hours per client compared to 1.9-5.1 for other metropolitan regions. The data shown in Figure 11 is similar to the state average of 2.7 hours and suggests that the User Characteristics data for the WMR of 10 hours per client is questionable, or that November in 1997 was unusual.

As might be expected, the number of hours per client in Figure 11 increases and decreases in an inconsistent manner across the LGAs. This may be due to the nature of tasks required within a given month. For example, one month may have had a large number of quick jobs to complete while in another month in a different year there may have been a smaller number of large jobs that would show higher average hours per client. To help show the differences in home maintenance services, Figure 12 shows the number of clients assisted within the 4-week period in May.

“Again there’s been a lot (of dissatisfaction) about Home Maintenance because once upon a time people could actually get services when they needed it. Now they are waiting so long. Lots of dissatisfaction in not being able to increase time in shopping, home maintenance, showering... I think they understand it’s not coming from our level. There’s really a lot of dissatisfaction (Hobsons Bay assessor).”

Figure 12: Number of clients receiving home maintenance during a 4 week period.

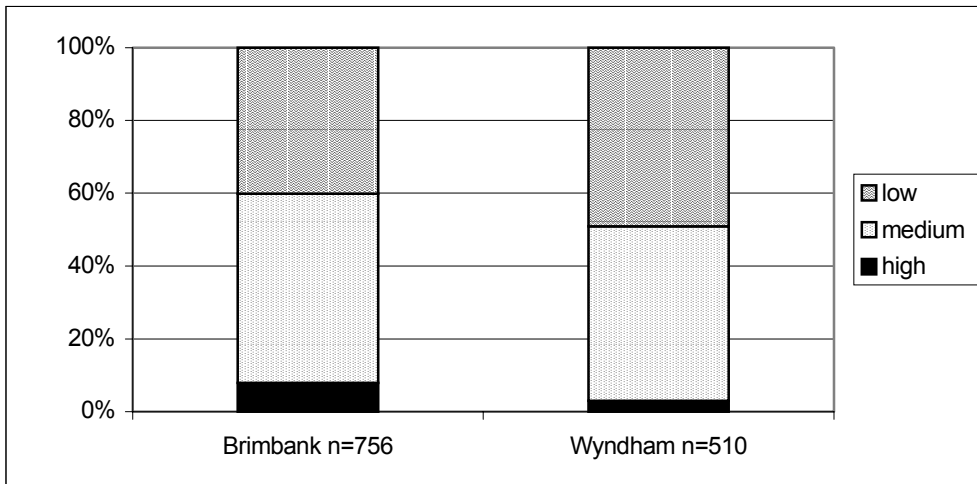


This figure shows that Moonee Valley provided home maintenance to a much higher number of clients than the other LGAs, followed by Brimbank and Maribyrnong.

5.2.6 Priority: A case example

It was initially intended that service provision would be investigated by comparing different clients with different levels of priority. In this way, it would be possible to examine demand management strategies and whether Councils were spreading hours over all levels of need or concentrating them on higher needs clients. Although there were known to be different practices for determining priority, it was potentially a useful way to examine service provision to clients with different identified levels of need. However, there were a number of limitations to providing data by priority for all Councils. Maribyrnong does not determine a priority level and Melbourne only records priority on the CIARR, thus, neither could generate any data on priority. Melton only began prioritising clients in 2000 and therefore many clients were still to have their priority determined. Due to these limitations it was decided to draw a case study comparing two Councils with available data; Brimbank and Wyndham. The following two figures show the number of clients who received home care during the 4 week period in May 2000 and then the average hours of home care these clients received. The same data is then presented for personal care.

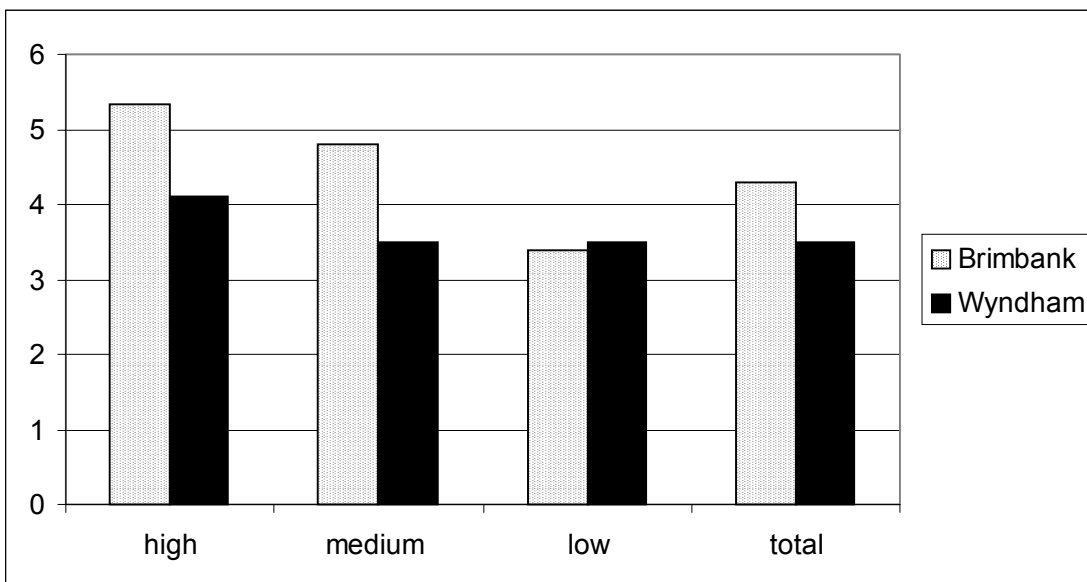
Figure 13: Percentage of home care clients who received a service during a 4 week period in May 2000 by priority



NB: Clients who did not have a priority recorded have been excluded from the above table – they accounted for one client at Brimbank and three at Wyndham.

Figure 13 suggests that Brimbank provided home care to a larger proportion of people assessed as medium and high priority. It is also interesting that these two Councils more consistently recorded priority levels than other demographic data on their clients. This may reflect a greater importance placed by assessors on data that is directly relevant to service provision. Demographic data does not always appear relevant for service provision despite its importance for describing the client profile for planning purposes.

Figure 14: Hours per client by priority for home care provided during 4-weeks in May 2000

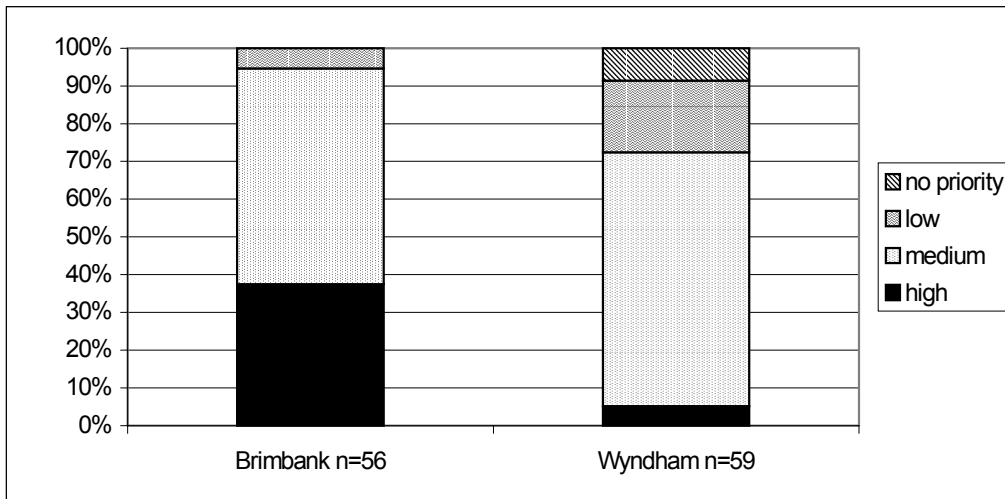


Clients who were not given a priority are not shown in this figure due to small numbers: a total of 4 home care clients from both Councils were not allocated a priority.

Figure 14 shows that Brimbank concentrated more hours in the higher priority clients while Wyndham appeared to provide a more consistent level of service for all priority levels with a slight trend of more hours for higher priority clients. This supports comments from Wyndham

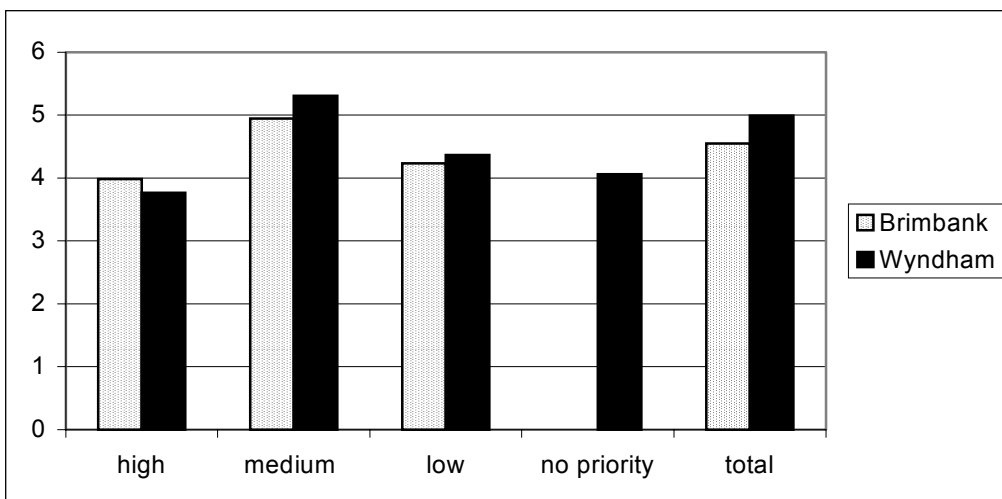
assessors that service hours per client have been reduced to enable a larger number of clients to access services.

Figure 15: Percentage of personal care clients who received a service by priority (May 2000)



As with home care provision, Brimbank appeared to provide personal care to a higher proportion of clients assessed as high or medium priority, with almost 95% of clients fitting into either of these priority levels. Wyndham had almost 20% of clients receiving personal care assessed as low priority, but also had almost 10% of clients without a priority recorded.

Figure 16: Hours per client for personal care by priority (May 2000)



Interestingly, for both Wyndham and Brimbank, clients assessed as high needs received on average less personal care over the 4 weeks than clients assessed as medium and low priority. It should be noted, however, that the number of low priority clients is very small with only 3 clients at Brimbank and 11 at Wyndham. The figure again shows that both Councils provided varying levels of service for personal care with an overall average of 5 or less hours of personal care over 4 weeks or about an average of 1 hour per week.

The above data provide some evidence of different management strategies for home care (but not personal care). It also raises the question why high needs clients are only receiving, on

average, an hour of personal care a week and even less than those assessed as medium priority. However, without data on the use of services outside Local Government in-home services it is difficult to determine whether those assessed as high priority receive less support from the service system overall.

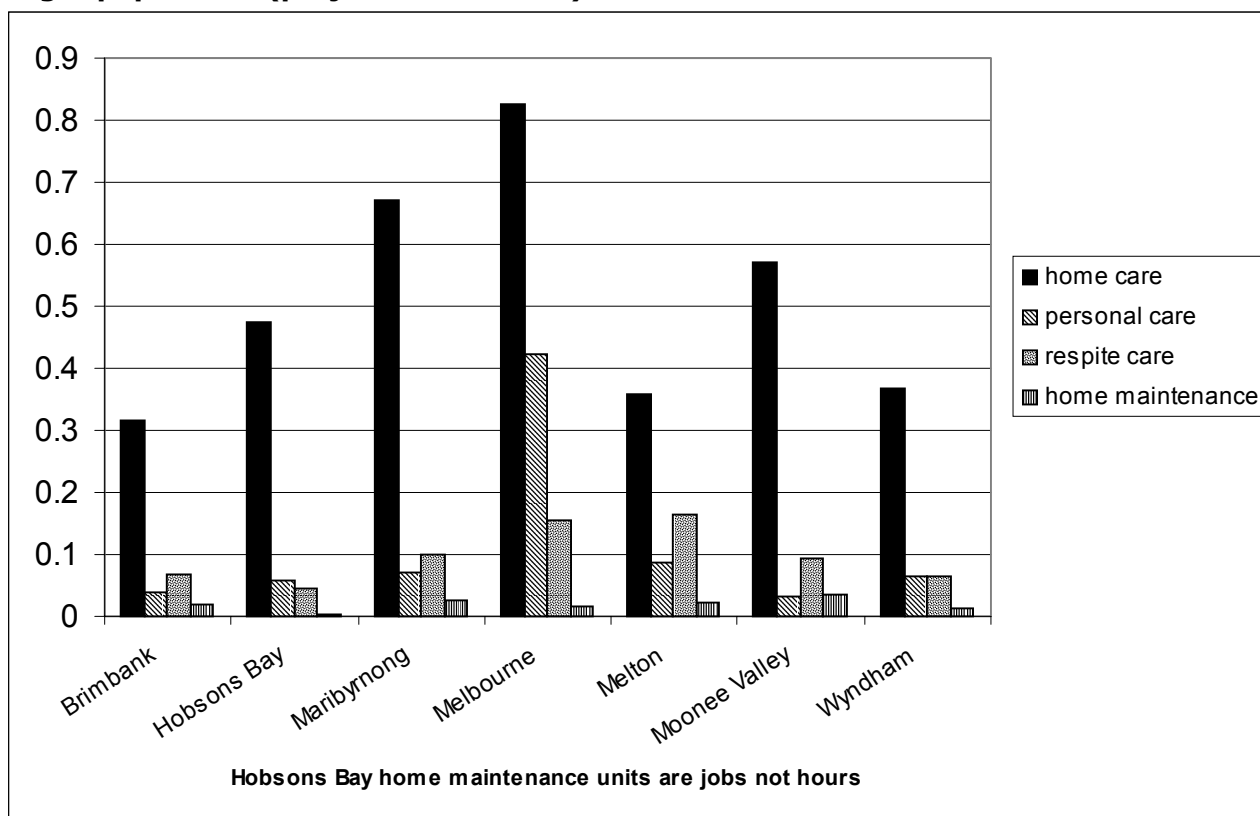
5.3 Average hours of service provision per individual in the HACC target population

To add another dimension to the investigation of hours of service provided by each LGA, Figure 17 indicates the average number of hours per individual in the HACC target population. So far average hours per client accessing the service has been considered. This section enables a comparison of hours provided in terms of the total HACC target in the community. It is important to note that the small number of hours indicated is to be expected, due to the likelihood that many people in the HACC target population choose not to access services or access other services in the system. It has been included here to demonstrate the differences between Councils in hours provided in relation to the overall target of their services. The data shown in Figure 17 has been calculated as:

$$\text{Average hours of service provision per individual in the HACC target population} = \frac{\text{Hours of service provision in a 4-week period in each LGA}}{\text{HACC target population for each LGA}}$$

The HACC target population figure is a projection for 2000 based on 1996 census data using the Relative Resource Equity Formula. Although there are limitations to the RREF (as described in the Introduction) using this estimate allows some comparison between provision of services in relation to the total population to be drawn.

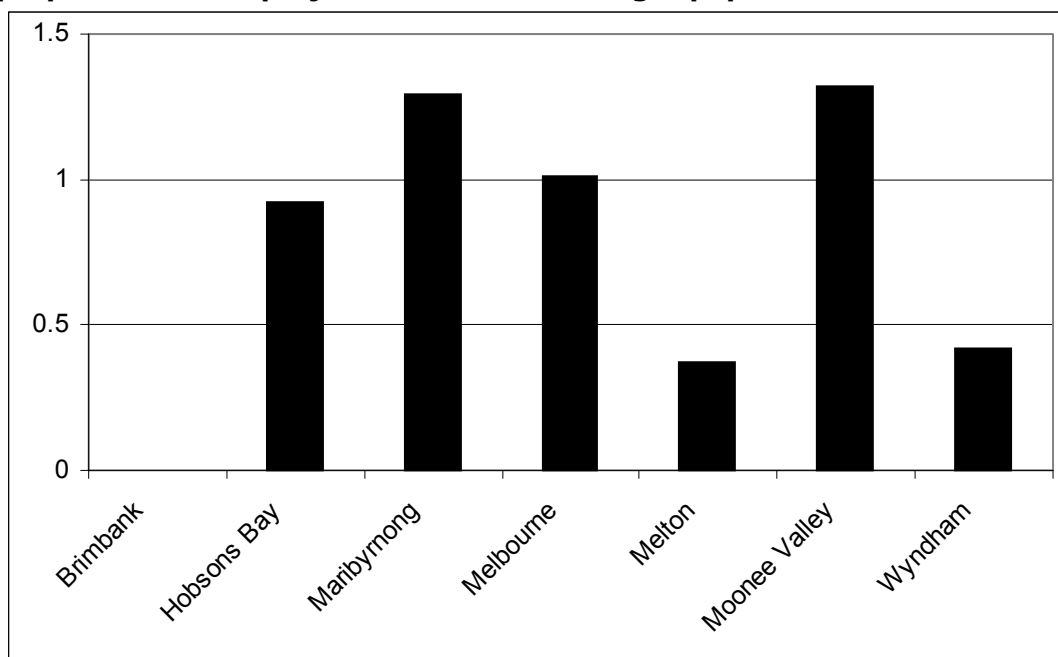
Figure 17: Average hours of service provision (May 2000) per individual in the HACC target population (projection for 2000)



NB: Hobsons Bay has number of jobs as the unit of measure for home maintenance, not number of hours. The projected HACC target population for 2000 is the RREF based population including the rural weighting for Melton and Wyndham.

