BETTER PLANNING AND FUNDS ALLOCATION FOR THE HOME AND COMMUNITY CARE PROGRAM IN VICTORIA

Background Paper

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CONTENTS

Introduction 1

Background 3

The Home and Community Care (HACC) Program 3

What are the concerns? 3

The HACC Agreement 6

HACC Planning Process 7

HACC Funds Allocation Process 9

Issues Analysis 11

High level priority setting 11

Transparency and equity in local area funding distribution 12

More consistent approaches to the distribution of funds to service types 14

Extending the planning horizon 16

Increase emphasis on partnership rather than open competition in funds allocation 17

Processes for planning and allocating service development and capital grants 18

Planning and funding role of local government 20

More consistent, transparent and accessible planning and funding information 21

Appendices 23

Appendix 1: Origins of Home and Community Care 23

Appendix 2: Departmental Advisory Committee on Home and Community Care 25

Appendix 3: Hypothetical formulaic approach to LGA and activity funds distribution 26

Notes **32**

INTRODUCTION

The Department of Human Services is responsible for planning and funding the provision of health, housing and welfare services delivered by external agencies amounting to over $5 billion. Aside from pre-schools, there are around 1500 providers delivering these services. A few of these are large public hospitals, many are mid-sized hospitals or NGOs, but the majority are local community-based agencies.

The Home and Community Care (HACC) program is jointly funded with the Commonwealth through the HACC Agreement and, as the main source of funding for home and community-based services for frail older people, younger people with disabilities and their carers, plays a pivotal role in Victoria's health and community services system. The program receives funding growth each year with annual funding in Victoria now in excess of $300 million.

The program serves around 120,000 Victorians each year. Among health and welfare services, it ranks third after GPs and hospitals in terms of the number of people who receive a service. It is a key part of a system of care aiming to prevent or delay premature or inappropriate admission to residential care.

HACC services are delivered by more than 500 providers. A quarter of these are small not-for-profit organisations that receive only a small amount of funding. There is another large group of providers – notably Local Governments and the Royal District Nursing Service – for whom the HACC program is their main source of DHS funding. This group of providers accounts for well over half of all HACC funding. Hospitals, community health centres and the larger non-Government organisations account for the balance.

The review of HACC planning and funds allocation processes derives from calls for reform both inside and outside DHS. The Department's submission to the Public Accounts and Estimates Committee's *Inquiry into DHS' Service Agreements* committed DHS to a more consultative, partnership approach with funded agencies, to more flexibility in allocating funding to replace the previous emphasis on commercial tendering, to more use of three year agreements and specifically to reviewing HACC planning processes in conjunction with the Commonwealth. DHS has since acted to establish a flagship *Partnership Project* to demonstrate the priority given to implementing these commitments. Departmental-wide work on partnership will provide the framework for reform directions in the HACC program.

This review also responds directly to concerns voiced by external stakeholders over a number of years about HACC planning and funding processes.

Key public documents advocating reform and providing the foundation for this review are:

- *HACC Status Report for Victorian Local Government*, Municipal Association of Victoria, 2000
- *Home and Community Care*, Australian National Audit Office, 1999-2000
- *Report on Department of Human Services – Service Agreements for Community, Health and Welfare Services*, Public Accounts and Estimates Committee, Parliament of Victoria, 2002
- *First* and *Second Submissions to the Public Accounts and Estimates Committee Inquiry into DHS Service Agreements*, Department of Human Services, 2000 and 2001
- *Community Care Programs: The Future*, Aged and Community Services Australia, 2001

Some of the concerns expressed about HACC can be traced to the overall complexity that currently characterises the aged and community care system in Australia. These can only be properly addressed at a national level. Some of the concerns relate to questions of overall funding

levels and unit prices which are outside this review.

This review responds to those concerns that are open to process improvements in the way HACC planning and funds allocation is undertaken, within the framework of the HACC Amending Agreement and the limitations imposed by the annual nature of Commonwealth and State budget policy.

In summary, the review aims to develop, consult on and implement:

- processes to ensure greater consistency and equity in HACC local and regional planning,
- a longer-term horizon for local and regional planning, and
- less cumbersome and more timely ways of deploying the available funding.

BACKGROUND

The Home and Community Care (HACC) Program

The Home and Community Care (HACC) Program is a joint Commonwealth and State program that funds a range of basic maintenance and support services to support frail older people and people with disabilities to live independently and avoid premature or inappropriate admission to residential care.

The major kinds of services provided are home care, delivered meals, personal care, nursing, allied health care, and respite for carers.

Both at a national level and in Victoria, the HACC program is the main source of funds for these types of services for people living independently at home. Recurrent funding provided by the Commonwealth and State Governments for HACC services in Victoria in 2002-03 amounts to $316 million.

Over 400 agencies, plus almost all Local Governments, are funded to provide HACC services. Local Governments in Victoria, unlike in other States, are also major funders of HACC services contributing, on one estimate, over $70 million per annum[1].

Annual planning for service expansion occurs in the context of what has been a reasonably consistent level of growth funds. Under the HACC equalisation strategy[2], Victoria currently receives growth funds from the Commonwealth of around 3.5% pa in real terms. Victoria contributes funds according to a ratio set by the HACC Agreement (60% Commonwealth 40% State) as well as providing additional funds above this minimum matching requirement. These are referred to as 'state-only', or State unmatched funds and currently total $23 million. An 'imputed' Local Government contribution amounting to 7% of the State matching amount ($8.8 million in 2002-03) is included in the State matching ratio. This 'imputed' contribution, so called because it is not part of State Budget appropriations and is well under Local Government's total contribution to the program, dates from the origin of the HACC Agreement[3].

In 2002-03, Commonwealth/State matched funding for service expansion is $8.6 million with these funds distributed across DHS regions on the basis of the Regional Resource Equity Formula (RREF). State unmatched funds for service expansion amount to a further $1.4 million.

Funding to providers for service expansion is allocated through an advertised submission process known as the annual HACC growth funding round. For many smaller community-based agencies in the voluntary sector, the HACC program represents an important opportunity to secure new funding. For many others it enables expansion or intensification of service provision.

Appendix 1 provides additional details on the commencement of the HACC Program in 1985 and also sets out a number of process and program changes that have been implemented over the past 5 years with a particular bearing on the work of this review.

What are the concerns?

Recent Major Reports

Concerns have been expressed across a range of DHS and external stakeholders that HACC business processes are resource intensive, overly complex, out of step with agency (and DHS) budget cycles, poorly integrated with similar services with separate funding sources, and spread limited growth funds too thinly to be effective in achieving the Program's objectives.

In 2000, the MAV issued a major report, *HACC Status Report for Victorian Local Government*, which drew attention to a range of problems with the program, particularly affecting Local Government. The Report proposed seven strategies for consolidating the HACC program as the best way of addressing the level of unmet need.

Each strategy contained a range of proposals. Some of these concerned overall funding levels and unit prices, some service development matters, and some would need to be addressed through reform at an intergovernmental level. However many can be addressed through relatively modest improvements to planning and funding processes, such as proposed for consideration as part of this Review.

In 2000, a report by the Australian National Audit Office into the HACC program[4] identified a range of concerns relating to HACC funding and program administration, including the relationship between HACC and related programs such as Community Aged Care Packages (CACPs).

In 2000, the Public Accounts and Estimates Committee (PAEC) of the Victorian Parliament established an inquiry into DHS service agreements in response to criticisms from providers about the nature of the Department's relationship with the funded sector, in particular its planning, funding and monitoring processes.

The Department's second submission to the Inquiry in January 2001 outlined a range of measures that would be taken to address the issues that had been raised by agencies. Commitments made by DHS in its submission included.

- More consultative, partnership based approach
- More flexibility in allocating funding to replace emphasis on commercial tendering
- More use of three-year agreements
- Review HACC planning processes, in conjunction with the Commonwealth
- Streamlining and consolidating services
- Improving service agreement processes
- Streamlining and consolidating agency data collections
- Improved unit pricing, including recognition of fixed and variable costs, and rural cost factors

The Committee's Report was released in April 2002 and included 53 recommendations to improve the planning, administration, financing and accountability of community, health and welfare services[5].

Referring to the issues that underpinned these Recommendations the Chairman of the Committee said:

> *"These are not problems unique to Victoria, but rather, issues that governments and community organisations throughout Australia, and around the world are grappling with as they struggle to find new and hopefully better ways to address community, health and social problems."* (p.11)

In 2001, the peak body for Australia's aged and community care providers, Aged and Community Services Australia (ACSA), published a discussion paper drawing attention to a similar range of problems facing the community care system across Australia[6]. The paper presented four broad reform options as the basis for a wider community debate, the first of which – administrative streamlining – is in line with the options presented in this paper. ACSA's other options all entail structural reform which can only be properly addressed at a Commonwealth-State level.

ACSA's discussion paper focuses particularly on the array of similar programs seeing these as leading to a lack of coordination, inflexible program rules and boundaries, Commonwealth - State rivalry and the uncoordinated planning of new services.

However at the same time the ACSA paper argues that this should not be seen in too negative a light:

> *The fact that a range of programs, funded by different levels of Government, have been created to support older people, younger people*

with disabilities and their carers may not be a problem in itself. In some ways it can be positive as it creates diversity of services and models of delivery that can enhance quality and availability for consumers as well as providing multiple funding sources for providers.

Some of the boundary issues are not due simply to the number of programs, although it is recognised this creates an unnecessary burden for agencies because each program tends to have its own quality, reporting and accountability framework. The most difficult issues from a service system perspective arise from providers being simultaneously responsible for a proliferation of programs with overlapping geographic boundaries and/or target groups for their particular mix of services.

Some of the identified concerns can be traced to the HACC Amending Agreement. Despite simplifying the new funding approval process for DHS and the Commonwealth, the Agreement added a new set of requirements, particularly the development of an annual funding plan and a business report as new accountability tools. At the same time it retained key provisions that require a clear demarcation between services funded under the Agreement and similar services with separate funding sources. This is a particular problem in Victoria because of the State Government's substantial contribution of unmatched funds to HACC and HACC-like services.

This review responds to those concerns that are open to process improvements in the way HACC is planned and the way funds are allocated, within the framework of the HACC Amending Agreement and the limitations imposed by the annual nature of Commonwealth and State budget policy. These concerns include:

- whether comprehensive annual planning processes are really required when changing patterns of demand unfold over a longer time span;
- insufficient regard to research evidence in determining Ministerial priorities;
- the need to improve collaborative arrangements with providers and consumers in overarching planning and program decision-making, in line with the Government's commitment to a partnership approach;
- variability in the planning capacity of DHS regions and in local planning approaches, and the lack of clarity in the way local and regional planning processes are linked with statewide planning;
- the need for an agreed approach to the way Local Government's statutory service planning role and independent (but variable) contribution to HACC funding should be recognised and incorporated;
- the administrative burden of the annual HACC growth funding submission process for DHS regions and agencies, which is separate from, and additional to, the service agreement negotiation process; and
- lateness in the allocation of growth funds, and the impact of this on agencies' own budget and planning processes.