As expected, home care hours per HACC target population are the highest due to the much larger proportion of the HACC target population requiring this level of assistance. Also consistent with other reports on service provision, Melbourne stands out as providing a higher number of hours per person within the HACC target. This pattern is especially so for personal care where Melbourne provides at least four times more hours per HACC target than the other LGAs. Also consistent with other data is that Wyndham, Melton and Brimbank provide a much lower proportion of home care, although Melton provides a relatively higher level of personal and respite care. Moonee Valley provides a higher proportion than most for home care and home maintenance but their personal care levels are one of the lowest along with Brimbank. Although these figures may provide a useful insight into the differences in service provision across Councils, consideration of other services in the region needs to be taken. The availability of services per HACC target population may prove to be equitable when the provision of non-HACC services are included in the equation.

Figure 18: Total number of meals delivered during a 4 week period in May 2000 as a proportion of the projected 2000 HACC target population



NB: The projected HACC target population for 2000 is the RREF Base population including a rural weighting for Melton and Wyndham

Unlike most of the other services shown in Figure 17, Melbourne does not provide a higher proportion of meals per HACC target population than the other LGAs shown. Melton again stands out as providing a much smaller number of meals as a proportion of the HACC target population, with Wyndham providing the second lowest number.

5.4 Service provision: Summary

In summary, service provision per client for home care and personal care is generally low with approximately one hour per week average for both of these services. For personal care this seems an extraordinarily low level of care, however the contribution of other services such as RDNS may raise this amount. To consider the impact on clients of this level of service provision, the total amount of services received needs to be examined including the total number of clients receiving one service type from multiple agencies.

Provision of respite care from Councils is only a little higher than personal care and home care with an overall average of approximately two hours a week. Melbourne appears to provide a higher level of service to home care, personal care and respite care clients who are accessing services, as well as in relation to the HACC target population. In comparison to the HACC User Characteristics data, the WMR appears to provide a much lower level of respite care and delivered meals than other Melbourne metropolitan regions. For food services there does not appear to be any large differences between LGAs in the number of meals per client and per HACC target population. Melbourne, Melton and Wyndham provide a higher number of hours per home maintenance client, however, Moonee Valley provides service to four times as many clients as these three LGAs. Although accounting for a much smaller proportion of clients, families with children with disabilities generally receive higher levels of home care, personal care and respite than older clients accessing services. In terms of priority rating for Wyndham and Brimbank, medium level clients appear to receive more hours of personal care than high priority clients, although this pattern does not apply to home care provision.

This data provides interesting insights into the provision of service in relation to priority rankings and suggests that LGAs may need to monitor the amount of service they are providing different priority levels in the context of the total service system. Consistent assessment and recording of priority, together with review of access to the system would provide very useful information for planning, service provision and evaluation of equity issues.

6. Population profile of those receiving Local Government “in-home” HACC services in the WMR

The following section provides a profile of the clients receiving Local Government “in-home” HACC services obtained from reports from each Western Region LGA. Where possible LGA data has been compared with other data on total population demographics from the Australian Bureau of Statistics. Most of the LGA data is presented as a proportion, rather than total number of clients, to enable comparisons between Councils. The following table shows the number of clients that are represented in these proportions.

Table 6: Total number of clients included in demographic data by 4-week period in May

	1996	1998	2000
Brimbank	1417	1690	1595
Hobsons Bay	1590	1331	1777
Maribyrnong	3938	3392	3040
Melbourne	1401	1171	733
Melton	N/Available	N/Available	Sample of 40
Moonee Valley	2634	3565	4147
Wyndham	1840	1986	1445

NB: Refer to Appendix 4 for numbers of clients for each of the different service types.

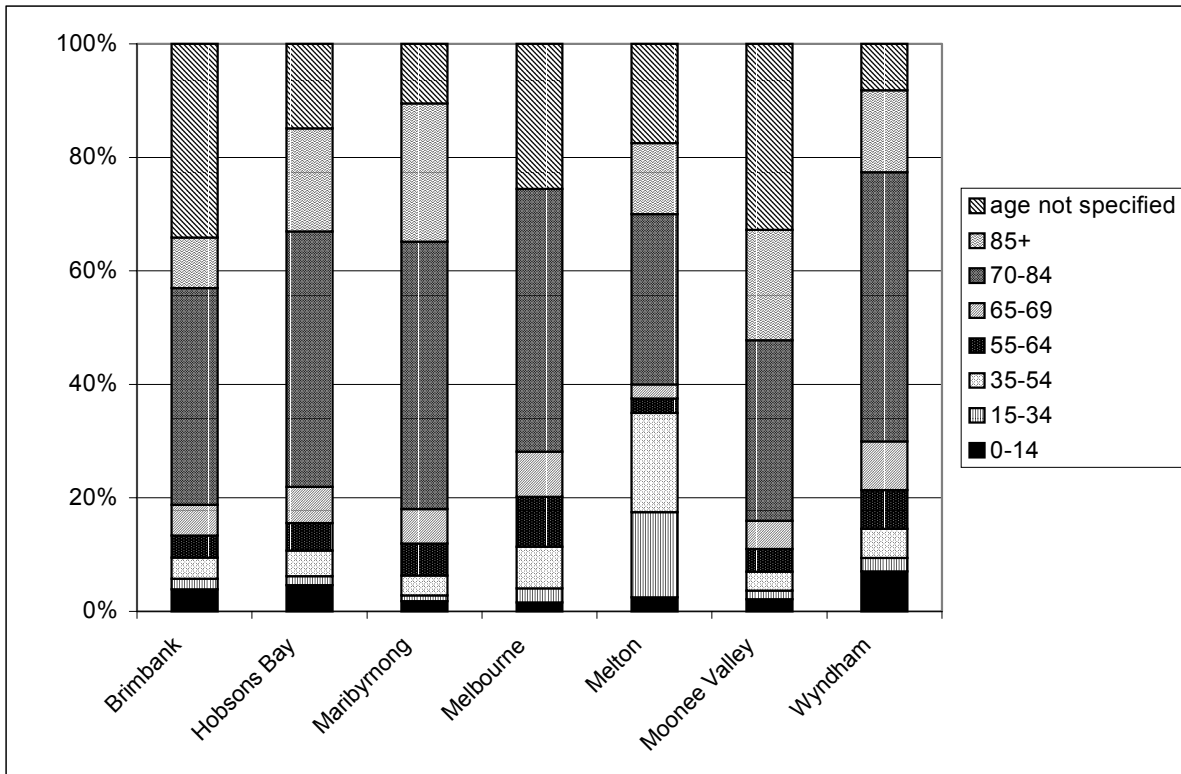
It is important to note that these figures represent the number of “active” clients on each system within the four-week period specified. As described in the methodology section, the number of active clients will be greater than the number of clients who actually received a service in the same period. The number of active clients will include all clients who were suspended and did not receive a service within the four-week period as well as clients whose service may have ceased but whose record was not “terminated”. It will also include home maintenance clients who may have received one visit for home maintenance and were kept on the system in case they became a client again in the future.

Melbourne and Wyndham have been systematically “cleaning up” their systems to ensure that clients who have not received service for a few months have their record terminated. This explains the apparent decline in clients from 1996-2000. (Having a record terminated does not mean that the record can not be “re-activated” in the future. Simply deleting the termination date will make the clients record “active” again). The contrasting increase in Moonee Valley clients is partly due to the fact that home maintenance clients were only included on the system from 1997. Home maintenance clients at this Council are generally not terminated after a once off visit in case they need services again in the future. It seems likely that this process will mean that the number of client records will continue to increase. Melton was unable to produce any demographic data on the total client group due to limitations with the software program they use. Where data is presented for Melton, it was obtained from the 10% sample HACC user characteristic reports collected for the DHS. As it is such a small sample, the data should be read with caution.

6.1 Age and Gender

Figure 19 shows the proportion of clients for 7 different age categories.

Figure 19: Age of clients during 2000



As expected, the majority of clients are aged 70+ with a larger proportion aged 70-84 than 85 plus. Wyndham has the largest proportion of children aged 0-14 and along with Melbourne has at least 20% of clients less than 64. Melton appears to have a much younger client group as would be expected with a younger population (Department of Infrastructure (Victoria) 1997). However, the small sample size limits this generalisation. Interestingly Melbourne has no clients listed as being over 85 years of age. This was also suggested by a Melbourne assessor who remarked: "generally people [clients] are between 70 – 80 [years] and then there's younger people with psychiatric disabilities or 50 year old men who have been homeless before."

Surprisingly, 10% - 30% of clients from all participating LGAs, did not have age recorded, one of the core demographic variables. The Aged and Disability Services Manager from Maribyrnong commented that the HACC clients in that area were typically younger;

"We tend to see a lot of prematurely aged people – a working class area with a high proportion of people for Non-English Speaking Backgrounds – they have a range of chronic health issues that manifest much earlier".

While this comment reflects a good understanding of the demographic features of the local area, the observation is not supported by the HACC client data.

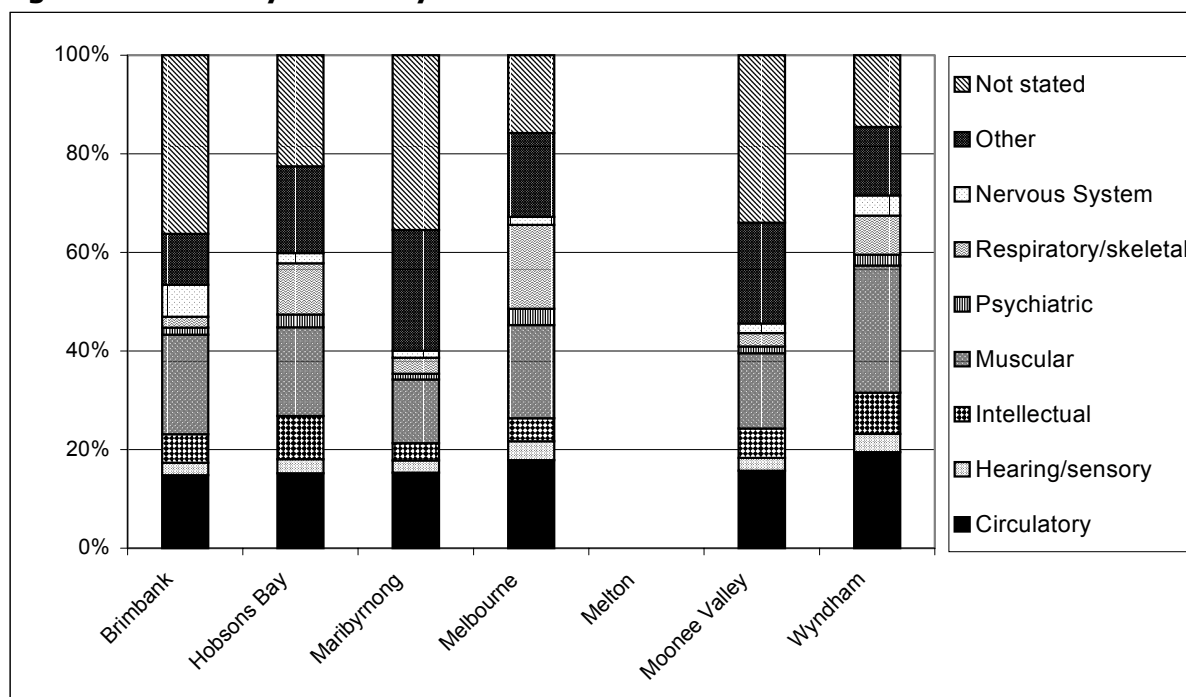
The proportion of clients who were female was between 60% and 70% for each Council for each of the three time periods with the exception of Brimbank in 2000 with only 57% of clients

who were female and Melton in 2000 with 77.5%. This higher proportion for Melton may be a result of the sampling technique for data reporting.

6.2 Health data

6.2.1 Primary disability

Figure 20: Primary Disability of clients for 2000



Clients' disabilities are entered onto Sharikat and are grouped together according to the 8 categories shown (not including "not stated").

Large proportions of clients did not have a primary disability recorded. It is possible, although unlikely, that they do not have a disability. Of those with a disability recorded, all LGAs tended to have a similar proportion of clients with circulatory disabilities. Brimbank has a larger proportion of people with nervous system disabilities. Hobsons Bay, Melbourne and Wyndham had larger proportions of clients with respiratory and skeletal disabilities. One assessor at Hobsons Bay explained why this might be the case:

"A lot of them have been manual workers or factory workers and they have a lot of diseases caused by that or physical disabilities and illnesses that have been caused by the work they have undertaken...That means that there are quite a lot of people who need access to services at a younger age. I would suggest we probably have got quite high incidences of respiratory diseases and back injuries".

Hobsons Bay and Wyndham also had a larger proportion of clients with intellectual disabilities. Comparing this data to other published data on disease and disability is difficult due to the inconsistencies in categorising between different studies. Other studies on mortality, morbidity and hospital use do not show diseases or disabilities in these categories. As up to 60% of clients did not have data recorded or are included in the "other" category, it is difficult to make reliable comparisons.

6.2.2 Multiple disability

The percentage of clients from the total client population who had three or more disabilities recorded is shown in figure 21. The percentages are a proportion of all clients – including those who had no disability recorded (as indicated in Figure 20).

Figure 21: Percentage of clients with multiple disabilities

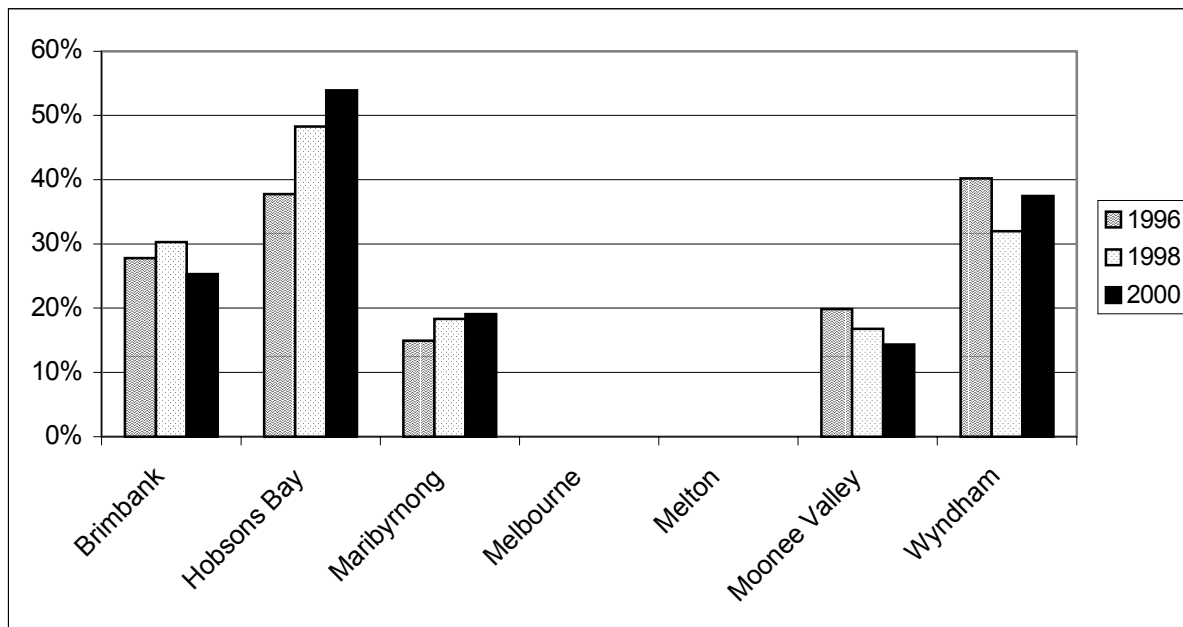
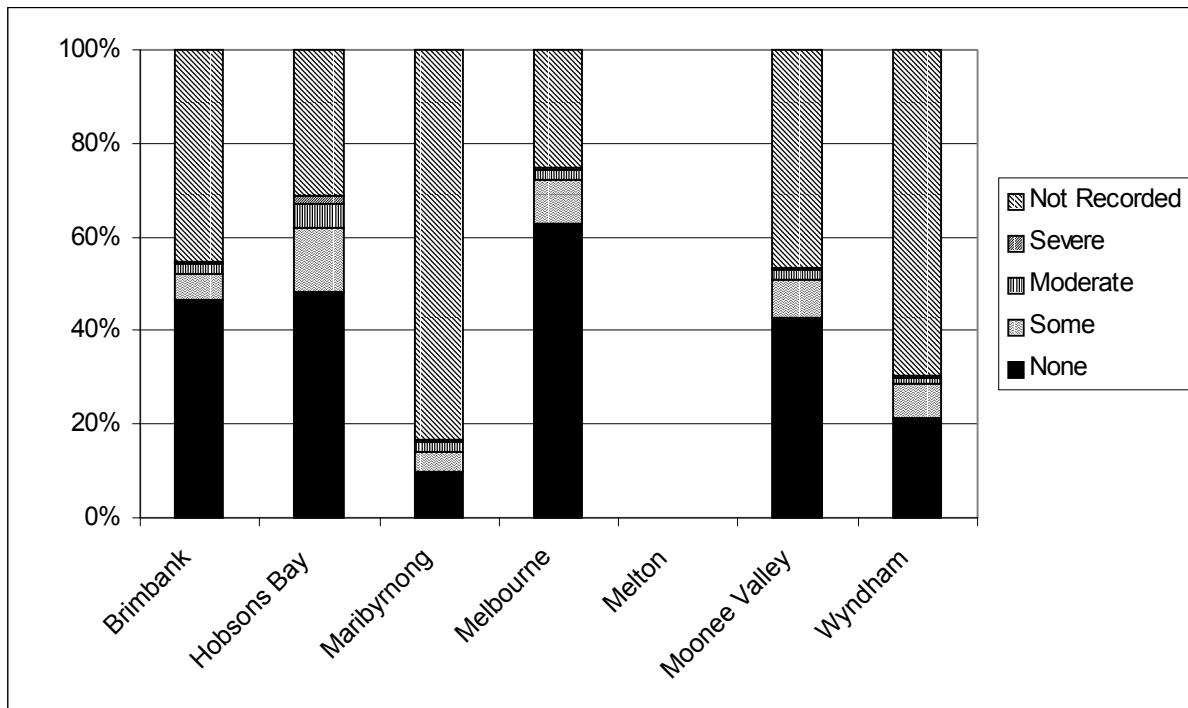


Figure 21 shows that Hobsons Bay had the largest proportion of clients with multiple disabilities and that this had been increasing since 1996. This may be a reflection of the tightening of priority criteria and the subsequent higher proportion of high priority clients. Hobsons Bay used a priority scoring tool with 5 levels and as one assessor reported; “the lowest level has dropped off the scale. Basically if you score 0 – 10 you don’t get anything, if you score 11 –20 you would probably be eligible for weekday meals on wheels on a rare basis”. In comparison to HACC guidelines on high, medium and low priorities this assessor commented; “ours are probably more strict. You would have to be more disabled”.