Recent Improvements

At both a DHS-wide and a HACC Program specific level some significant administrative gains have been achieved in the past two years, as well as an improved approach to regional resource allocation.

For DHS generally, improvements were made to service agreement processes and timeliness in 2001-02. These included:

- provision for new funds to be provided to agencies prior to the full Service Agreement being signed,
- reduction in the number of performance measures, and
- inclusion of a new schedule in service agreements to deal with broader DHS-agency partnership issues.

Further initiatives are underway. These include a move to increased use of three year service agreements as part of the *Partnerships Flagship Project*, and an internet site (the **Funded Agency Channel**) through which providers will be able

to access information relevant to their relationship with DHS (e.g. on-line access to their service agreement) and where on-line 'communities of interest' can be created.

In 2001-02 improvements also occurred for HACC.

- An advisory committee was established by the Department to provide a central point for statewide planning and integration of DHS-managed community based services for older Victorians, younger Victorians with a disability and carers (see Appendix 2 for *Terms of Reference*).
- A revised regional resource equity formula (RREF) was implemented to take better account of the needs and diversity of the population in each of the nine DHS regions.
- The call for growth funding submissions set out the target groups, areas and activities where the regional planning and priority setting process had judged that new funding should be directed, so assisting agencies target their effort and reducing the number of applications.
- Growth funds were approved and announced in January 2002, earlier than at any time since the HACC Amending Agreement was established.
- A move to greater transparency with the publication of agency funding information on the internet.[7]

The HACC Agreement

The HACC Program is subject to unique constraints arising mainly from its joint Commonwealth/State administrative arrangements, but also from the unique and leading role that local government plays in the program in Victoria. The formal administrative framework is set out principally in the *HACC Amending Agreement* 1998 that articulates respective program, planning and financial responsibilities between the Commonwealth and State Governments.

The original *Home and Community Care Agreement* was established in 1985 combining four previously separate Commonwealth/State funding programs, covering home nursing, home help, allied health and delivered meals, and extending this to cover other services including respite, community transport, home maintenance, assessment, service coordination, training and information provision.

Under the original Agreement, known as the principal Agreement, the process of allocating funds to providers was jointly managed by the Commonwealth and the State. A Joint Officers Committee, comprising Commonwealth and State officials, managed the annual HACC growth funding round, with each new "project" recommended for funding requiring the personal approval of the relevant Commonwealth and State Ministers.

The Agreement set the funding contribution required of the Commonwealth and State (including a specified Local Government contribution) in terms of a 60:40 matching ratio. Accountability at the end of the year to the Commonwealth was based primarily on whether or not the approved funds had been expended, since data collection systems were not in place to allow service output – in terms of direct client contacts – to be monitored.

HACC Amending Agreement

In 1998 the original Agreement was replaced by the HACC Amending Agreement, with a key aim of the new Agreement being the implementation of *". . . measures for the more efficient and effective management of home and community services"*.

It sought to do this principally by replacing the requirement for joint Commonwealth and State approval of each new project with the joint approval of an annual plan that would guide the way new funding would be applied.

However, while ending the need for joint approval has taken one step out of the funding process, the new requirements, particularly the need to prepare an annual funding plan (the

HACC Annual Plan) approved by both Commonwealth and State Ministers, have added to the administrative complexity.

There are various reasons why this is so. First, the Agreement requires that State unmatched HACC funding be excluded from the Annual Plan because these funds are not recognised under the HACC Agreement. While this does not necessarily prevent a more holistic approach to planning, the apportioning measures needed to deal with this have little 'real world' relevance and create a layer of complexity at a variety of levels.

Secondly, the Agreement sets milestones in the HACC business cycle that lie outside Victoria's control and do not fit well with either DHS or agency business cycles. These include the receipt of the Commonwealth funding offer, which generally does not come until July and leads to late unit price determination, and the approval of the Annual Plan well after the commencement of the financial year.

Thirdly, although the need for joint project approval has been dropped, in other ways (e.g. notification, joint announcement, and monitoring) the Commonwealth's role at the individual project level has been preserved. The introduction of a new national project data repository by the Commonwealth, known as HACC PlanNet, was intended to streamline these functions. However there are concerns that the current proposals for HACC PlanNet may embed business processes that are themselves in need of review and may not be compatible with Victoria's approach, for example by requiring the use of national, rather than Victorian service types.

The implementation of the HACC Minimum Data Set (MDS) provides a possible alternative vehicle for meeting Commonwealth monitoring requirements, although there would be significant issues to be addressed before such an approach could be realistically considered.

Another initiative of the Amending Agreement was the establishment of a national Triennial Plan setting out the major developmental tasks for the program over the coming three years, as well as forward estimates for funding. However, although a draft plan was prepared, the proposed Plan for the first triennium (2000-2003) was not finally presented to State and Territory Ministers for endorsement until May 2002 by which time there was little point in including forward funding estimates.

While current Commonwealth policy settings provide a basis for forward funding estimates, longer-term planning would be improved if the uncertainty around these estimates could be reduced. This could be achieved if the next Triennial Plan was agreed prior to the commencement of planning for 2003-04.

Review of HACC Amending Agreement

The Amending Agreement stipulates that a review of its operation be held in 2002-03. While no decision has been reached on how such a review will be conducted, or what its scope should be, it should as a minimum be able to address some of the issues relevant to this Paper.

It is anticipated that the Commonwealth will make an announcement on its intentions for a review later this year.

HACC Planning Process

HACC planning entails a defined sequence of steps at a statewide and regional level, from the distribution of the available funds to each DHS region, to the indicative distribution of these funds within each region by local area, target group, service type and, for one-off funds, by purpose.

This planning occurs in the context of a range of related regional planning processes. These processes include regional strategic planning for aged and disability services, the development of Community Health Plans by Primary Care Partnerships, the development of Municipal Public Health Plans by Local Governments, and planning by the Commonwealth for new residential aged care places and community aged care packages.

Each agency's own strategic planning and annual budget processes are also important since they determine the extent to which providers are in a position to seek HACC service expansion.

Distribution of growth funds across DHS regions

Once the Commonwealth and State funding, including the cost indexation factor, is known – generally in July each year – funding for service expansion can be distributed among DHS regions.

Since 1992 HACC the majority of growth funds have been distributed across DHS regions according to a population-based formula, the Relative Resource Equity Formula (RREF). Until 2001-02, this formula was based on the population aged 85 and over, plus the estimated population younger than 85 with a profound severe or moderate disability living in the community, and with a weighting applied to rural regions.

In 2001, following criticism by the sector that the RREF did not properly reflecting the characteristics of the target population generating demand for services, the then Victorian Minister initiated a review of the formula. An Options Paper[8] was issued for public consultation with a Final Report[9] issued later that year. Following agreement with the Commonwealth, the new formula was implemented in 2001-02.

The new formula uses a new base population and a wider set of need variables. The new base population is the estimated population under 70 with a profound, severe or moderate disability and all people 70+, but excluding people in institutional care and those eligible for Veterans Home Care services. The need variables used cover socieconomic status, health status, koori population, cultural and linguistic diversity and rurality. The formula does not take account of existing recurrent funding levels across regions.

The RREF is not the only means by which new HACC funding is allocated across regions. For example, the allocation of additional State unmatched funding to expand Planned Activity Groups and the Hospital to Home program was based on the population aged 70 and over as these initiatives were targeted specifically to older people.

HACC Annual Plan

Under the Amending Agreement each State and Territory must prepare an annual funding plan (the HACC Annual Plan) to be approved by the Commonwealth Minister each year. The Plan sets out the regional and statewide priorities for the program for the coming year, and how Commonwealth/State matched funds are planned to be applied across each region in the year ahead for each service type.

As part of the preparation of the plan, regions assemble and analyse service provision and demographic data to inform regional consultation processes. Some central DHS support is provided for this, mainly in terms of core dataset provision.

In recent years there has also been a statewide consultation process to ensure appropriate consultation with agencies with a statewide service focus, and agencies serving' special needs groups' such as Kooris and people in insecure housing. The overall consultation process and regional planning process typically takes around eight weeks.

A draft State Program, or Annual Plan, is then assembled incorporating the inputs from each of the nine DHS regions. In line with the provisions of the Agreement, it must specify program outputs expected to be provided in each region. The Agreement currently requires that the Plan can deal only with Commonwealth/State matched funding, so limiting its use as a wider planning tool for agencies and regions.

Once the draft Plan is finalised it is submitted to the State Minister for endorsement and, subject to Ministerial agreement, is then forwarded to the Commonwealth Minister for consideration. Funds can only be allocated to service providers after the Commonwealth Minister has endorsed the Plan.

As well as being a planning document, the Annual Plan serves as a key program accountability tool for program via the

preparation of an annual business report. The Business report must be lodged with the Commonwealth four months after the end of the financial year, with an explanation of any significant variances from the forecasts in the previous Annual Plan.

HACC Funds Allocation Process

Base renegotiation

Prior to the start of a new financial year, DHS regional staff discuss with service providers their performance against the targets set out in their service agreements. These discussions are expected to cover issues relevant to the roll-over of their recurrent funding into the new financial year, including changes to the mix of services in the light of changing demand. Any reallocation of services to other providers is also dealt with at this time.

Call for submissions

After the State Minister has approved the Annual Plan, an advertisement is placed inviting submissions from providers for new funding. While the Annual Plan itself can be made available to service providers, recent practice has been for each region to develop summary documents identifying the local, regional and statewide priorities, by service type and target group. DHS regional staff assess the submissions and in recent years there has also been a separate central office assessment process to deal with cross-regional and statewide services. Recommendations for the allocation of funds are then submitted to the State Minister for approval.

Once the State Minister has endorsed the recommendations, the Amending Agreement requires that they be referred to the Commonwealth Minister to ensure that public announcement of the new allocations for the year can be coordinated.

These features of the current process make it extremely difficult to settle approvals much before November in any year.

After allowing time for the annual submission process, joint announcement of successful projects, revisions to service agreements, and the Christmas/New Year holiday period, January is the earliest that new services can realistically be expected to commence.

ISSUES ANALYSIS

High level priority setting

Since the inception of the HACC Amending Agreement the planning of Commonwealth/ State growth funds has been guided by priorities set by the Victorian Minister. The HACC national triennial plan also sets out national priorities that States and Territories are expected to reflect in the annual funding plans, although these are framed in terms of broad overall program directions, with limited impact on the annual planning process.

The Victorian priorities have been designed to strike a balance in the planning process between the need to improve service responsiveness to particular population groups that may have difficulty accessing 'mainstream' services, and the need for continued growth in mainstream services to reflect general demand growth.

As well as the priorities for the matched Commonwealth/State growth funds, in recent years specific priorities have been set for the additional $41 million over four years in State unmatched HACC funding provided by the Bracks Government. These funds have been applied to the expansion of core services, Hospital to Home and planned activity groups.