Although the proportion of Moonee Valley’s clients with multiple disabilities appeared to be dropping, this could be skewed by the increase in home maintenance clients who may be less likely to have multiple disabilities than those receiving other types of in-home services such as personal care.

6.2.3 Level of confusion

Figure 22: Level of Confusion of clients during 2000



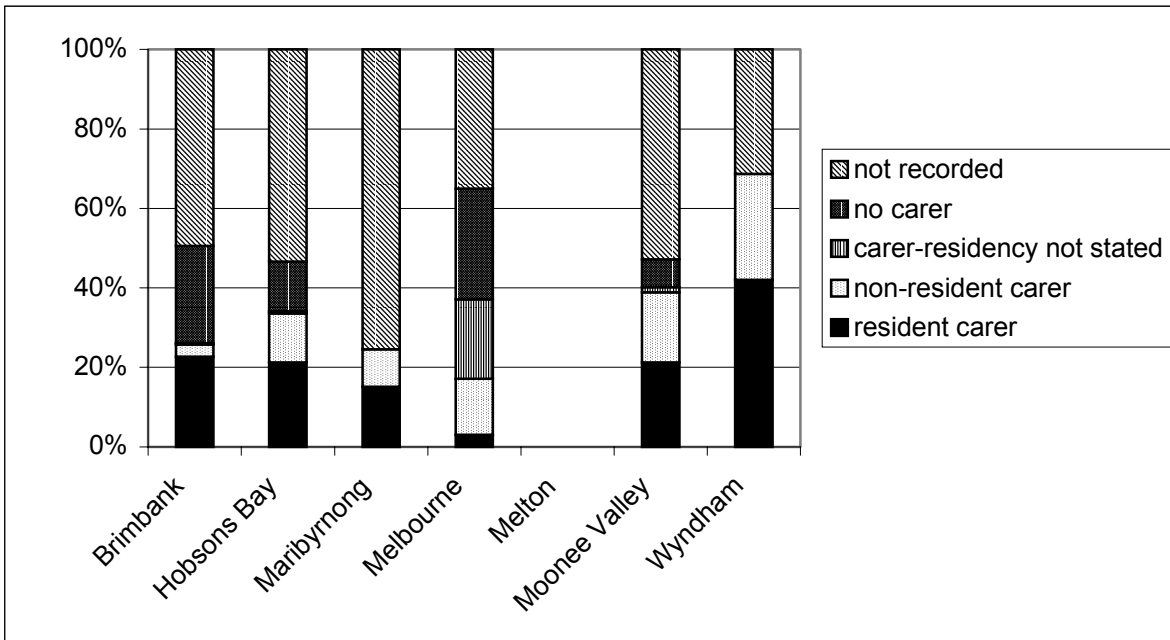
Level of confusion was poorly recorded for most of the Councils, making it difficult to make comparisons. One manager commented that where data for this variable is not recorded the client probably does not have any confusion. Although this is a possibility, this approach to data entry prevents comparisons between Councils on clients' level of confusion.

In summary, the high levels of 'unrecorded', 'other' and variations in coding variables reduces the ability to draw any accurate comparisons between Councils on clients' health status.

6.3 Informal support

The following figure presents data on the availability and residence of the primary carer within the client's informal network.

Figure 23: Availability and residency status of an informal carer for clients during 2000



NB: Maribyrnong and Wyndham do not have a category for clients without a carer and, therefore, these must be included with those not recorded.

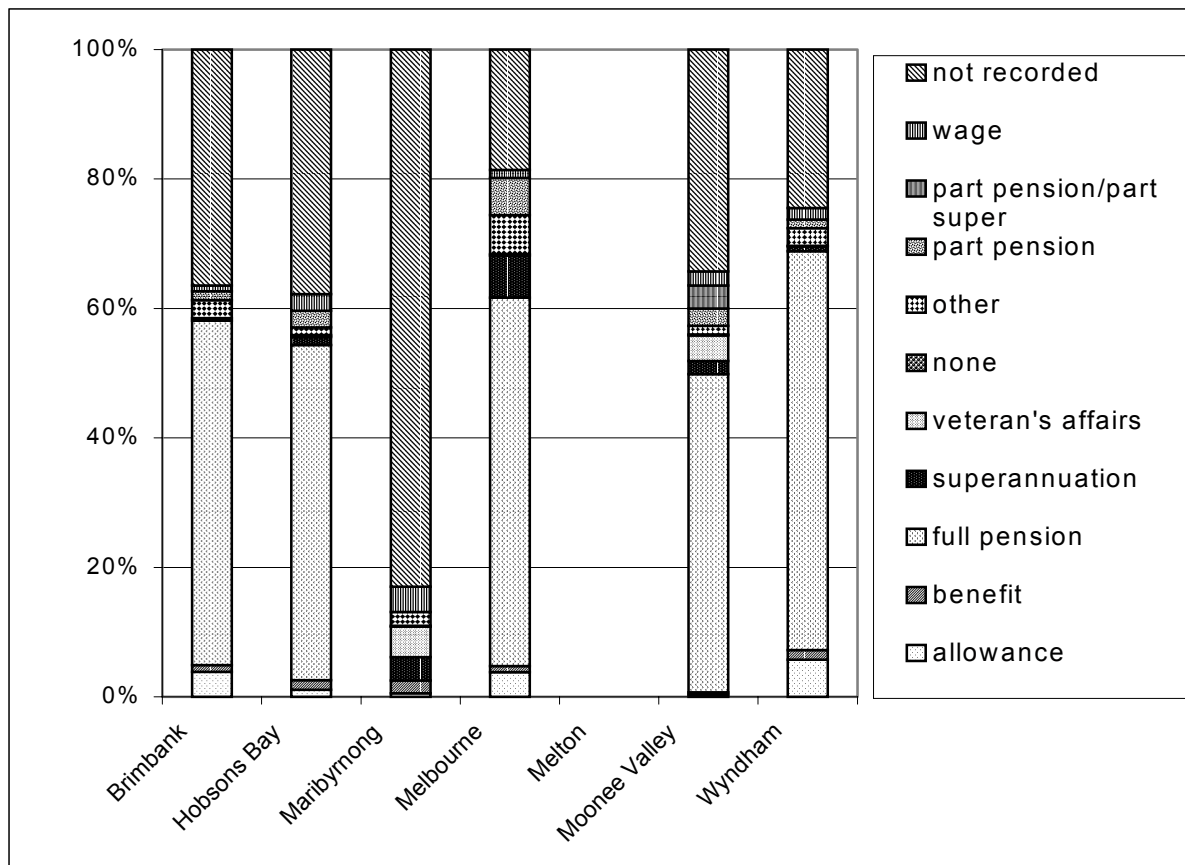
The large proportion of clients without information about a carer makes it difficult to make any generalisations about the client population. As Maribyrnong and Wyndham did not have a category for "no carer", it is likely that a number of the "not recorded" entries are actually clients without a carer.

Using the data shown, Melbourne had the largest proportion of clients without a carer (33%) followed by Brimbank. Wyndham had the highest proportion of resident carers.

6.4 Socio-economic Background

6.4.1 Income source

Figure 24: Income source of clients during May 2000



Maribyrnong does not separate full and part pension. Unable to identify what the code 'wa' meant and was included with "wage"- it accounted for 17 clients (code not on parameter file listing and not known by staff). 'Non-Australian Pension' recorded at Wyndham included in 'other' category. 'Child Disability Allowance' recorded at Wyndham included in 'allowance' category.

Again, poor recording of income source limited analysis. For those who had data recorded, a pension was the most common source of income for clients followed by other government benefits. This is consistent with the HACC Status Report where approximately 80% of clients from the sample of Councils were on an aged care pension (Howe 2000). Melbourne had the highest proportion receiving superannuation with Maribyrnong the second highest. Data on income levels for the total population over 70 shows that Melbourne had the largest proportion of its population earning over \$30,000 (Western Metropolitan Region 1998) suggesting that their amount of superannuation may be at a higher level than those at Maribyrnong. Moonee Valley and Maribyrnong had the highest proportion of clients receiving Veteran Affairs benefits.

Despite the relatively higher income level for people over 70 in Wyndham, as well as a higher Index of Relative Socio-Economic Disadvantage (indicating economic advantage) clients had a comparatively smaller number recorded as receiving superannuation and wages.

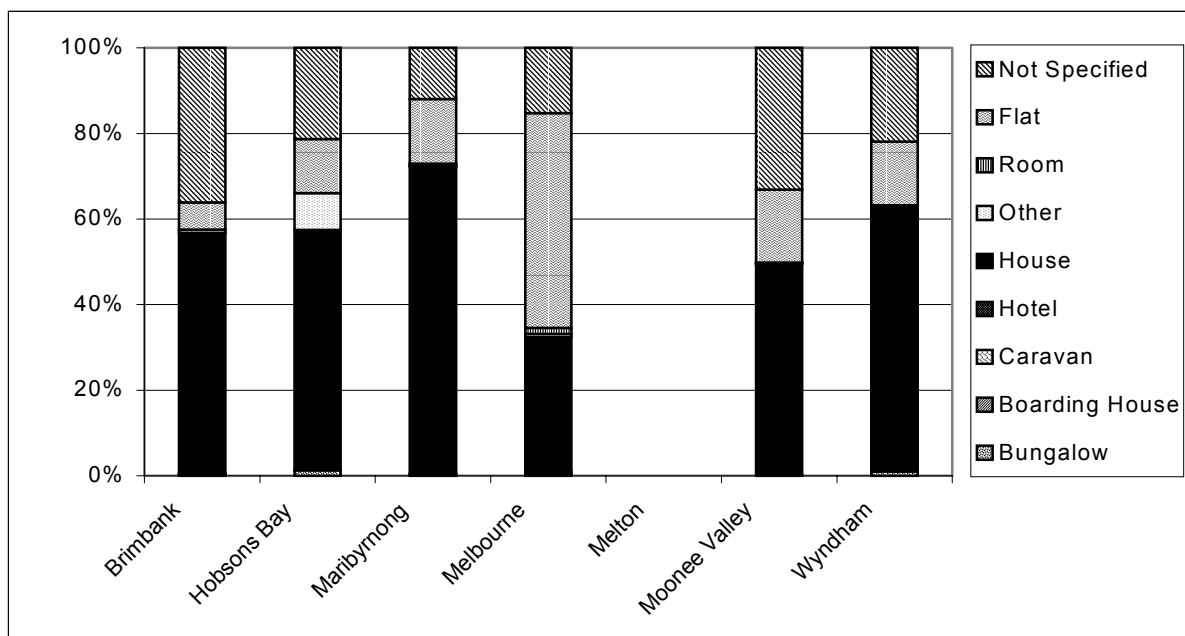
A number of assessors commented on the relative disadvantage of people in the WMR:

"...most of the people we see are on aged pensions. There are not that many people who live in the West who have superannuation, however, as time goes on in the next 20 years or so that will change... But at the moment people aren't going out and getting private services because they can't afford it and that's another reason why there are more people to share our services between. In other areas – maybe there are quite a lot of people who go out and buy a direct service and don't ever come through the Council" (Hobsons Bay assessor)

"Most people cannot afford services provided by private agencies... Sometimes families will pay private agencies for their relatives' care" (Brimbank).

6.4.2 Housing type

Figure 25: Type of clients' housing (May 2000)



NB: The large proportion of "other" at Hobsons Bay is due to the different categories used. Some of the categories included in other include "public rental", "private rental" and "fully owned". These could apply to houses, units, flats and other types of housing. Melbourne: Boarding house includes public housing.

In contrast to the income source data, Maribyrnong had the highest proportion of clients for whom type of housing had been recorded. The data shows that for most of the Councils most clients resided in flats and houses. Melbourne is the one exception with a much higher proportion of clients living in flats and rooms, as would be expected in the inner city. The large proportion of "other" in Brimbank results from the categories used. Some of the categories that were included in this "other" category were 'public rental', 'private rental' and 'fully owned'. Although this is useful data it is usually included under the "nature of occupancy" variable within Sharikat Khoo. Rented and fully owned dwellings could be either a house, flat or unit.

6.5 Cultural Background

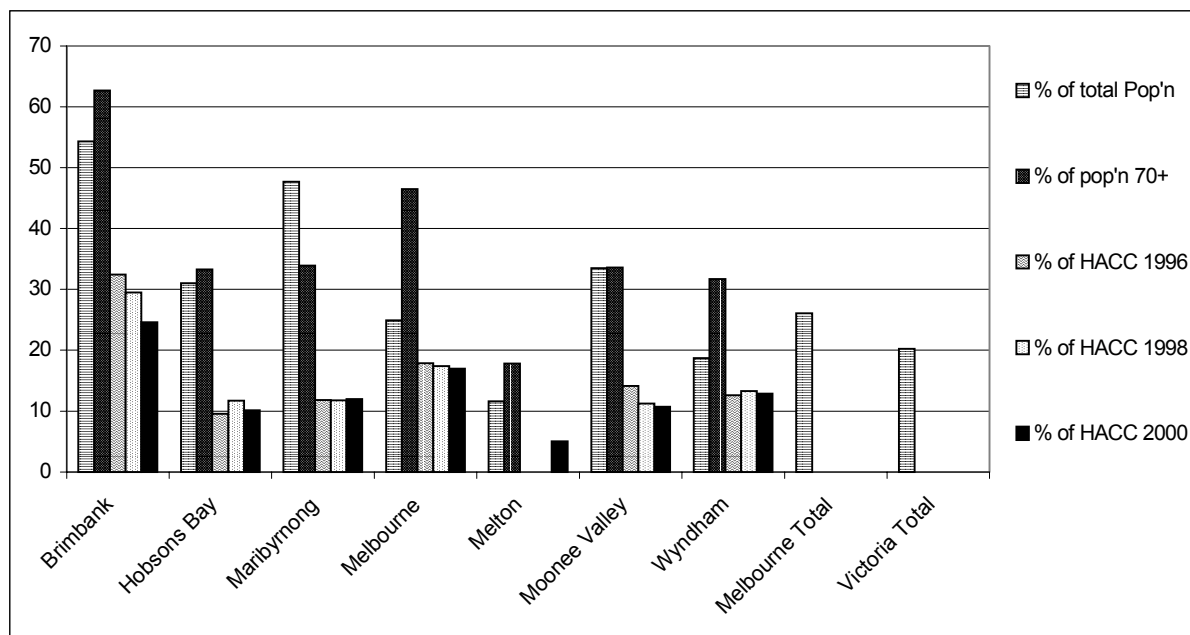
6.5.1 Country of birth

Victoria in Fact (Department of Infrastructure, Victoria, 1997) provides details of where people living in each LGA were born. This provides a base to compare the birthplace of clients receiving LGA "in-home" HACC services to determine whether clients from different backgrounds are representative of their proportions in the general population. Appendix 7 gives the proportion of the HACC population for 1996, 1998 and 2000 who were born in the six countries that are the most common birthplaces in the total LGA population. The data shows that there was a much higher proportion of HACC users born in Italy than in the general population for most of the seven LGAs, especially in Brimbank, Maribyrnong, Melton and Wyndham. There is an apparent under-representation of people born in Vietnam for Brimbank, Hobsons Bay, Maribyrnong and Melbourne. One possible explanation of this apparent under-representation in the HACC user group, is that the Vietnamese population, having migrated more recently than some other groups, may have a younger population and therefore less likely to require HACC services. There is, however, evidence to suggest that there is under-utilisation of HACC services by the Vietnamese community (National Ageing Research Institute 2000). Extended family arrangements and expectations of care from family members may also impact on their use of HACC services. This issue is also considered in the following section on language spoken at home. Other groups that appear to be underrepresented include Maltese in Hobsons Bay and Melton, and New Zealanders and Malaysians in Melbourne.

6.5.2 Language spoken at home

Figure 26 shows the proportions of people who speak a language other than English at home. For each LGA, data are presented for the percentage of people in the total population who speak a language other than English at home, the percentage of people over 70 years of age as well as the percentage of LGA HACC clients in 1996, 1998 and 2000.

Figure 26: Proportion of clients who speak a language other than English at home



NB: Total population and population aged 70+ were obtained from ABS 1996 census data (Western Metropolitan Region 1998) (Department of Infrastructure, Victoria, 1997). Also note that the Council data for 1996, 1998 and 2000 has higher proportions of 'not recorded' data than the ABS data. Not recorded data ranges between 10-30% as shown for each LGA in Appendix 8. The data shown in this table, therefore, may under-represent the proportion of clients who speak a language other than English at home. Even if all of the clients who did not have this data recorded did speak a language other than English at home, it appears that the proportion would still under-represent that of the total population and total population over 70.

It is interesting to note that for Brimbank, Melbourne and Wyndham there was a much larger proportion of people from a NESB in the population over 70 years. For Maribyrnong the 70+ population had a much lower proportion than the total population. None of the LGA's proportion of NESB clients is as high as for the general population. Appendix 8 shows the above data for each LGA but also provides a breakdown for different ethnic groups. The use of data for the over 70 population provides a useful comparison. For example, many of the Councils report a high level of use by the Italian community:

"There are groups who choose not to access services, there are certain ethnic specific (groups) who don't access services, but there are other communities who access them fairly routinely... The Italian community seems to access services very easily, so do members of the Yugoslav community and Polish community" (Maribyrnong assessor).

Investigation of the data shows that compared to the general population there does appear to be a proportionately higher number of Italian HACC users. However, the data for people over 70 shows that there is a much higher proportion of Italians in the older community than in the general community and that most of the LGAs provide services to a smaller proportion of Italians than in the older community, including Maribyrnong. Brimbank appeared to have a lower representation of Macedonian, Italian, German and Polish clients than exist within the 70+ population. If considering the total population, Brimbank Council would appear to have an under representation of Vietnamese clients.

Further investigation would be required to examine the utilisation of services for children with disabilities from different ethnic backgrounds. Hobsons Bay appears to have a low representation of Polish, German, Maltese and Italian clients while Maribyrnong has a low number of Italian, Polish, Greek and Vietnamese clients. Melbourne and Moonee Valley have a low representation of Cantonese clients while Moonee Valley also has low numbers of Maltese and Italian clients. Wyndham has an under-representation of Macedonian, Tagalog (Filipino), Greek and Italian. Most of the assessors indicated that they were aware of the under representation of different ethnic groups:

“I am sure there is a higher proportion of those people within the Council who would be eligible than actually use the services. And we find that people who do get referred quite often are eligible and we offer them service and they cancel or refuse” (Hobsons Bay assessor).

The data in Appendix 8 may provide useful information for each LGA about which ethnic groups are not accessing services to increase targeting and promotion of services to these groups. However, it must also be noted that the large number of clients who do not have this data entered may influence the proportions shown.

6.5.3 Proficiency of English

Proficiency of English is categorised in Sharikat Khoo as speaks English – “very well”, “well”, “not well” and “not at all”. Although proficiency of English is a useful indicator when considering ability to access services, this variable was poorly recorded and therefore, has not been presented here (refer to Appendix 9 where the data is presented as a figure). Of the clients who did have this recorded, the majority speak English well or very well. The smallest proportion recorded as speaking English “not well” or “not at all” was at Maribyrnong. However, only 20% of clients had this data recorded, and therefore, provides a poor indication of clients’ proficiency in English.

6.5.4 Aboriginal or Torres Strait Islander

Based on 1996 ABS census data, the number of Aboriginal and Torres Strait Islander people living in the Western region is below half a percent of the total population for each LGA (Australian Bureau of Statistics 1997). Wyndham had the largest proportion with 320 people accounting for 0.43% of the Wyndham population (Australian Bureau of Statistics 1997).

The number of Aboriginal or Torres Strait Islander (ATSI) clients was unavailable. None of the participating LGA services recorded this on the database and many did not record it on the CIARR either. One assessor commented that asking people this would often create a long discussion yet achieve very little. Anecdotally, it was noted that there were very few ATSI clients, however, failure to ask clients whether they identify themselves as ATSI prevents examination of whether this HACC special needs group is gaining access to services.

6.6 Summary of demographic data

Unfortunately, the lack of routine recording for most of the demographic data has limited the ability to provide a comprehensive demographic profile of clients. This is particularly so for Aboriginal and Torres Strait Islander people who do not have their indigenous status recorded, thus preventing any analysis of the service provision and unmet needs of this group. Proficiency of English was another category with such limited data it was not reported in the body of this report.

For the other demographic categories considered, there were some patterns and differences noted. Although for many of these variables 20% of cases were not recorded, an 80% sample represents the majority of clients and is likely to be reasonably representative of the remaining 20% of clients. The exception to this is where data is systematically not recorded. This may be the case for level of confusion where assessors may not feel that it is vital to always complete this category when clients are not confused.

It should also be noted that a large proportion of the not recorded data represented home maintenance and food services clients who do not necessarily have a holistic assessment to access these services. To investigate this issue further, another set of reports was generated at Moonee Valley where a large number of home maintenance clients are maintained on the database after receiving services. These reports only included clients who received home care, personal care or respite care in the 4-week period in May. As expected the proportion of "not recorded" data on these reports was lower than the reports that included home maintenance and food services, especially for age, income and housing where not recorded data was almost absent. For other categories the decline was not so sharp. Availability of a carer dropped from about 50% not recorded to 30% not recorded and proficiency of English dropped from 56% to 34%. Language spoken at home improved from 40% not recorded to 12% not recorded. Although there is a much higher level of reporting for home care, personal care and respite, there is still room for improvement.

Of the available data, Hobsons Bay appeared to have a client profile with higher levels of multiple disability. This supports assessors' comments reflecting changes in service provision where people assessed as a low priority are no longer able to access preventative services in this LGA.

Another area for concern is the under representation of people from NESBs. This is supported by assessors who reported that some clients who don't speak English are reluctant to access these services and were concerned about not being able to communicate effectively with direct care workers. Most of the WMR Councils actively employ staff who speak different languages, however, perceptions and expectations about Local Government services may not match what is available. The limited promotion of services would also prevent people understanding the capabilities of the service. This lack of promotion, especially translated into languages spoken by very few people, also indicates that there is a group of people who may not be aware of Council services.

6.7 How can data collection be improved?

6.7.1 Demographic data on current clients

The introduction of the Minimum Data Set (MDS) in January 2001 will require that all HACC agencies provide details on a variety of demographic and service provision data for all of their clients. Some of the demographic variables required in this data set include:

- Aboriginal and Torres Strait Islander identification
- Country of Birth
- Language spoken at home
- Accommodation
- Source of referral
- Existence of a carer

The data collected during this report indicates that Councils in the WMR do not routinely collect and record this data on their databases. For many of the variables investigated in this project there were at least 20% of clients in which the data had not been entered on the database. For data about the number of Aboriginal and Torres Strait Islander clients, no data at all was available. Further limitations were encountered due to different codings used by different Councils. Hopefully, the introduction of the MDS will mean that codes become consistent. It will require, for some Councils, however, substantial re-categorising of clients when the new MDS categories are introduced. Areas such as income type and housing type will need particular attention.

To provide a useful measure of the demographic profile of each client population, and to meet requirements of the MDS, assessment officers and/or relevant administrative staff must record this data more routinely. It appears that time constraints are the key barrier to this data being recorded accurately. In some instances, however, the data was being collected on the CIARR form but then not transcribed across to the database. Understandably, assessment staff may not feel that this is a valuable use of the skills and limited time, however as the data has been collected, it may be more appropriate for an administrative staff member to enter the CIARR form onto the database. Another approach that is currently being trialled at Wyndham is the use of a Laptop computer during an assessment. This could almost halve an assessors time in completing an assessment, as the assessment module, containing all of the CIARR information, is entered straight onto the database during the assessment. Although a number of limitations with this method have been identified it appears that many of them can be overcome as assessors become more experienced using this method;

“It’s been a real problem with the laptops and the interface with the Sharikat program so it seems all to much trouble. Should be good once we get it going properly... Some people say that you would think that we would already have them because the District Nurses have a handheld computer” (Wyndham Assessor) and;

“With anything new you feel funny... I think it will go well, its just getting it down to a fine art. I’m a little bit aware that some people might feel that it’s a bit intrusive, especially the older people. A lot of them are very interested in what we are doing” (Wyndham assessor).

Of course one of the major limitations to using laptops is the cost of the equipment. However, the time-savings for assessment staff could be considerable. The issue requires further investigation as to the amount of time it can save and the ease in which it can be implemented in clients’ homes. The lack of input of demographic fields greatly reduces the ability to describe the profile of the client population and, therefore, preventing analysis of whether different client groups are accessing services equally.

6.7.2 Reviewing termination processes

The termination of client records practices of different Councils have a great impact on the ability to develop a client profile. In particular, two areas need to be addressed;

1. Clients who are no longer requiring a service need to have their records terminated immediately, particularly if they have died or moved into residential care permanently. This ensures that when reports are produced, these clients are not included. The fact that some Councils had clients aged over 115 indicates that these clients records have unnecessarily remained on the system for many years (alternatively, it could be due to an incorrect date of birth entered). Client records where anomalies such as this occur need to be investigated. Reports of suspended clients also need to be generated on a regular (perhaps monthly) basis so that clients who have been suspended for a number of months can be followed up with a call to their next of kin.
2. The other practice that needs to be reviewed is the practice of not terminating client records from a one off visit such as home maintenance. It appears that a number of Councils keep these records active in case the client needs the service again in the future. This may have some value if the Council followed up with these clients on a regular basis, however, this does not appear to occur. It is recommended that where a client has received a once off visit, their records be terminated as “no longer needed”. If this client then rings up again requesting service, their records can be found and the termination date removed, enabling the clients details to be re-activated.

6.7.3 Review of different levels within one service type

One of the difficulties in determining a total number of home care clients at a couple of the Councils, was the use of different levels pertaining to different levels of pay for direct care staff. The different levels are not mutually exclusive groups meaning that a level-1 home care client may also be included as a level-2 home care client.¹ This creates confusion when trying to determine the total number of clients receiving home care at one Council.

¹ This was evident as a report that showed three different levels of home care and three different levels of specific care had a figure labelled “number of individuals”. This figure was less than the sum of clients using each of the six different service levels, indicating that the six levels were not mutually exclusive.

7. The Impact of the Demand for HACC Services

This section reports on the key factors influencing demand for services, and considers the impact of this demand at the individual client, organisational and service system levels. The majority of the information in this section was drawn from interviews with relevant referring agencies, Council assessors, and Aged and Disability Managers.

7.1 Factors in the WMR influencing demand

All interviews included a question that asked the respondent to identify the most important factors influencing demand for in-home HACC services. The responses were varied but certain themes were evident and are summarised in the following table. Respondents often pointed out that the level of available HACC funds from the State and Commonwealth Governments was inadequate to meet the current care needs of the HACC target group. This is regarded more as a contextual issue for the broader HACC Program, rather than a specific issue for the WMR.

Table 7: Factors in the WMR influencing demand

Factors Identified	Comments/Explanation
Ageing population	General expectation that the frailty/dependency of the older population has and will increase due to the complexity of physical, medical and psychological issues
Early discharge practices	Greater expectations for Councils to provide services earlier and clients with higher/more complex support needs
New managerialist changes occurring in human services	Purchaser/provider split brought new complexities to an already fragmented service system
Low socio-economic status of WMR	Inability of people to pay for private services as an alternative to subsidised services Poor social and family networks can be associated with this which can mean that informal support is not as readily available (particularly relevant in growth corridors) Demand per head of population is greater than in other areas with a higher socio-economic profile
High ethnic population	General inability to pay for private services Poor social networks which can mean greater reliance on services

The factors influencing demand identified by assessors from Councils and referring agencies broadly reflect the profile of the WMR, described earlier in this report, particularly in relation to socio-economic status, ageing of the population and high NESB groups. Early discharge practices and the resulting impact on HACC services was

identified as an issue for the Western Region, and is a theme reported elsewhere (Department of Human Services 1999a).

7.2 Individual client level

For individual clients, the impacts of community demands on the HACC program can be marked. Some inferences about the impacts at this level can be drawn from some of the client and service provision data reported earlier. In particular, there is an apparent lack of preventative services that could lead to a deterioration of clients' well-being and general ability to cope at home. Assessors felt that the preventative value of in-home HACC services cannot be maximised due to competing demands from others with higher relative needs. As one assessor pointed out, in general, low needs clients are not accessing services, and this in turn leads to their deterioration and becoming in even greater need for services.

Whilst this issue has been debated vigorously by stakeholders in the HACC service system, and some evidence is available to support the view (Turvey and Fine 1996; Lindeman 1997), there remains the need for more research to study the effect in detail and obtain more conclusive data. In addition, there is a need to consider the impacts of other interactions with the service system as having a potentially similar preventative effect, rather than simply the allocation of HACC service hours being the only contributing factor. For example, systematic consideration of individuals' health promotion needs (including psycho-social factors) at the time of assessment may lead to a range of interventions (such as referrals for dietetic input, community recreation programs, or for falls and balance expertise), but have little or no immediate implications for the provision of in-home HACC services. Similarly, the strategic use of personal alert systems (Department of Human Services 1998c), or health assessments for the older population (Byles 2000) may add to the range of interventions available for consideration by assessors. These interventions are likely to have a medium to long term benefit, not necessarily implications for immediate demand for in-home HACC services. One referring agency worker suggested that service demand would be better managed through the use of "multidisciplinary teams, the one-stop shop idea, and complete health assessments", rather than persisting with current models of assessment which rely on individual agencies assessing according to their own service delivery role. The important message here is that while there appears to be an overall low level of "in-home" HACC service provision, this needs to be considered in relation to other interventions or services involved.

The impact of low levels of service provision for clients requiring higher levels of service also requires further attention. Many assessors commented about the large numbers of clients waiting for packages and case management services who in the mean time had to manage with low levels provided by Councils.

"If you look at a couple of programs, ie Linkages Program or CAPS they have very specific level of services they can provide, whereas the HACC programs are providing less and less. The difference between HACC [Local Government] programs and packages programs is increasing" (assessor).

Some Councils tried to provide equivalent levels of service to packages programs for those waiting to receive a package.

“People are assessed to go onto packages... in the interim we have to put them onto support services –it could take 5 to 6 months before they access a package... they are utilising a package in a sense – [they] should be using brokerage services but the Council is actually providing service while [clients] await packages” (assessor).

This appeared to reduce the availability of services for those assessed as a lower priority for services.

High demand for service reduces flexibility. This is likely to lead to increased pressure on informal carers who may feel unable to take breaks and have increased responsibility during crises. This may be the difference between maintaining independence at home and being at risk of deterioration leading to alternative care arrangements. High demand for services and/or the potential for inflexible service provision can also lead to certain types of clients missing out. Each assessor and referring agency interviewed was asked to indicate the client groups whose needs were not adequately met by HACC services provided by LGAs. The responses are presented in summary form in the following table.

Table 8: Client groups whose needs are not met

Client groups with unmet needs	Comments
Younger people with a disability: adults with disabilities in general; people with neuro/ cognitive disabilities e.g. ABI	For those that are prematurely aged, services aren't well set up. The 16 – 64 age group tend to have more complex recreational/ social needs and complex carer dynamics.
Families with a child with a disability	For families, 1.5 hours of home care per fortnight does not meet their needs in the long-term.
New mothers	Previously supported by HACC so there may still be community expectation
People from Non-English Speaking Backgrounds.	Many older people nervous about having people in the home. Poor information available for these groups. Bilingual services are not always available in each Council.
Adults/families with complex or particular support needs.	For those that require lifting by two people, they often get none, or a reduced service (because it uses more resources). Very difficult to find staff for clients who require 24 hour on-call support. In-home overnight respite not well catered for by services.

	<p>Councils not well set up to respond to emergency respite needs.</p> <p>Worker skills not always appropriate, particularly for children who have particular interaction/communication needs.</p>
General HACC target group.	<p>Levels of services are generally too low to be effective.</p> <p>Many tasks needed by clients (e.g. heavy cleaning such as windows) not provided by Councils.</p>

Equity of access to in-home HACC services is an area that requires substantial discussion. There is the high possibility that people who may be eligible to receive services do not hear about services due to inadequate promotion of Council services. This is supported by the data collected during this project that shows under representation of clients from different ethnic backgrounds. However, their lack of utilisation may also reflect a reluctance to use Council services.

Most assessors reported dissatisfaction from clients, especially where they had cut down the number of home care hours to clients who had received services over a number of years. Assessors reported that many of these clients viewed the service as a “cleaning” service rather than a maintenance service; “People feel home care is cleaning their house from top to bottom as they used to do. They feel frustrated because the (Council) carers cannot do all the things they used to do themselves.” Some assessors commented on the difference between what clients may *want* and what they *need* to maintain health and safety. GP referrals seemed to add to these high expectations; “There seems to be this perception by GPs that if they write a letter recommending home help that it will be automatic. GPs need to be aware that service is priority based and not automatic” (assessor). There were also some reports of clients having refused services as the amount offered was too low.

Another factor that contributed to clients having unrealistic expectations of available services was their past experiences of Council services. For example, a younger person who had received home care after an operation 5 years ago, would be unrealistic to assume the same level of services after having an operation today, as services for people in these situations were usually not available.

“Newer ones (clients) tend to know the service is under-resourced. Most of the time they will just accept whatever you can give them. We have had instances where people have been away for extended periods and when they come back we might re-assess them and reduce their service. We get some complaints from younger people who ring up and say they had home help after they had a hysterectomy 5 years ago and they go and have another operation, why can’t they have that now. We get complaints from younger people who have been to private hospitals because PACFU won’t pick up private hospitals and they can’t access HACC services either. So they are another. A lady said I feel I have been pushed into the private health system been encouraged to take up private health insurance and now I have done that and had my operation, now you are telling me I can’t get the help that I got 5 years ago when I went public. They are clearly not eligible for HACC services” (assessor).

One referring agency reported instances where clients had spent periods in hospital or rehabilitation, with their Council services suspended for this period, but were placed on the waiting list on their return home, rather than having services re-instated immediately, despite having the same or sometimes higher needs for support. It was also reported that for other clients returning to services or being referred for services for the first time, despite having a comprehensive discharge plan which details the person's health, functional ability, and need for support, were reassessed by the Council. This was regarded as an unnecessary duplication of assessment resources.

7.3 Organisation level

7.3.1 Staff Structure

As organisations struggle to meet increasing demands, variations of staffing structures can be one method investigated by managers to ration resources to more effectively meet these demands. Individual LGAs adopted different service delivery models. Table 9 demonstrates the different staffing structures of each Council, and indicates whether assessment and service delivery were separated.