However, the setting of the State priorities is an inexact process, involving judgements in the face of imperfect information about service utilisation, effectiveness, and need. The priority setting process has also been criticised on the grounds that there has been insufficient input from provider or consumer representatives to assist the Minister set the annual priorities.

The availability of data from the HACC minimum data set (MDS) represents a major advance for HACC planning. The analytical insights obtained from the MDS will make it possible for priority setting to be based on a much clearer view of who is getting a HACC service, how much, and of what kind than has been previously possible. It will also enable comparisons with other States.

However substantial information gaps will still exist. For example, it would be desirable for more detailed priority setting to be informed by outcome and effectiveness data. Yet there is little data available on how effective different services, alone and in combination, are in improving people's quality of life and in forestalling or preventing the need for admission to residential care. There has been relatively little attention paid in Australia to measuring outcomes of community care interventions, although a recent set of studies in Canada has looked at this issue in depth[10].

Assessing the relative need for services among different clients is more amenable to analysis given the emphasis in the HACC program on assessment, however there is still no consistent statewide data available on this. This will change over the next few years with the implementation of the national dependency measure for HACC, and its inclusion in a forthcoming version of the HACC MDS.

To date, Ministerial priorities have been set in terms of improving access to particular population groups, leaving the regional planning processes to translate these into more specific service priorities at the regional and local area level based on local knowledge, and regional consultations and analyses. The key question is whether, with an improved evidence base to draw upon, program effectiveness would be improved if Ministerial priorities were more detailed. More detailed priorities could be based on service types, or client dependency measures, as well as (or instead of) population sub-groups, and could also entail the setting of quantitative goals.

For this to occur, the emphasis of the analytical processes underpinning service planning would shift from the regional office to the central office level, and would occur earlier in the planning cycle. Draft priorities would need to be developed, in consultation with the Departmental Advisory Committee on the

HACC program (see Appendix 2, p. 25), in time for Ministerial consideration well in advance of the forthcoming planning period.

Transparency and equity in local area funding distribution

The process for distributing growth funds by regions has a number of strengths, including its emphasis on collaborative relationships between DHS and stakeholders in regional planning and priority setting, capacity to bring qualitative and descriptive material into the planning process, and generation of a sense of collective 'ownership' of the funding round outcomes.

However, these processes also require a substantial commitment of regional, central office and agency resources and the ability of all stakeholders to devote adequate attention to this process is limited. Although there is extensive demographic and service provision data that can be drawn on, the capacity of regions and service providers to use this information to best advantage is variable. There is a need for existing service provision data to be made more accessible, and analysed and interpreted consistently. Even with this, until a consistent approach to measuring the needs of current and potential clients is in place, and data available on the results, such analysis still will not reveal the extent to which access to HACC is broadly equitable across the State.

In response to these uncertainties, and also with a view to geographic equity considerations, most regions use the Relative Resource Equity Formula (RREF) – which is a tool designed only to apportion the available HACC growth funds across regions[11] – to inform the distribution of growth funds to a local government area (LGA) level. In some regions this only provides a baseline that is adjusted significantly according to the analysis of local needs and existing service distribution, but in other regions little adjustment is made and it therefore serves as the principal determinant of local area allocations.

For a widespread home and community-based based service such as HACC, planning to a local area level is critical, especially given the significance of local government's role in the program. An appropriate formulaic approach could not only improve equity, but also the transparency and simplicity of the planning process.

It is recognised some flexibility needs to remain with regions to adjust any formulaic results to account for distinctive local factors not well measured in a formula. There is also a need to be able to adjust for services for subpopulations, where a sub-regional approach rather than a LGA level approach makes more sense, such as specialist services for homeless people, or Kooris.

There are various options for adapting the current population formula to function better as a means of distributing regional growth funds between LGAs. The approach outlined below aims to avoid distributional anomalies that might result from applying weighting factors that are suitable for distributing funds between regions but are unsuitable at a local area level. A simple approach would be to use the base RREF population (all people over 70 plus those under 70 with a disability) plus those weighting factors that vary according to characteristics of the entire population, namely socio-economic status and health status, as the components of a local area formula. The other weighting factors are, by virtue of the relatively small population numbers on which they are based and the uneven needs characteristics they seek to address, less amenable to a formulaic approach.

Table 1 (p. 17) shows that a formulaic approach built on this model accounts for around 90% of the variability in the RREF and that this is reasonably uniform across all regions.

Those factors omitted – representing ethnicity, Koori population, and remoteness – along with homelessness and accommodation insecurity also correspond to the Ministerial priority groups. These factors relate more to service access issues than to service need and it would make sense for any refinement in the distribution of funding due

Table 1: Formulaic share according to population base weighted for health and socio-economic status

	Barwon	Gipps	Gramps	Hume	Loddon	EMR	NMR	SMR	WMR	VIC
Share due to RREF base pop'n *plus* health and socio-economic status	95%	90%	94%	91%	90%	94%	89%	94%	90%	91%
Share due to remaining weighting factors	5%	10%	6%	9%	10%	6%	11%	6%	10%	9%

to these factors to be settled through the regional planning process rather than a formulaic model.

A way to balance the competing considerations of consistency and flexibility that would also align with the proportions shown in Table 1 could be to allow an agreed proportion of local area growth funds (say 10-20%) to be allocated outside the formula. DHS regions – acting as now on the advice of HACC stakeholders – would have discretion over these funds. This flexibility could also be used to make provision for regional/ sub-regional services.

However applying such a modified formula to all the growth funds still has a major shortcoming since it takes no account of any uneven distribution of existing recurrent funding at a local area level. For example, areas at the fringe of Melbourne that have experienced rapid population growth can have a below equity share due to the exclusion of base funding in the operation of the formula. For a formulaic approach to be useful, it should at least be able to deal with this since this is currently an important consideration in the planning process.