Table 9: Staffing structure

	Staffing Structure (reported as EFT, not number of staff)	Assessment & service delivery separated?
Brimbank	2.8 assessment officers 1 CACPs co-ordinator 0.5 administrative officer Service provision staff are: 3 administrative staff, 1 business support, 1 co-ordinator	Yes
Hobsons Bay	3 assessment officers 1 administrative officer (for HACC & CACP assessors) Service provision staff are: 2 team leaders, 2 administrative officers	Yes
Maribyrnong	2.6 assessment officers (includes some coordination) 1 administrative/intake officer Service provision staff are 3 team leaders, 1 direct care coordinator, 1 administrative officer CACP coordinators additional	Yes
Melbourne	2 assessment officers 1 team leader 1.5 administrative officers (admin, coordination, projects) 1 case manager (for CACP & Linkages) Service provision staff (external) are additional	Yes
Melton	2 team leaders (role includes assessment) 2 administrative staff 4 co-ordinators (community care, ADASS, food services)	No

	and social support)	
Moonee Valley	6 team leaders (role includes assessment) 1 direct care team leader (assists with assessing) 1 complex care coordinator, eg for CACP (who assists with assessing) 4 administrative officers	No
Wyndham	1.8 assessors 0.8 administration (supports all of HACC services) Service provision staff are; 2.5 team leaders/coordination 0.8 administration	Yes

Varying staff levels between LGAs appears to relate to the number of clients accessing services and the amount of service provided. Staffing structures also vary according to whether assessment and service provision is separated or integrated. The decision about whether or not to separate assessment and service delivery was made at the time of preparation for Compulsory Competitive Tendering (CCT). Councils that decided to keep the functions together felt that the contractor (whether in-house or not) would be in a better position to offer a more personalised service for clients, "and better job satisfaction for team leaders" who would have a more varied role. It was also felt that this model offered an integrated service that contributed to the quality of client care, for example, "we can match client characteristics and preferences with the right staff". Where assessment and service delivery were separated, the roles of the team leader were removed from assessing and care planning, and included rostering, staff supervision and service monitoring. For one person who had worked in both types of systems in different Councils, her experience suggested that where the functions were separated, it resulted in "low staff morale, and a fragmented and inefficient structure". A number of assessors also commented that the division led to a tightening of resources and sometimes conflict. In contrast, Aged and Disability managers from Councils that decided to separate the functions of assessment and service delivery reported that it was better for the client and staff because "there is no blurring of roles and decisions". One assessor made the comment:

"I don't know the other systems, but I think the [split between assessment and service provision] works well. I think you need to keep assessments separate from service provision because we see ourselves as advocates for the client" (assessor).

The comment was also made that clients tend to be more honest about service delivery issues because they can view the assessor as their advocate. An Aged and Disability Services manager also noted that it is difficult to find people who have all the skills needed for the combined role of assessor/team leader.

In instances where the separation of functions had meant that the service provision had been contracted to another agency, some effects were felt by referring organisations. As one assessor from a common referring agency remarked, "having an external service provider has created a barrier between the service and the client – another layer – leading to disadvantage for clients and us being further removed, and sometimes confusion". Similarly, a referring agency reported that the separation in one Council led to duplication in assessment – the service provider also sends someone in to collect

client details. The impact of the different models adopted in individual Councils is an issue that requires further investigation.

7.3.2 Impact on Staff

Interviews with assessors highlighted the impact of demand on stress levels and ability to keep up with assessments, requested and routine reviews, and data entry processes. There were also reports that heavy workloads had led to two assessment staff resigning during the project's timeframes. High staff turnover is likely to have detrimental impacts on an organisation as well as for individuals trying to access services. The impact of turnover on consistency in prioritising clients, having skilled assessors and maintaining continuity for clients, requires further discussion and potentially further investigation. High demand also impacts on targeting strategies. As Gibson notes, "the more stringently services are targeted, the more emotionally difficult become the decisions about boundary cases, and the more dire the consequences for those who fall outside the boundary" (Gibson 1999).

Time pressures on assessment and administrative staff was also evident by the reports collected during this project that contained substantial amounts of missing data and large number of records for clients who were no longer requiring services. The workloads of administrative staff must be manageable to allow for regular updating of the database to improve the ability to develop a comprehensive client profile for planning purposes.

Where clients have had hours reduced through a review process, the impact on direct care staff also needs consideration. There was some suggestion that the reduction in hours could increase pressure on these staff who may feel obliged to maintain their previous tasks for their regular clients. It was also apparent that social aspects of a home care visit are the first to be cut when a client's hours are reduced, despite the potential social benefits that this aspect of the service has for clients.

7.4 Service system level

At the service system level the inconsistencies between Councils due to differences in resource levels, demands, and demand management practices, was a theme reported consistently:

"Yes- all have limits on how much service – these limits are now decreasing, eg. used to be a maximum of 4 hours now 2 hour limitations. Assessment is really good. Waiting lists are a problem- especially at Melton and Brimbank. Full cost recovery purchasing above HACC services is much more expensive at Hobsons Bay and Wyndham".

In general, the research suggests that there was a high demand on the service system overall which led to other services increasingly relying on Council services - Councils were expected to make up for other services' inability to meet service requests. Council assessors in particular reported that the inability of other services to meet people's needs led them to refer them to Councils in the first place. For example, it was now common practice for RDNS to refer all basic personal care provision to Councils and focus instead on complex personal care. This relates to the increasing frailty of the

population living in the community. These practices may have the effect of increasing the likelihood that HACC-eligible people “miss out”, rather than placing greater pressure on other services or the service system more broadly.

The general expectation of Council staff that referring agencies may decide not to refer to Councils because they had little expectation of service availability often proved to be unfounded. Information from referring agencies suggested that this did not occur as frequently as Councils expected: “We inform clients about what might be available, make recommendations about what is suitable, then refer to the most appropriate service” (referring agency assessor). Some agencies were not influenced by the apparent lack of availability of services but did recognise that it was a “difficult call” if they felt that clients’ may end up getting nothing from Councils, or less than what the referring assessor felt they needed.

In relation to the response times of assessors, most of the referring agencies interviewed reported that they did not experience difficulty in accessing Council services. However, it was commonly reported that some Councils had more difficulty responding to requests for service than others. For example, one commented that “Hobsons Bay, Melton and Brimbank have difficulties”.

“Brimbank closed their books – they expect us to be core. Melton has a waiting list, but really they have closed their books. A waiting list implies that when someone who is getting services dies or goes into other care, they are replaced by someone on the waiting list... But if they can refer to us they will – we just top up services – there is constant squabbling – they use us as core. Mooney Valley uses us as a top up- that is what we are for. Don’t know about Maribyrnong.”

In relation to the referrals received *from* Councils, the majority of other organisations reported no major issues, with most reporting that referrals from Councils were appropriate. To paraphrase one respondent: “we have a good relationship with Council staff. We work directly, personally with the co-ordinator of services. They attend our weekly meetings, we know them, which assists the process, and if a referral is required we discuss it first.” There was, however, some indication that these referral links were not as strong with some agencies as the following comment from an Ethno-specific agency illustrates: “Local government is often the first in, but there are no links with them [we rarely, if ever, get a referral from them]. We can offer advocacy and liaison which could be used by clients of local government services”.

The general low level of resources available in the Region was an issue that had arisen in Primary Care Partnership discussions occurring within the alliances: “what is the point of putting all the effort into re-developing assessment systems, when we simply don’t have the resources available to meet identified needs?” (Aged and Disability Manager). Clearly, the direct relationship between availability of resources and assessment outcomes (Branch 2000) is an issue that needs to be addressed through the PCP process.

7.4.1 Maintenance of Effort

The Maintenance of Effort policy was introduced at the time of the expansion of the Linkages program in Victoria, with the purpose of the policy being to maintain the effort of existing agencies with clients when they became Linkages clients. Rather than this being determined for each individual client, the usual application of the policy was for sub-Regions or individual organisations to agree on “core levels” of service that agencies would continue to fund when their client became a Linkages client. As one Aged and Disability Manager in the WMR pointed out, a review of the policy in their area has been “overdue for three years”.

Table 10: Comparison of Maintenance of Effort Agreements – Linkages

	Agreed Levels	Comments
Brimbank	*	
Hobsons Bay	2 – 4 hours home care weekday meals home maintenance 1 day p/w ADASS	The maximum of 4 hours home support is now rarely applied Clients of other brokerage programs are individually assessed and judged according to current priority criteria
Maribyrnong	2 hours home care (if pre-existing level was under 4 hours) 4 hours home care (if pre-existing level was more than 4 hours) 5 meals p/w	
Melbourne	No set levels	Generally, Council maintains effort up to 10 hours per week, which may include delivered meals and ADASS
Melton	2 hours home care 1 day p/w ADASS 3 weekday meals	Discretion is possible following negotiation with brokerage services
Moonee Valley	2 – 4 hours home care weekday meals	Having to go to the maximum 4 hours more often. More flexibility is possible if more service can be provided at the full cost recovery rates.
Wyndham	2 hours home care 3 weekday meals 2 hours home maintenance for each episode	Some negotiation is possible for higher needs clients

*Information not available at the time of data collation.

The perception of case management services on the ability of Councils' to maintain their effort suggests that the maintenance of effort arrangements in the Region is in need of review. As one worker from a case management/Brokerage program commented: "We are supposed to be a service that tops up what Councils can provide, but they aren't even providing the core". Another Aged and Disability Services Manager commented that they had poor relationships with the brokerage services. This was likely to stem from the increasing level of expectation on Council to meet the increase in demand for higher need clients, but with little extra input from the side of the brokerage services.

7.4.2 Service System Fragmentation

Service system fragmentation is a theme that arose in the interviews conducted during the project, and is worthy of further exploration. A fragmented service system may be a product of the increase in demand on services; the number of providers involved in the service system and the number of funding sources has steadily increased along with the general increase in demand for community support services (Howe 2000). As well as an increase in the number of funding sources there has been a trend in Victoria towards purchasing from an increasing number of private providers, a product of directions to improve efficiency within the HACC program and influenced by Compulsory Competitive Tendering in Local Government. Equally, however, service system fragmentation may also be a factor that contributes to the increased demand on service providers. As one Aged and Disability Manager reported;

"As more and more people [organisations] are playing around with a person's care, the complexity of service delivery increases. This makes it more difficult in terms of the paper work such as billing and accounts management, and maintaining effective liaison and relationships with other organisations. This fragmentation also costs the HACC Program dearly, as each organisation has it's own costly infrastructure."

Initiatives to reduce duplication in assessment, such as the introduction of the CIARR into the HACC Program in 1993/1994, appears to be increasingly difficult to implement as the number and type of organisations involved in service delivery increases and diversifies. However, simple measure to improve networks for assessors/care planners could help to ameliorate the difficulties associated with a complex and seemingly fragmented service system. For example, one referring agency reported much better relationships with Councils where community services networks existed for workers at the assessment and care planning level in Wyndham and Melton as opposed to other areas where such networks were not as well established or understood.

The Primary Care Partnership (PCP) approach initiated by the Department of Human Services in Victoria is expected to assist with the problems associated with service system fragmentation. There was, however, mixed opinion amongst Aged and Disability Service Managers about the ability of the PCPs to have any real impact in relation to service system fragmentation. As one Manager said; "PCP won't fix it. The changes are not being focussed in the right areas – what about all the service types [identified in the MAV report about local government provision of community care in Victoria]. How will PCPs help that?" In contrast, others expressed confidence that the "PCP may help the fragmentation, duplication and resulting complexity for service providers and clients. It

will do away with competition for resources, and improve co-ordination and planning.” (Aged and Disability Services Manager).

7.4.3 Regional and State-wide Planning

Aged and Disability Managers recognise the need for better planning “between Councils in the region, and between the State and Commonwealth” to ensure that resources are distributed fairly and strategically. The PCP ‘cross-alliance’ project operational in the WMR was highlighted by one Aged and Disability Manager as likely to be particularly beneficial in improving planning between the different Councils and PCP alliances.

There was also the recognition that better planning between related programs such as respite and CACP needed to occur. This needed to occur to assess the real impact that they are having on HACC, and to ensure:

- there is no duplication between programs, and
- there are no assumptions of community needs being met because of the existence of other programs, without data to support the assumption.

8. Conclusion

The stated purpose of this research project was to develop a picture of demand and user profile of in-home HACC services delivered by local government in the Western region of Melbourne, with the expectation that this information would be important for consideration during the WMR five-year strategic planning process to be conducted during 2000/01. In particular, the project aims were to:

- Gain an understanding of the level of demand for HACC services, including unmet demand, in the WMR
- Identify factors contributing to unmet demand
- Develop strategies to assist Councils deal with demand issues
- Recommend a consistent method of data collection, including definitions of low/medium/high needs, for all WMR Councils to enable accurate measurement of service demand and service delivery. It was stated that such a framework could also be used in any future prospective study of HACC service demand, should the opportunity for this type of research arise.

The project was focussed on the "in-home" HACC services provided by local governments in the WMR, namely home care, personal care, in-home respite, property maintenance and delivered meals. It did not encompass out-of-home services, or services provided by other organisations.

The report presents data describing the population profile of clients receiving Local Government in-home HACC services in the WMR for the period of May 2000 with particular reference to age, gender, cultural/linguistic background, and some socio-economic measures. Limited data were available in relation to levels of client need and carer status. Data indicating types of Council and other services received by individual clients were not available. Whilst limitations in the data collected may be due to characteristics of the software programs, many of the issues could be addressed through adopting strategies to improve data recording and entry. This relates directly to staffing levels, and the priority placed on these tasks within individual organisations and the resources they have to support these staff. To measure unmet demand, attention needs to be given to recording assessed clients who do not access services. There is potential to do this using the assessment module in Sharikat Khoo. However, the Councils in the Region use three different software programs currently. Production of consistent reports that enable Region-wide data analysis would require an agreement by all LGAs to record the same variables and data items within whichever software program they use. Achieving this consistency would require considerable collaborative effort.

Where possible, client demographic data were compared with other available data from sources such as the Australian Bureau of Statistics, Victorian Department of Infrastructure, and the recent MAV HACC status report. In particular, there was evidence that NESB groups are under-represented in LGA HACC services. This issue requires further investigation in relation to service promotion, access and cultural appropriateness.

The report discusses the various demand management strategies employed by WMR Councils including prioritising clients, rationing services, the use of waiting lists, limiting service promotion, and increasing HACC funding through Council contributions. The report also considers the impact of the level of demand for HACC services at the individual client, organisational, and service system levels. Detailed reports of service provision data were also presented in the report. As this type of study had not previously been conducted in Victoria, the appropriate data were not available to compare service provision in this level of detail, or levels of demand in the WMR with other areas. However, the researchers conclude that there is high demand for "in-home" HACC services in the region, evidenced by, in particular:

- Use of waiting lists.
- The practice of refusing service to low priority clients.
- The practice of reducing hours to existing clients.
- Apparent low level of service provision and low service ceilings (eg 3 hours per week maximum for high priority clients). However, with the absence of appropriate benchmarks and knowledge of other services received by individual clients it is difficult to draw conclusions about the impact of these practices.
- Increased (although potentially unsustainable) Council contributions to HACC budgets.

The inability for the majority of Councils in the WMR to meet service demands is an issue that requires attention through the statewide RREF review and the five-year HACC strategic planning process in the WMR, both due to report early in 2001. The inadequate level of State/Commonwealth HACC funding, and the increased pressure on Councils to contribute above the previously agreed level of 20%, is an important contextual issue for this project and the resulting recommendations.

8.1 Key Recommendations

The researchers recommend that:

1. The information presented in this report be made available to contribute to initiatives designed to address planning and funding issues at a statewide and/or Regional level.
2. That prioritisation tools/assessment tools are further developed to introduce consistency across the region. An initial step would be to convene a working group to examine the issue and to consider the appropriateness and feasibility of standardisation of such a tool. A discussion about the philosophies underlying the different approaches to assessment also needs to occur during this process. This action needs to link with PCP initiatives in the Region, which could be a useful vehicle for development.
3. A review of maintenance of effort agreements is undertaken in the WMR.
4. Councils consider initiating a review (regional or statewide) of the practices of separation or integration of assessment and service provision functions.
5. Further research is undertaken to investigate demand and the impact of demand on individual clients and on people who are not accessing services. Such a study could investigate groups that appear to under-utilise services to determine whether under-utilisation relates to a lack of knowledge of services, cultural expectations (eg. that family

should provide care), attitudes about the quality of LGA care, availability of appropriate/suitable direct care staff, use of other services or other factors.

6. WMR Councils and DHS explore the possibility of employing a region-wide data 'expert' to advise and support each Council (and potentially other HACC agencies), through a HACC service development grant.
7. Improvements to data collection and data analysis be considered to ensure greater opportunities for effective measurement of demand for HACC services. Suggested actions are to:
 - Follow-up on missing client data.
 - Review client data termination practices for clients that require one off services and those clients who have been suspended for a number of months.
 - Review the client data categories used by individual Councils, with the aim of improving consistency across the region (the implementation of the MDS will enable a standard set of characteristics to be defined).
 - Ensure that key 'data staff' are able to develop their software skills by attending relevant training and software user groups.
 - Develop a consistent system for recording and reporting characteristics of people who are referred but not offered services.

(These recommendations are dependent on each Council having adequate funding to ensure administrative staff availability to enable accurate data entry and maintenance).

- WMR Councils and DHS establish a working group (once the consistency of data collected is improved) to consider the following points:
 - How will data *across the region* be collated and analysed to maintain an accurate picture of demand and service provision capabilities of each LGA (and potentially other HACC services)?
 - How will data collection processes be reviewed and revised over time?
- 8. Councils consider options for more effective and strategic use of assessment officer time, in particular, through increasing the availability of assessment staff to conduct reviews (for example, where assessment staff have data entry responsibilities administrative staff could perform these functions); and exploration of the use of laptops or other technological solutions during assessment.

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Appendix 1: List of key referring agencies that participated in interviews

- Australian Polish Community Services Inc
- CareConnect
- Carer Links West
- Doutta Galla Community Health Centre
- Interchange Western Region Inc
- ISIS Primary Care – Linkages Case Manager
- ISIS Primary Care – Occupational Therapist
- Maltese Community Council of Victoria Inc
- Melbourne Extended Care and Rehabilitation Services – ACAS
- Melbourne Extended Care and Rehabilitation Services – PACFU
- RDNS Altona Centre
- Sunshine Hospital- Discharge Planner

Appendix 2: Priority of Access Guidelines: Brimbank and Wyndham

Priority	Brimbank	Wyndham
High	<p>Service users characterised by: unable to, or require significant support to perform essential activities of daily living live alone or have carer who is either unable to provide the level of assistance required and/or require time to participate in social, family and community activities have minimal other informal / formal supports or services tasks required include household tasks, personal care, personal assistance, regular monitoring and respite</p>	<p>Two or more out of: confused and unable to make decisions socially or geographically isolated no family or informal support need for regular support for personal care needs unable to prepare own meals high level of frailty or disability unstable health</p> <p>high carer burden require case management using multiple services multiple family needs financially disadvantaged most likely to require residential care if services not provided experiencing difficulty with a range of activities of daily living.</p>
Medium	<p>Service users characterised by: require some support and assistance to perform essential activities of daily living either live alone but have access to informal/formal supports and services or have a carer who can provide some support tasks required include household tasks, personal assistance, limited monitoring and respite (personal care excluded)</p>	<p>Service users characterised by: Some informal networks or family support require some assistance with personal care needs moderate level of frailty or disability</p> <p>health usually stable some carer stress able to attend to some ADLs with assistance, and some monitoring required.</p>
Low	<p>Service users characterised by: require assistance with mostly household maintenance tasks</p>	<p>Service users characterised by: good informal networks low level of frailty or disability stable health no or low level of need for a carer</p> <p>attends to own personal care minimal monitoring required require Home Care only, or occasional users of home maintenance services.</p>

Appendix 3: Score based priority tools: Melbourne, Hobsons Bay, Melton and Moonee Valley

	Melbourne – 10 items	Hobsons Bay and Melton – 10 items	Moonee Valley – 15 items
Isolation *	(1) independently access community supports to (5) housebound	(1) resident carer /no mobility, sensory or co-ordination problems, no problems making contact with others to (5) lives alone / no informal support	(1) living alone & managing well or living with carer and carer managing well to (3) alone with no support / carer unable to provide support
Physical capacity *	level of physical vulnerability and restrictions they impose: (1) independent to (5) dependent	(1) good health – no identified health issues, able to perform ADLs to (5) frailty / debility – medically unstable, mostly dependent, requires significant support to perform essential ADLs	physical health: (1) generally good health to (3) several high risk diagnoses and / or unstable (risk of falling) capacity to perform ADLs: (1) mainly independent to experiences significant difficulty with a range of ADLs
Mobility *	(1) ambulant – no aids to (5) bedridden	(1) independent without aids to (5) bedridden / housebound	X – overlaps with physical health above
Cognitive and emotional capacities/ perceived memory function *	perceived memory function: (1) alert to (5) dementia	(1) no identified cognitive or emotional concerns to (5) at risk behaviour	cognitive impairment: (1) does not effect capacity to organise and accept help to (3) unable to function independently of carers mental health: (1) little or no effect on function to (3) greatly affects capacity to function in the community
Sensory capacities *	impact of sensory deficits on safety from (1) no deficits to (5) dependent on care for safety	(1) no sensory loss to (5) profound sensory loss	X
Carer Issues *	X – overlaps with “household capacity” below	(1) Carer physically / emotionally able to meet caree’s needs / no need for carer to (5) carer unable to meet caree’s needs / person lives alone at risk	(1) carer coping fairly well to (3) carer not coping with carer duties – requires constant outside support. capacity of carer to maintain adequate level of support from (1) able to continue to (3) totally unable to continue providing adequate support

	Melbourne – 10 items	Hobsons Bay and Melton – 10 items	Moonee Valley – 15 items
Communication *	X – overlaps with risk of neglect/abuse below	(1) able to communicate effectively to (5) not able to communicate needs	Impact of cultural background: (1) does not impact to (3) greatly affects capacity to organise appropriate help
Physical environment *	(1) easily accessible for client in and out of home to (5) risks in and out of home	(1) no health and safety issues to (5) sub-standard housing / non-resolvable health and safety issues	safety: (1) dwelling, self care and substance use appropriate for current needs, to (3) situation unsafe – requires immediate attention
Capacity of household/availability of support *	(1) no support needed from carer / household members to (5) other (inability of carers / household to cope is implied)	(1) household coping to (5) complete breakdown	X
Risk abuse / neglect *	Likelihood of person being at risk from (1) no risk factors to (5) over 3 risk factors; risks include inability to verbally communicate, confusion / dementia, inability to identify risks	(1) no identified risk to (5) evidence of neglect or abuse by self or others	(1) no physical, emotional, financial or sexual abuse to (3) confirmed and serious threat to wellbeing (also neglect combined with “safety” above)
Household income / financial situation	Household income: (1) 60,000 + to (5) \$20,999 to full pension	X	financial situation: (1) independent means to (3) pension only
Supports required / available	level of support currently being provided from (1) ad hoc / fixed support to (5) 4 or more services involved	X	availability of other agencies and their ability to meet current needs and or geographic isolation: (1) effective to (3) ineffective
Willingness to accept current services / increased assistance	X	X	(1) willing to (3) refusing
Commitment to stay at home	X	X	(1) considering other options to (3) very committed
Nutritional status	X	X	(1) adequate and independent to (3) unable to maintain adequate nutrition independently

Appendix 4: Active Clients

The following reports show the total number of **active** clients by service type during the 4 week periods in 1996, 1998 and 2000, in which the demographic and service provision data was collected. It does not show how many clients received service during that month but how many clients were on the database. Please note that different Councils may use different modules. For instance, Brimbank has all personal care and respite care clients in their home care module while Moonee Valley has their personal care but not respite in the home care module. Also note that the **totals provided for each year are the total number of individual clients** – not simply a sum of the number of clients in each module which would double up clients who receive more than one service type. **These totals reflect the clients who have been included in the demographic data section.** As Melton used a different software program and was not able to provide demographic data for all clients, this information was not possible to obtain. It is also important to note that the number of active clients does not indicate trends in service provision. Decreasing numbers of active clients from 1996 to 2000 is generally a better indication that Councils have been “cleaning up” their systems and removing client records who have not been accessing services for a while rather than a decrease in number of clients accessing services.

Brimbank	1996	1998	2000
Home care	1160	1229	894
Home maintenance	157	834	1693
Food Services	298	420	549
Specific services	162	196	135
Total	1635	2128	2516
Also has Linkages & CACP clients included*	1686	2182	2562

*When including Linkages and CACPs clients in the total it only changes totals by about 50 clients. These clients have not been included in the demographic and service use data as a large proportion of these hours would be full cost recovery.

Hobsons Bay	1996	1998	2000
Home care	1235	990	982
Home Maintenance	19	26	848
Food services	381	390	463
Children specific (0-12 yrs)	16	70	78
Specific services (13-25 yrs)	106	48	27
Linkages	56	39	40
Total	1590	1331	1777

Linkages clients have been used for Hobsons Bay totals as these clients are receiving 2 hours maintenance of effort that is covered through HACC funds.

Maribyrnong	1996	1998	2000
Home care	2560	1804	1254
Home Maintenance	2252	2320	2270
Food services	548	573	621
Specific services	100	98	79
Total	3938	3392	3040

Melbourne	1996	1998	2000
Total	1401	1171	733

Moonee Valley	1996	1998	2000
Home care	1899	1864	1666
Food services	1164	1328	830
Home maintenance*	54	1708	2978
Respite care	43*	54	56
Specific services	119	124	144
Total	2645	3575	4155

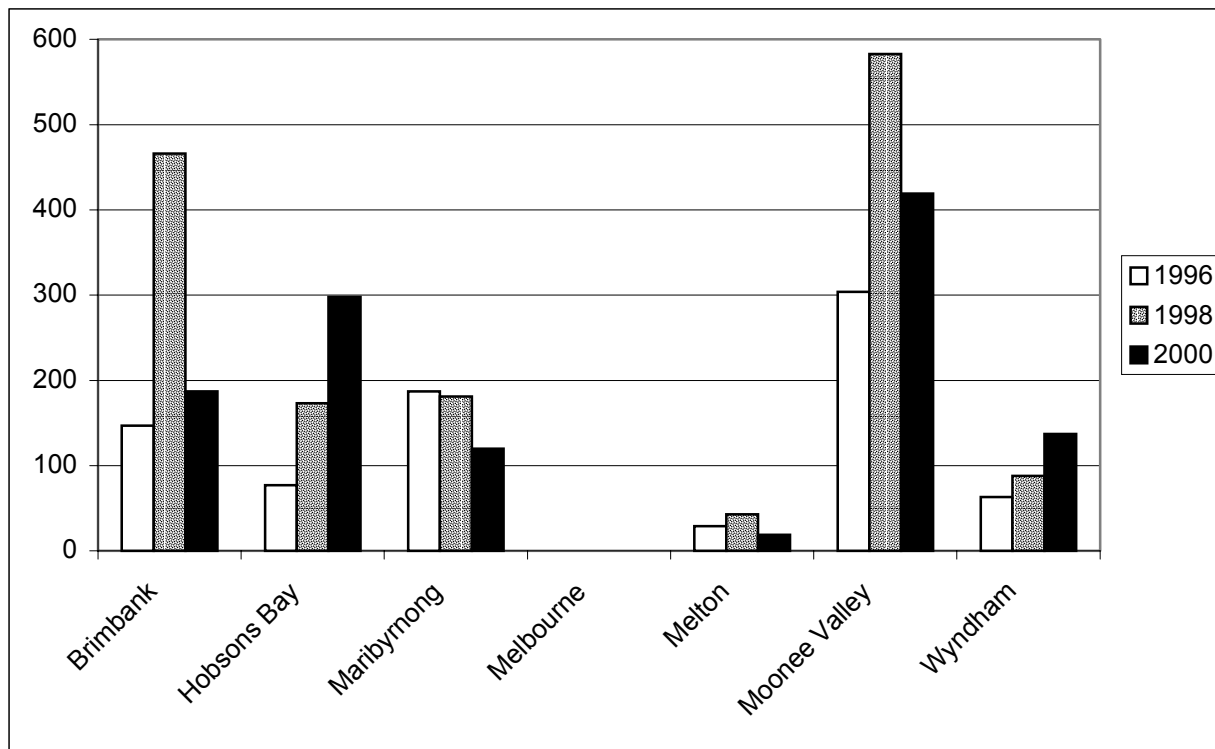
*Home maintenance module was not fully operational until 1997.

**The rapidly increasing number of clients relates to the number of home maintenance clients. This Council has decided to keep these clients active after receiving a once off visit due to the possibility that these clients will require other services in the future. If home maintenance is excluded whilst generating the report the number of active clients is 2727 in 1998 and 2244 in 2000.

Wyndham	1996	1998	2000
Home care	755	788	686
Home maintenance	975	1056	588
Food services	379	358	181
Specific services	168	153	106
Total	1840	1986	1445

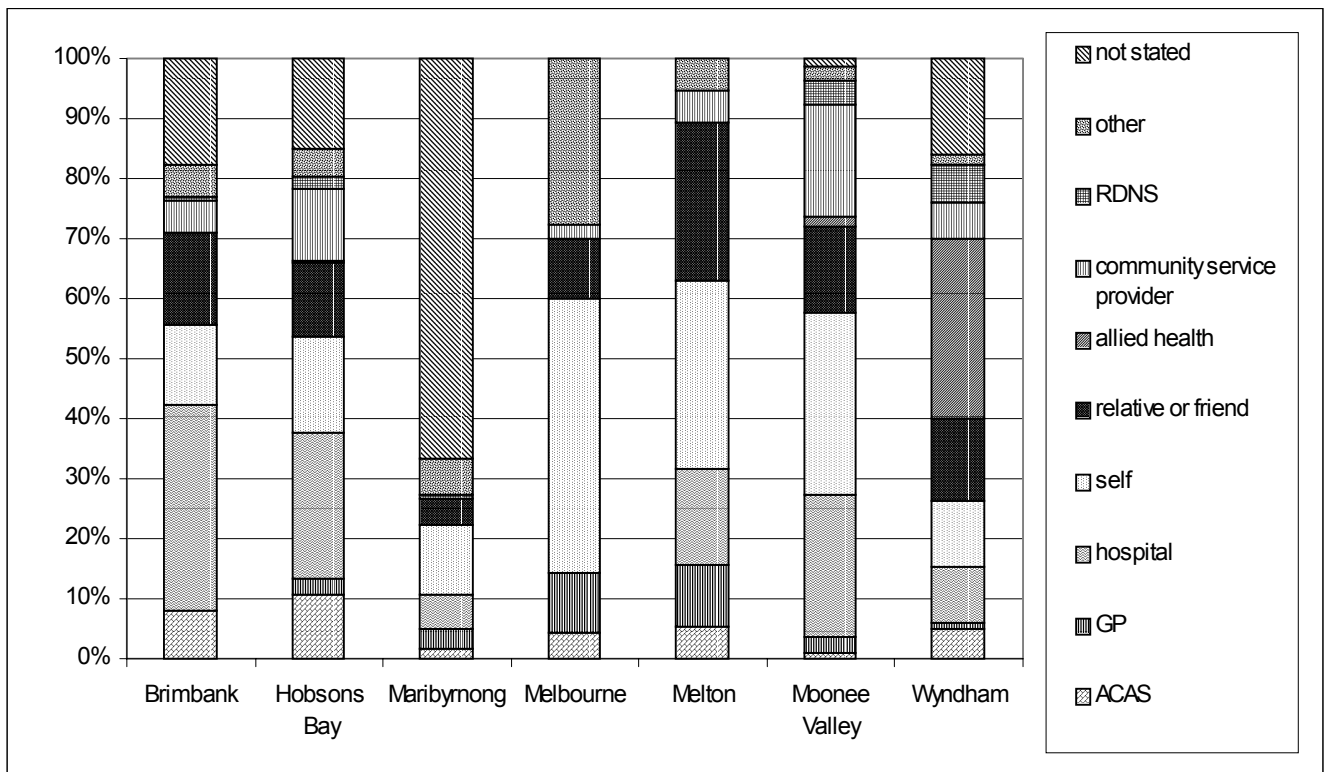
Food services module for Wyndham is not accurately maintained. The smaller number of active clients for 2000 reflects a general clean up of the system in progress prior to and during the project.

Appendix 5: Number of new clients between 1st February and 31st May



NB: The use of this data is limited. For those using Sharikat (all except Melton) the data has been drawn from a report that shows all new clients within the dates specified. It does not show number of new referrals but the number of clients who have been entered as new clients within the four months. With most Councils introducing an assessment module recently, the number of new referrals may be able to be generated in the future.

Appendix 6: Referral source of new clients between 1st February –31st May 2000.



NB: Melbourne referrals sources comes from all existing clients not just new clients

Appendix 7: Country of Birth by Local Government Area

The following figures show the country of birth of clients in the study as well as for the total population in each LGA. The 6 most commonly recorded countries of birth in the total LGA population (based on 1996 census data- refer to Victoria in Fact) determines the countries recorded.