This could be implemented through the operation of a 'base-equalisation' pool, such as applied in the past to the distribution of total growth funding across regions. Within each region this would entail a proportion of the region's growth funds being set aside for distribution to LGAs whose HACC funding was more than 5% below the regional average, with the amount distributed to each below-equity LGA being a function of how far it was below this level.

The proportion allocated to the base equalisation pool in each region would vary, depending on the significance of any base funding inequity. In fixing the size of such a pool, a balance would need to be struck between the needs of those LGAs, whose funding was above average and those below. One criterion for setting the size of the pool would be that no LGA should be made worse off – in terms of their existing per capita funding (on a weighted RREF target population basis) – than at present. Another would be to ensure that sufficient funds remain to allow for a minimum per capita funding growth in each LGA on the grounds that demand for HACC services is growing faster than the population figures alone imply. A worked example of this idea for one DHS region is presented in Appendix 3.

It would also be important that the formula does not override any specific historical funding arrangements that need to be preserved. For example, as part of the Government's rural *Hospital to Home* initiative additional funding for post-hospital care was distributed to regions according to the over 70 population, not the RREF. And while some regions allocated these funds to HACC providers for HACC services, others allocated these funds to their post-acute care agencies.

The flexibility to adjust the 'formulaically-determined' shares between LGAs would need to remain an essential element of a more formulaic local area approach. To ensure the transparency of the planning process, the proposed HACC regional plan would set out the calculations underpinning the formula and the planning reasons for any variations from it. Attachment 3 illustrates how such a formulaic approach might operate.

More consistent approaches to the distribution of funds to service types

Planning targets have long been considered a desirable direction for improved planning in HACC. A major study was undertaken in 1994 funded by the Commonwealth and NSW examining how a system of service provision targets could be used to improve resource allocation for HACC[12]. The study recommended that HACC regional planning should be based on the use of planning targets and the Commonwealth went on to develop a manual to assist regional planners put such a process into effect[13].

In line with the Commonwealth approach, DHS developed a set of linked spreadsheets, the HACC Planning Tool, that would enable comparison of existing HACC service provision levels between LGAs in a region, and with regional, statewide and metropolitan and rural averages.

However, the adoption of the HACC Planning Tool model in regions has been variable. The implementation of the tool coincided with the development of unit prices and output-based funding for Victoria. Until a standard output-based funding approach was fully implemented, there was a concern that funding by targets could reinforce historical funding differences between providers. Data on service and client information at the LGA level were also unreliable, given that neither the service agreement management system (SAMS) system, nor the HACC MDS were fully implemented. Finally, there was, and still is, a tension in setting the primary dimension across which targets should be set. For example, targets could potentially be designed to set a desirable balance

- between various activity types (e.g. relative quantities of home care, personal care and home nursing); or
- between major service groups (e.g. health care, independent living support; or
- between major client groups (e.g. ongoing support and maintenance of frail aged, support of younger people with disabilities); or
- between resources going to 'low-care' and 'high-care' clients in the HACC program.

As a result, while regional planning process currently involves making decisions on all the above questions decisions have been *informed* but not necessarily *determined* by quantitative analysis of local service provision levels.

With the accumulation of HACC MDS data now permitting a more thorough analysis of existing variations in levels of service provision, with output funding now almost fully in place, and with improved service catchment information now held on SAMS, it is now appropriate to consider the development of a *planning benchmark model*.

The difference between planning benchmarks and statistical norms is that planning benchmarks are a way for Government to express a view about what constitutes an *adequate* level of service provision in the longer term, while statistical norms focus attention on deviations from *existing* levels of delivery. This can also be expressed as a *normative emphasis* on adequacy compared to a *descriptive emphasis on equity*.

However, while data from the MDS, supplemented by population and target group data (e.g. the Australian Bureau of Statistics survey of Disability, Ageing & Carers) can be used to paint a picture of present patterns, it is only when data on client dependency is also available from the HACC MDS, and better data is available on levels of unmet need, that it will be possible to determine planning benchmarks on a sound evidence base.

In the interim, a standardised 'statistical norm' approach could be used to determine priorities for growth funds.

This approach is a logical extension of existing regional planning processes where service profiles are constructed alongside regional and statewide averages to help identify where growth should be directed. On this basis, it makes sense

for stronger central guidance to be provided about how these norms should be constructed and used.

The construction of statistical norms could drill down below simple regional, statewide and metro/rural averages, as at present, and be constructed based on profiles for 'peer' LGAs. Such peer groups could be constructed simply, distinguishing between rural areas, provincial cities, growth corridors and densely populated metropolitan area, or in more complex ways.

There is also a range of statistical measures that could be used, not simply an arithmetic average. For example the focus could be on service volumes that were below nominated limits (eg one standard deviation from the mean), rather than those that were simply below average. Alternatively, a small number of 'sentinel' LGAs could be selected by DHS, on the basis that they represented generally-accepted levels of provision in relation to need.

As far as possible, it would also be desirable to ensure that for specialised services an appropriate reference population is chosen. For example, in the case of Linkages which serves only high needs clients, it may be appropriate to use a measure of the population with a profound or severe disability (ie exclude those with a moderate disability) as the basis for service comparison, in line with planning models for DisAbility Services. In the case of home care, delivered meals, and property maintenance which are service types mainly directed at older people, the appropriate population base may be the weighted HACC reference population 70 and over. In the case of respite, which is a service type mainly used by carers of younger people with disabilities, the under 70 population may be more appropriate.