Figure 27: Brimbank

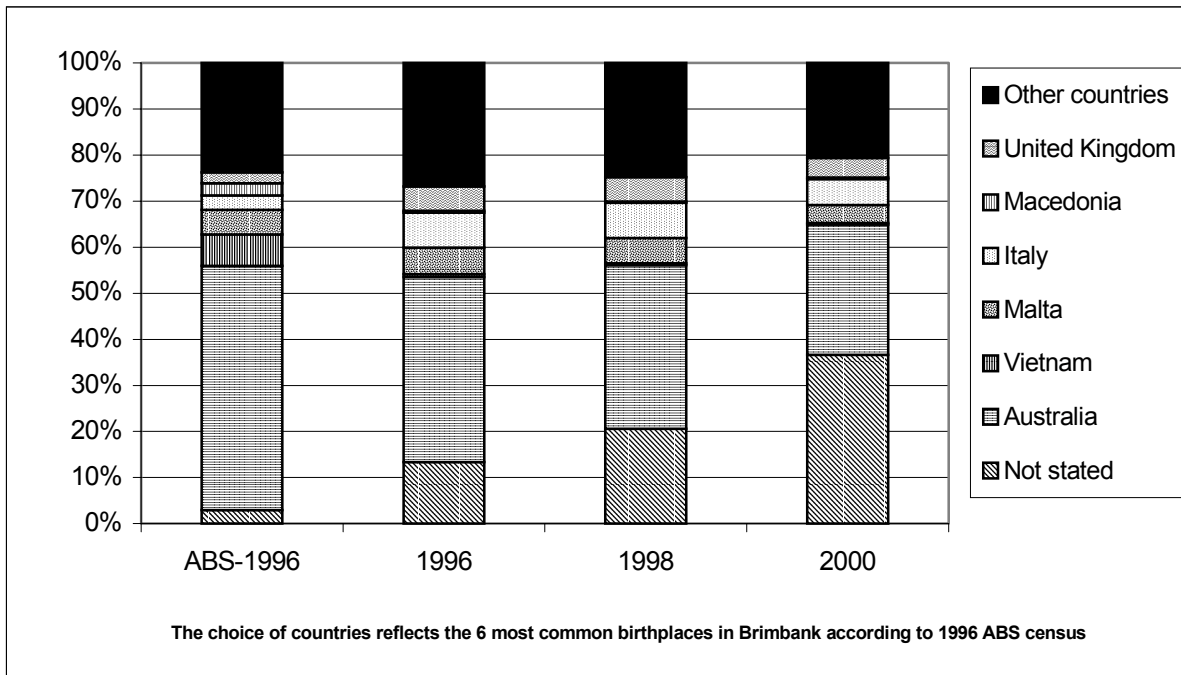


Figure 28: Hobsons Bay

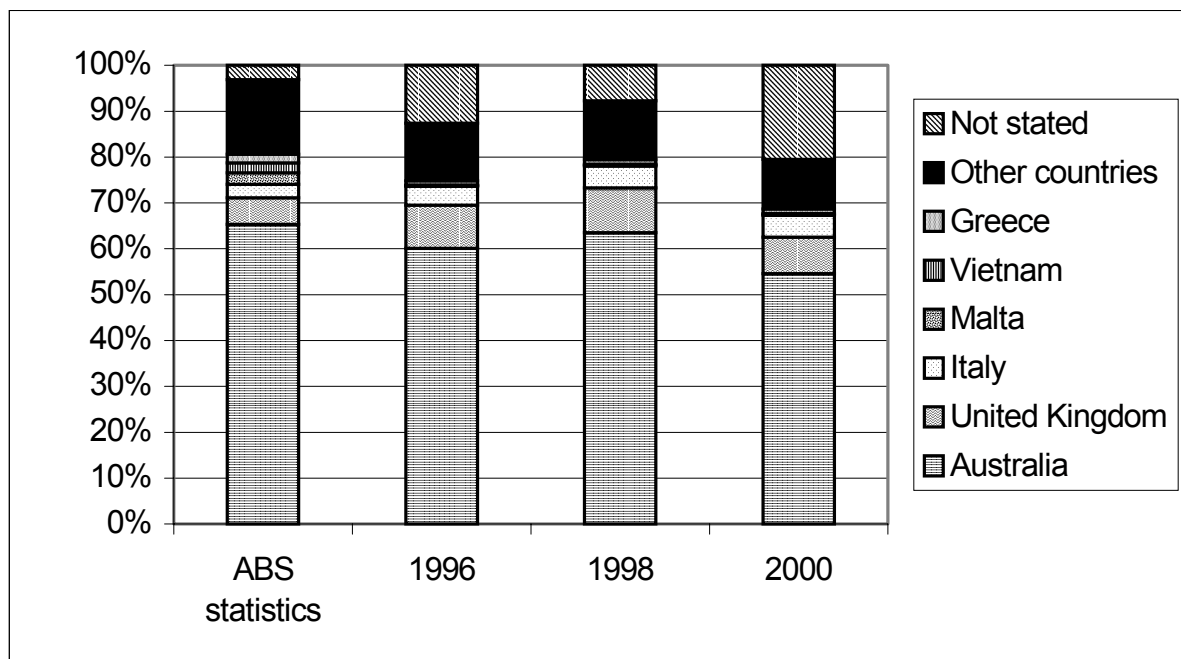


Figure 29: Maribyrnong

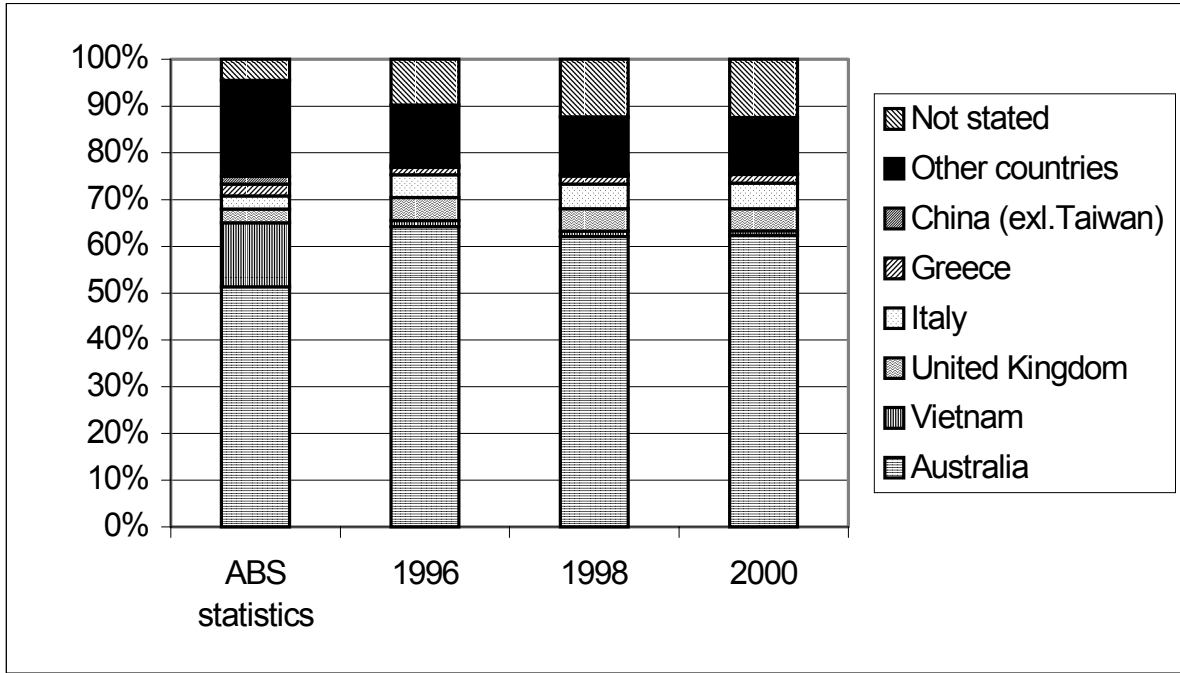


Figure 30: Melbourne

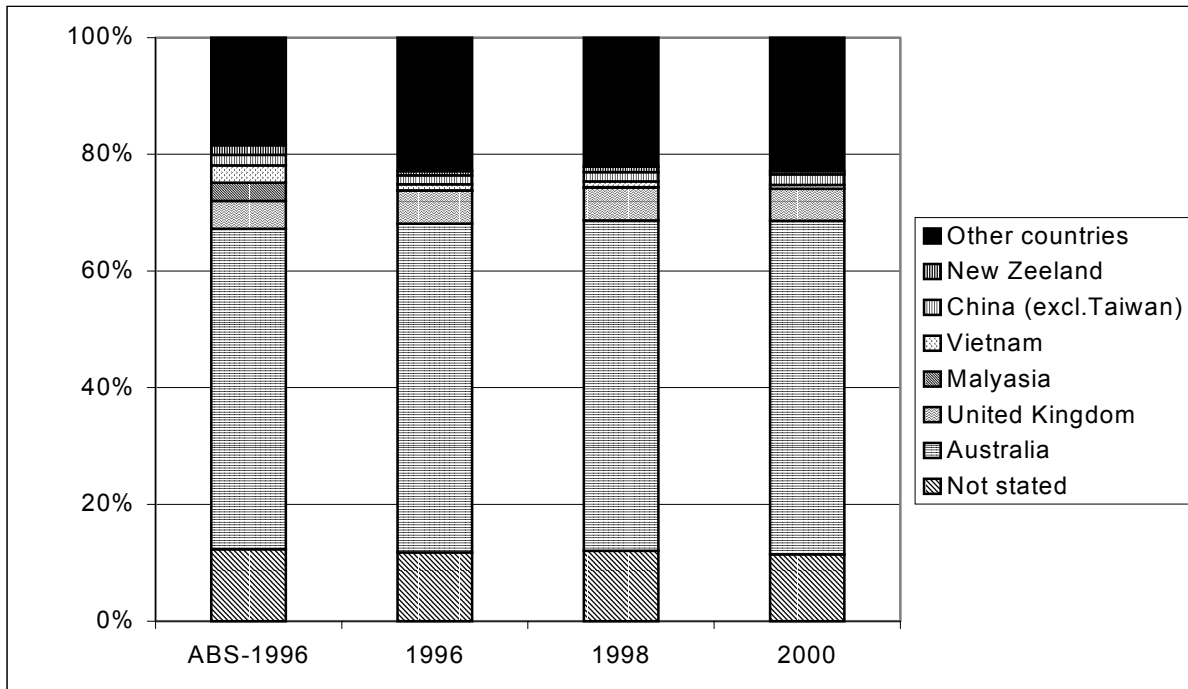


Figure 31: Melton- sample of 40 clients

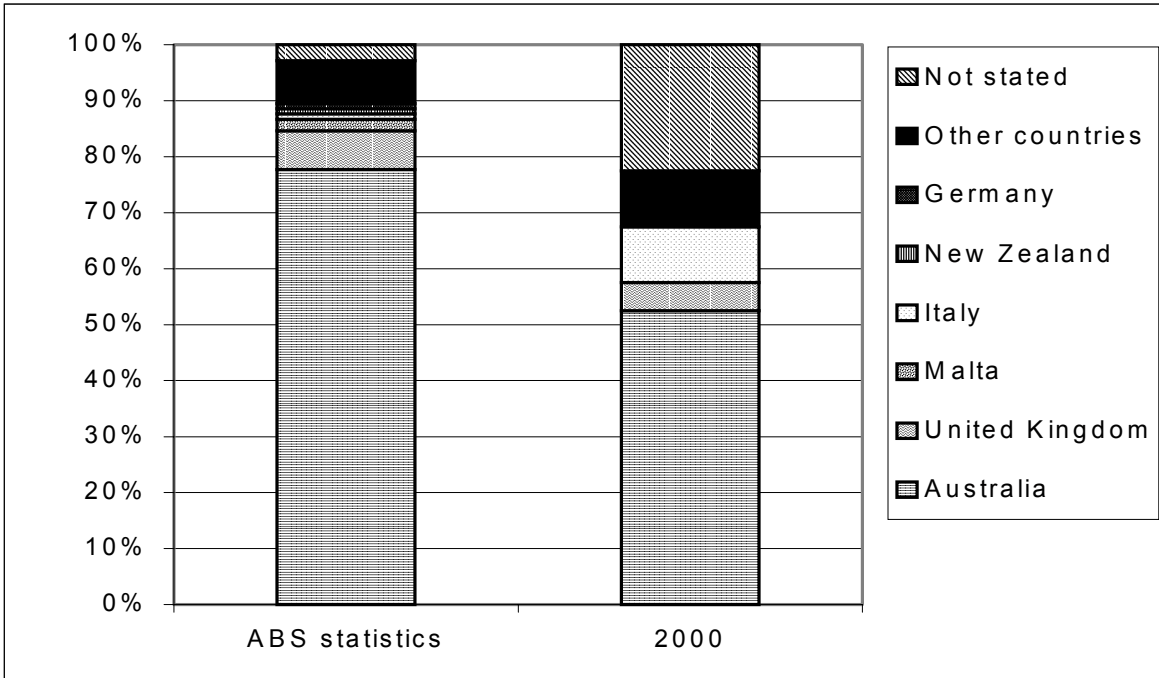


Figure 32: Moonee Valley

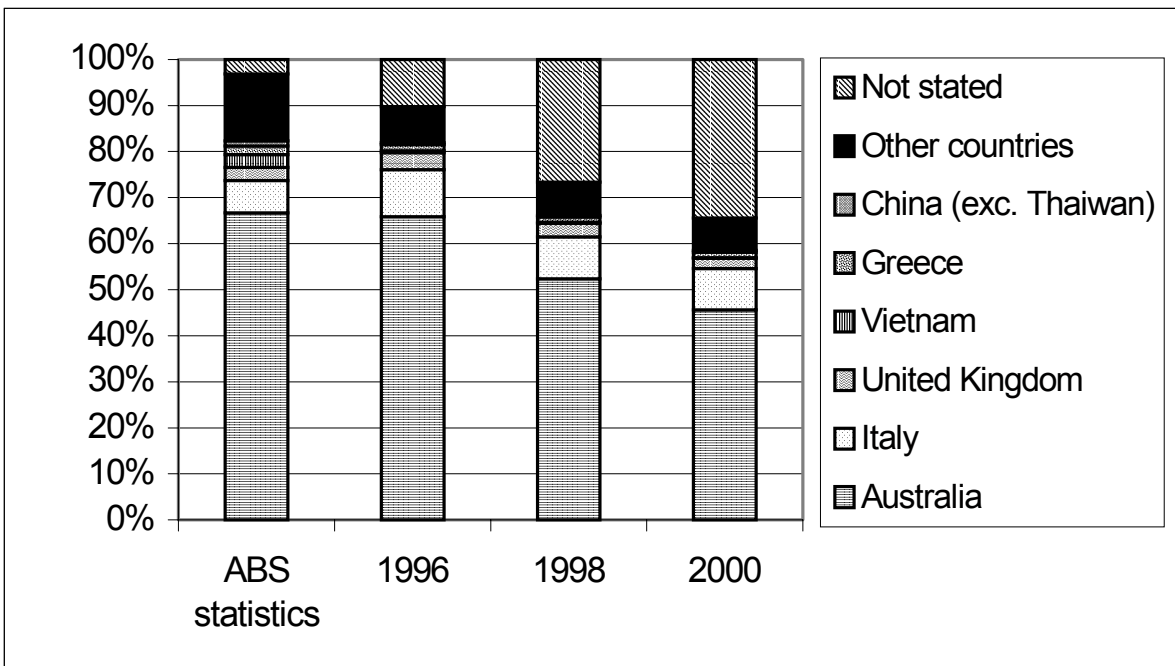
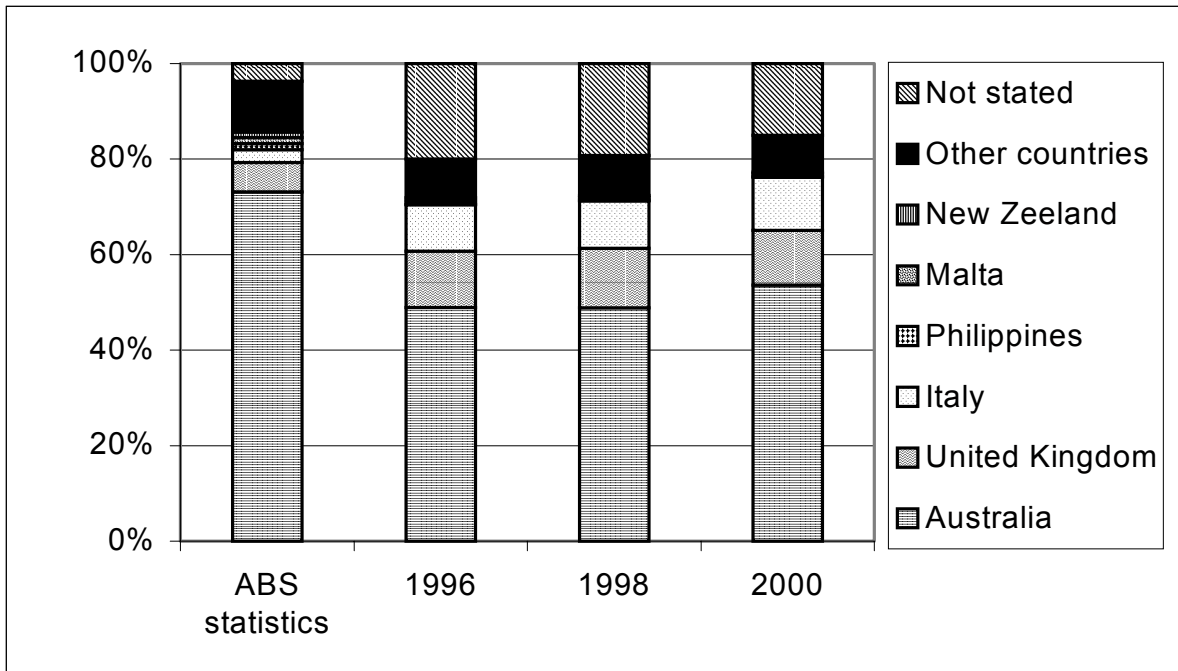
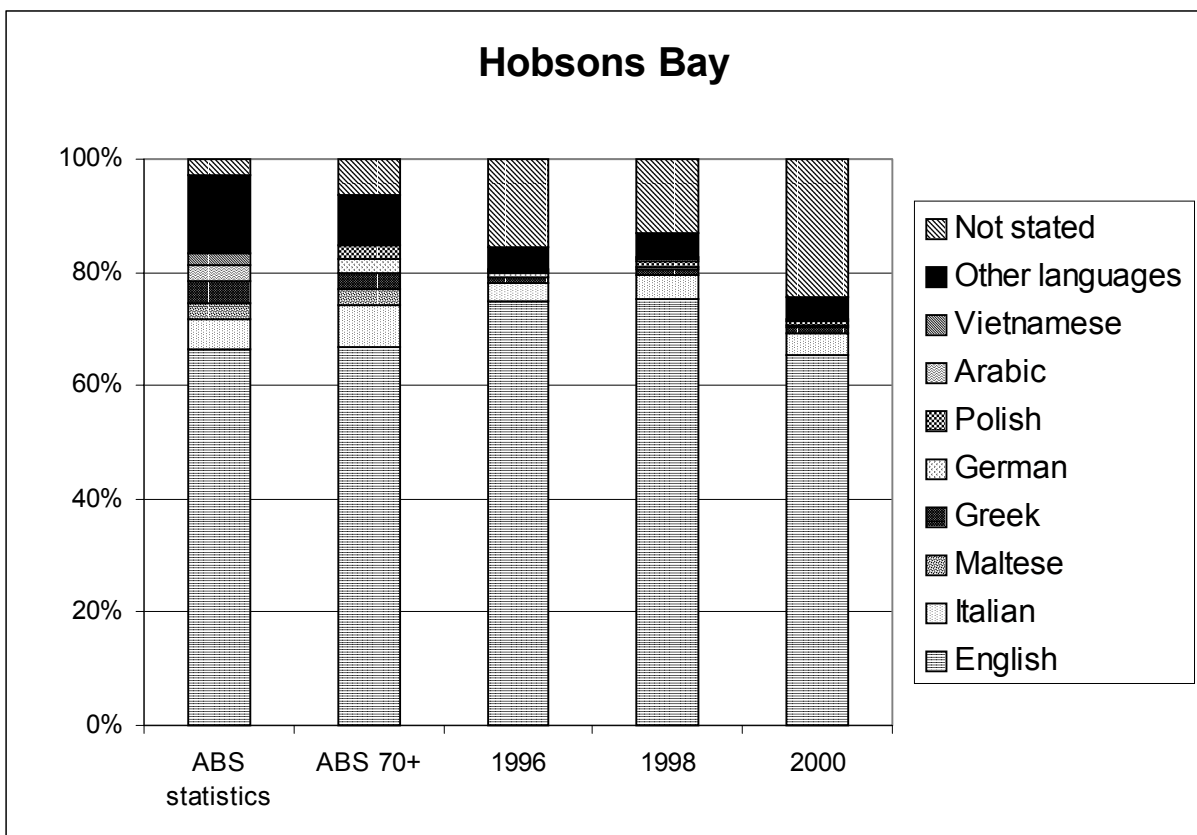
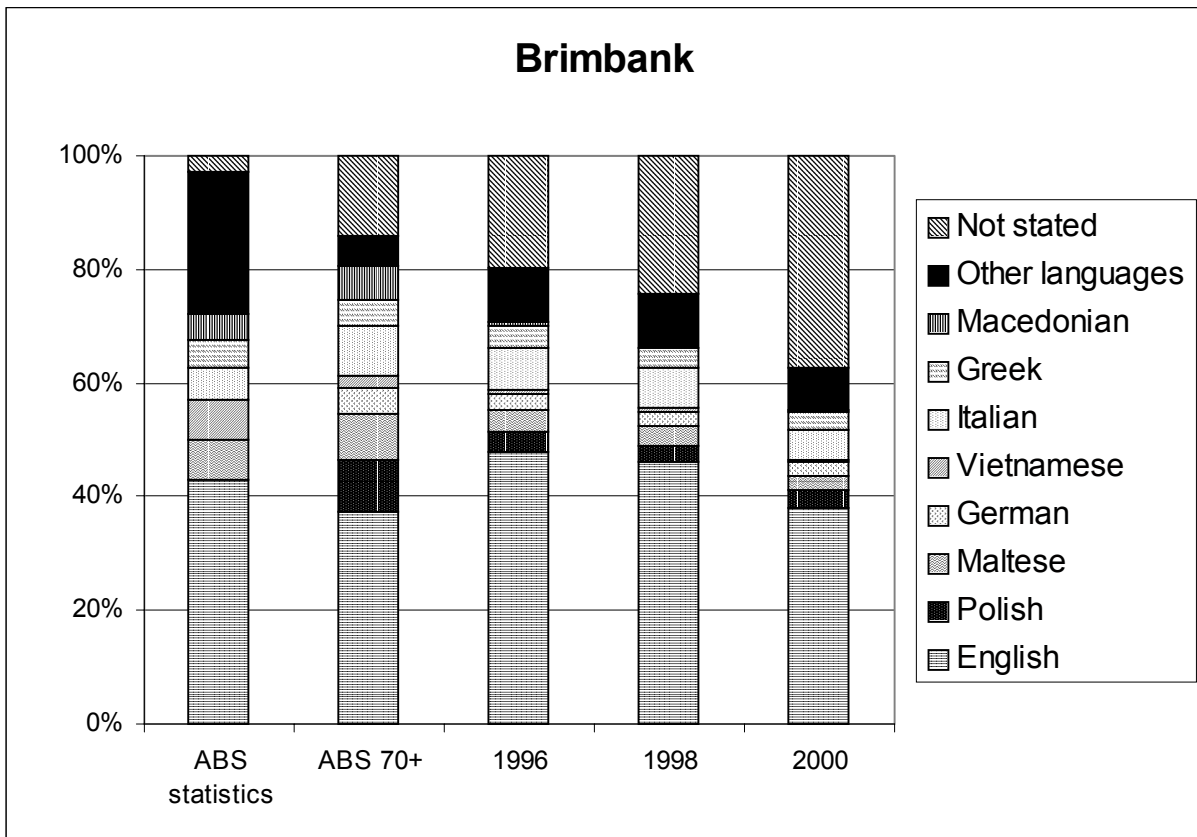


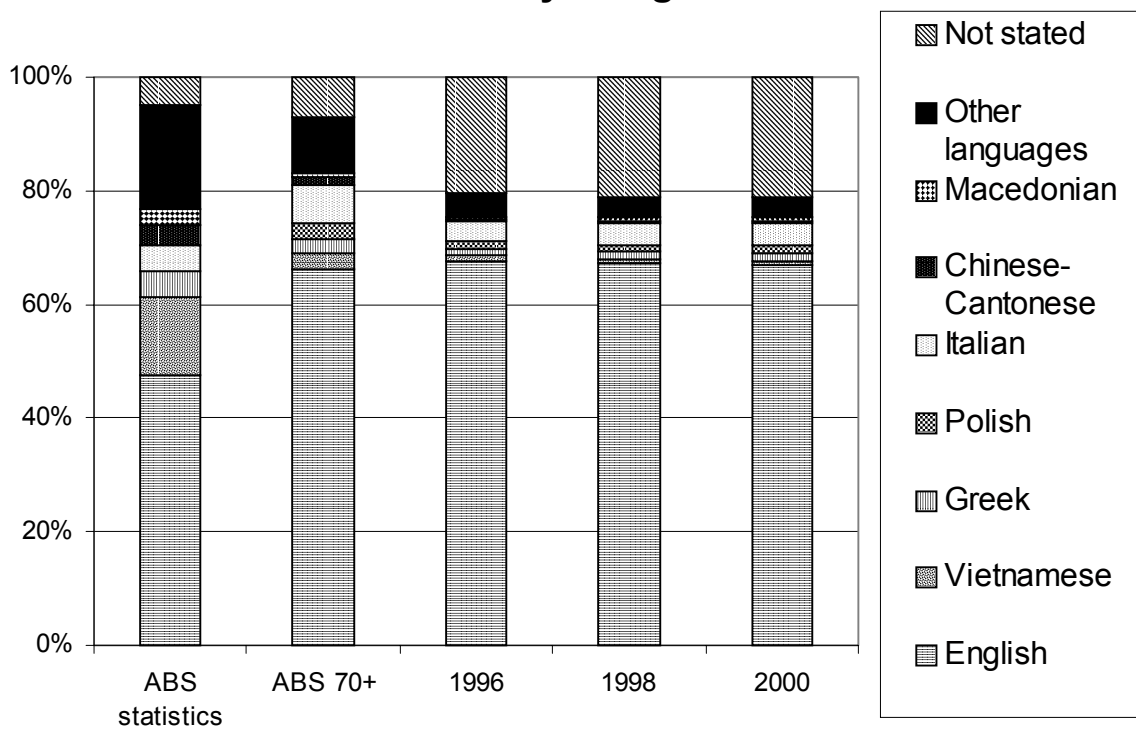
Figure 33: Wyndham



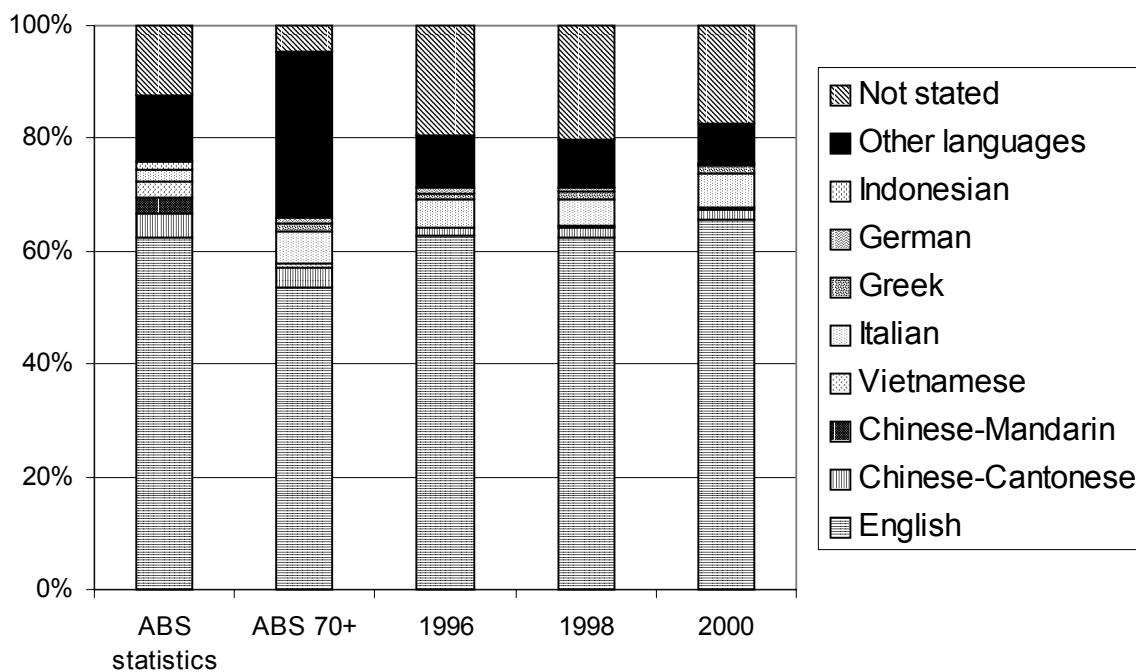
Appendix 8: Language spoken at home



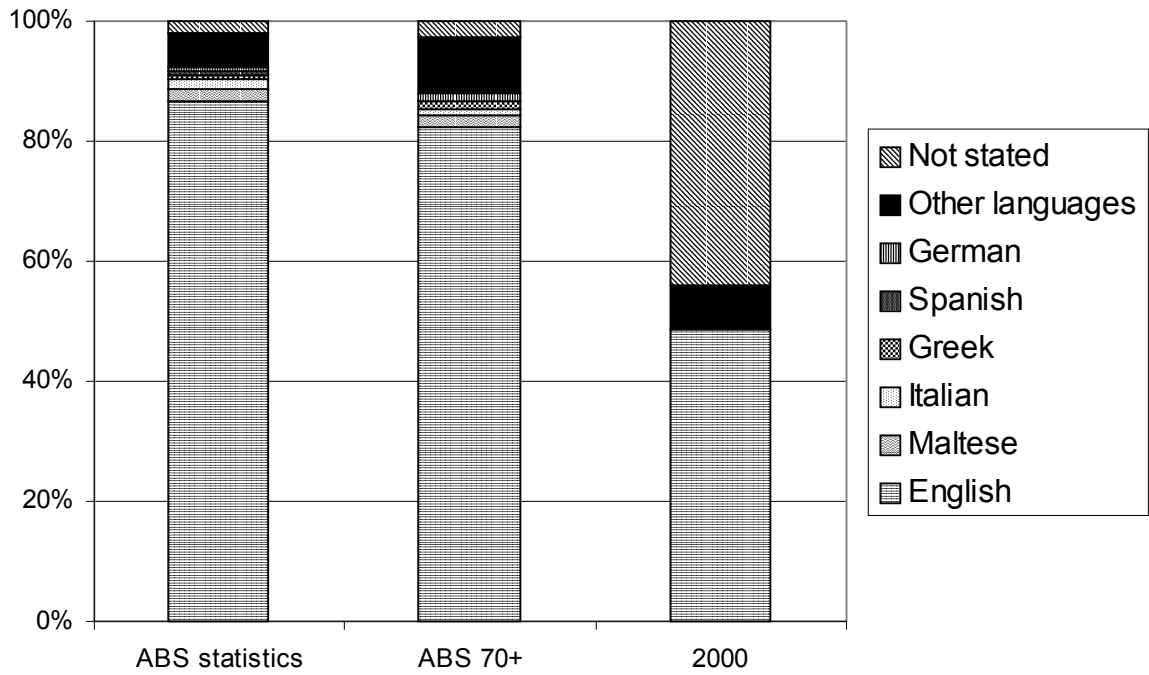
Maribyrnong



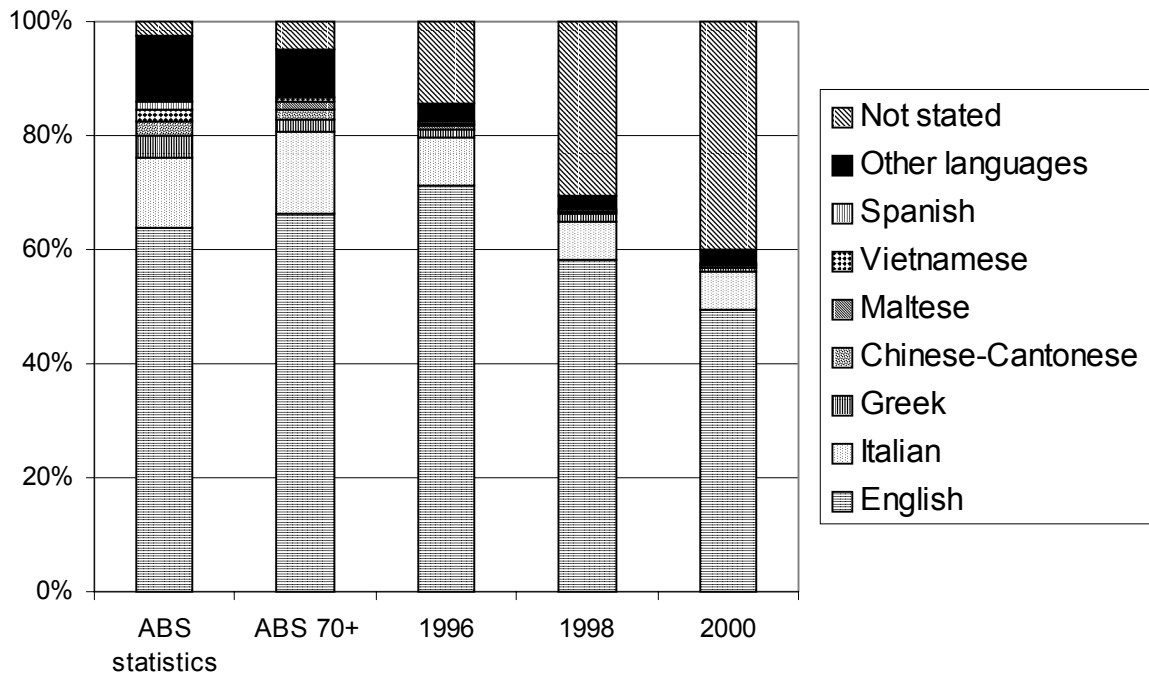
Melbourne



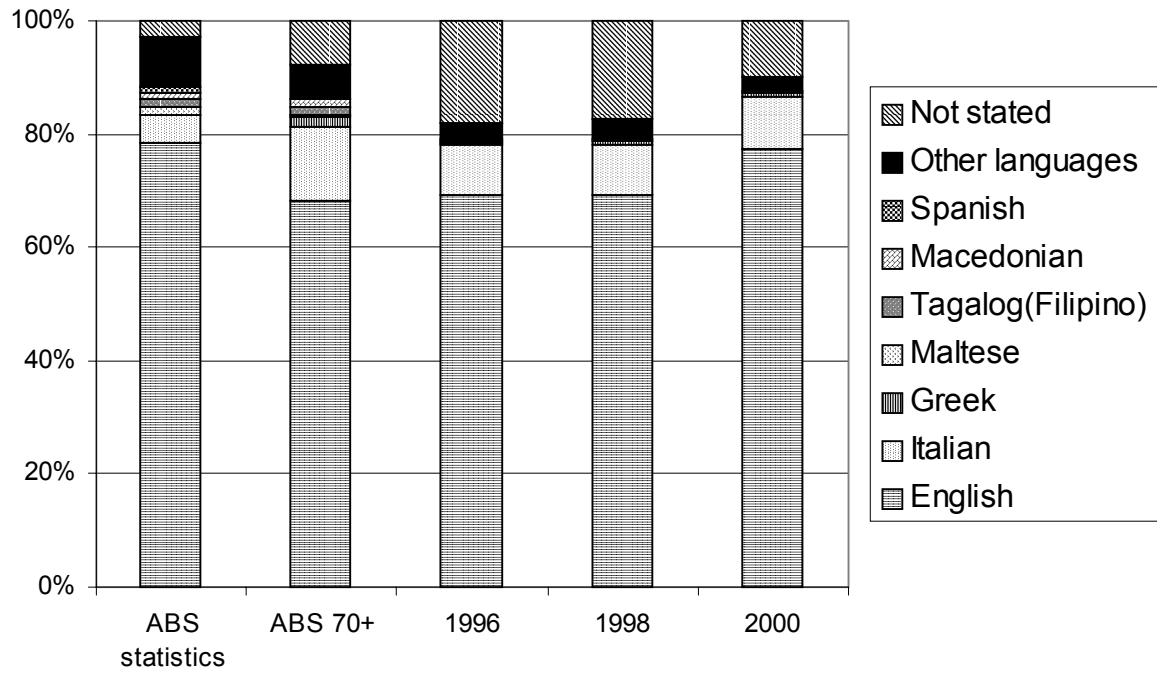
Melton



Moonee Valley



Wyndham



Appendix 9: Proficiency of English