In parallel with the development of an improved statistical approach, work also needs to occur within the HACC program and with the Departmental Advisory Committee on HACC, to work towards the development of planning norms.

Adjusting for related non-HACC services

Making allowance for related non-HACC services, which is currently one aspect of regional planning, is a key matter for consideration if greater consistency is to be achieved in how funds are distributed across activities.

The question is whether, and if so how, the distribution of HACC growth funding to particular service types should be adjusted to account for the availability of related services. This question is premised on the perspective of service users, for whom the source of funding – Commonwealth, HACC, DisAbility Services – is much less relevant than the need for an appropriate service to be available. The argument is that if HACC planning takes no account of the supply of related HACC-type services, it may find itself directing resources to areas which are already relatively well served, to the detriment of those in a worse overall position.

The alternative argument is that this creates unworkable complexity in defining and operationalising a more equitable approach to the distribution of HACC resources, and that the adjustment of HACC services to address distributional unevenness in the availability of related services, may run counter to the equity basis – where applicable – on which these other program funds are distributed.

At this stage there is a preference for central guidelines to be provided to regions on a consistent way to take into account the availability of related non-HACC services. Possible examples might include: CACPs in relation to Linkages; allied health in community health services or hospitals in relation to HACC allied health; and disability respite in relation to HACC respite for younger people with disabilities.

Statewide and specialised cross-regional services

Improving the way Statewide and specialist cross-regional services are planned and integrated with regional service systems is a task integral to planning reform. *Statewide services* are

primarily information and advocacy services, including peak bodies, whilst *cross-regional* services generally have a specialised service model with a client base spread across several regions. They tend to be focussed on special needs groups such as Kooris, and people from different cultural or non-English speaking backgrounds. They do not include mainstream services whose target group happens to span a regional boundary since these should be dealt with collaboratively between the relevant regions as a normal part of regional planning.

Statewide and cross-regional providers have indicated they often have difficulty participating in regional planning processes because:

- their focus is on Statewide rather than the regional issues which are the subject of the consultation process; or
- they lack sufficient resources to participate in multiple regional planning processes; or
- their specialised approach makes it hard for them to command sufficient focus in regional planning forums.

It is proposed that the approach that has been adopted in the past few years for a separate funding pool to deal with Statewide and cross-regional providers be maintained and enhanced. Funds in this pool would not be subject to formulaic distribution.

Extending the planning horizon

The current approach to HACC planning is heavily influenced by the requirements of the HACC Amending Agreement. The Agreement requires that a HACC Annual Plan be developed specifying, by DHS region and by service type, how the existing funding and new funding should be distributed. Preparation of the Plan entails analysis of existing demographic and service data, and consultation with service providers at both a statewide and regional level. At the same time, changes in broad patterns of demand generally unfold over a longer time span than one year.

The fact that HACC planning runs on an annual cycle means that little certainty can be offered to agencies for their own internal medium-term planning. Given that the planning process has generally not commenced until the State and Commonwealth Budgets are known, this has also meant that growth funds cannot be provided to agencies until half way through the financial year. However, given that the triennial planning provisions in the HACC Agreement require the inclusion of 3 year program funding estimates, it is possible that the current approach could be changed.

A longer planning timeframe would give agencies greater certainty about future funding levels, and funds could be provided to agencies earlier in the financial year. It might also mean that the equivalent of several years' growth for particular services could be provided to some agencies in a single year, offset by no growth in a later year. Bringing forward funding in this way would help overcome the problem where the available growth funds in a single year may be too small to be usefully taken up by a particular service.

A longer planning horizon would free resources in both agencies and DHS to focus on other matters, such as quality assurance and improvement, that are important to the program and its clients. It would also allow HACC planning to line up better with related planning processes, thereby assisting longer-term decision-making both by agencies and by related program areas.

Any multi-year process must have the capacity for annual change, but the issue is the extent to which this can be done without reintroducing the same kind of process burdens and uncertainties that the multi-year approach aims to avoid. For example, while the Plan would be expected to have the capacity to respond to population shifts that diverge from projections, should such shifts exceed a minimum level before they resulted in changes to the Plan? Should some funds be set aside to allow the implementation of new service models that may not be foreseen at the time the Plan is originally developed, and if so, what sums

would be needed? And how much flexibility should be built into the Plan to respond to funding trends in related program areas that are not foreseen at the time the Plan is originally developed?

A multi-year approach would need to be based on reliable funding projections over the period. The HACC program has access to reliable growth funds each year. At the Commonwealth level, 4 year forward estimates of HACC funding growth are published annually in the Commonwealth Budget, based on the Commonwealth's commitment of 6% growth in HACC in real terms each year.

Under the HACC Amending Agreement a Triennial Plan is required which includes forward funding estimates for both the Commonwealth and the State. The first Triennial Plan was for the period 1 July 2000 to 30 June 2003. This Plan has only recently been finalised and does not include funding estimates as the Plan's lateness made them redundant. This should be remedied with the second Triennial Plan.

A further advantage of a multi-year plan is that it would provide a transparent basis for funding adjustments between years. This would allow larger funding parcels to be created for LGAs (particularly rural LGAs) for whom a straight formulaic share in a single year may otherwise be quite small. Informal arrangements of this kind already occur where regions try to cope with provider's expectations exceeding funds available through a notional 'wait-turn' process. Thus, a provider in one area may not apply for funding in a given year in the expectation that an application the following year has a stronger prospect of success.

The key question is whether the period should be two or three years. Two years would be preferred if planning precision and adaptability were dominant concerns. Three years would line up with the HACC Agreement Triennial planning provisions and would be the preferred approach if planning and funding certainty were the dominant concerns. DHS has a preference for three years, with an evaluation to be carried out before the end of the period to determine whether, in the light of experience or as a result of program developments, the period should be varied or an annual process reinstated.

Increase emphasis on partnership rather than open competition in funds allocation

There are two main phases involved in allocating HACC funds to agencies each year. The first phase is the negotiation of any changes to the mix of funded activities within their existing recurrent funding. The second phase is the assessment, approval and allocation of growth funds.

There is a strong view in DHS and among agencies that these annual funding processes, particularly the annual funding round, involve too much effort for agencies with little end benefit for clients or the wider service system.

While there are clearly some positive features of an advertised submission process, growing demand means most annual growth funding is needed to deliver 'more of the same'. This raises the question of whether an open submission process is the most appropriate method for allocating funding to agencies, or whether with strengthened multi-year planning processes simpler allocation processes, such as invited submissions or direct allocation, would be more appropriate.

Last year, as part of the Department's response to the Inquiry by the Parliamentary Public Accounts and Estimates Committee into DHS Service Agreements, Departmental policy on funds allocation was changed to allow greater flexibility to adopt such methods.

It is noted that under DHS' current policy settings for funds allocation, the Minister would need to agree that the community benefits of direct allocation outweighed the disadvantage to potential new entrants. Subject to Ministerial

agreement, the Victorian multi-year plan could set out which activities or providers should have growth funds directly allocated, with regions able to argue for invited or advertised submissions if justified by local circumstances.

Examples of *activities* which might attract direct allocation include home care in rural regions or Koori-specific planned activity groups. Examples of *providers* include local councils, the Royal District Nursing Service, community health services and rural health services.

A means of bringing together both the benefits of a competitive process and the certainty and stability of direct allocation, is greater use of *preferred provider panels*. Regions could conduct an advertised or invited submissions process for the first year of a multi year plan. Providers with capacity to take on growth funding for the planning period and meeting HACC quality and performance standards would constitute a *preferred provider panel* to which direct allocation of funds could then be made. The requirement for greater transparency would need to be met via the Regional Plan.

A more straightforward option, based on the assumption that the existing service mix in each LGA is reasonable at present, would be to increase funding to each provider in proportion to their share of existing funding. Such an approach would need to allow for exceptions for providers who did not wish to accept additional funding, and for providers that regions may consider should not receive additional funding, for example for reasons of poor service performance. The merits of this approach are that funds could be distributed earlier in the financial year and there would be significant savings in DHS and agency time and effort. Regions would be able to focus their effort on a range of quality improvement activities within and between agencies because funding decisions would be automatic.

Processes for planning and allocating service development and capital grants

The timing of current HACC planning and funds allocation processes mean that although increases in Commonwealth and State recurrent funding are for a full year, agencies receive less than a full year effect of new recurrent funding – generally six months – in the first year. The balance of the funds, now amounting to over $5 million, comprise a funding pool that is used for capital or service development projects.

Submissions for service development and minor capital purposes are considered as part of the annual growth funding round with an expectation that the projects can be completed by the end of that financial year.

Under a multi-year planning process there would be no automatic creation of a 'one-off' pool of funds, since all the new funds in the post-initial year, or years, of a multi-year process would potentially be available for allocation from 1 July. Thus, a specific decision would need to be taken as part of the planning process on the proportion of funds to be applied to non-recurrent purposes – which could reasonably be set at around the current level of 1.5% of total program funding.

Service Development Grants

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

In consultations around the development of this paper, it has been suggested that these problems could be overcome if more service development funding were centrally managed. This could entail not only a central process for allocating funds, but also someone from HACC central office being involved in project monitoring and review. There could also be a role for the Departmental Advisory Committee in monitoring outcomes. Processes would be established to ensure that the learnings from project outcomes were disseminated by publishing results where possible.

At the same time local service development capacity is needed, either to address mainly local service issues, or to support agency strategic planning. Funds should continue to be allocated to regions to support these purposes.

If a multi-year planning time-frame can be adopted, it would also deal with the problem of service development projects being expected to be completed within a financial year. Subject to discussions with the Commonwealth on program accountability requirements, projects could be carried out over a longer and more realistic time frame.

Capital

The major share of non-recurrent HACC funding is applied to capital purposes, amounting to 1.2% of total recurrent HACC funding. However, total capital expenditure attributable to HACC is higher than this by virtue of other funding sources, including vehicle trade-ins, agency contributions, expenditure from recurrent funding sources and funding from the State capital works program for hospital and community health centres that allow for HACC-related needs.

The kinds of purposes to which capital funding is applied include IT infrastructure, buses acquisition and replacement, and building upgrades and improvements. While annual priorities are set for capital funding, there are currently no overarching guidelines on the types of capital expenditure eligible for separate funding, as opposed to expenditure that agencies would be expected to meet from recurrent funds.

A difficulty in establishing such guidelines is that when the original cost survey work was undertaken to inform the setting of unit prices, depreciation may not have been comprehensively recorded. Thus, there is a question mark over the extent to which existing unit prices can be considered to include adequate allowance for depreciation and hence capital asset replacement. Compounding this uncertainty is the historical role that most providers, particularly local governments and non-government agencies, have played in providing some capital funding from their own resources as part of their contribution to the program.

However, the question of how much HACC funding should be set aside specifically for capital purposes, and whether this should be included in the unit price is a matter that will need to be dealt with outside this review.

Pending the outcome of that work a sensible approach would be to hold the capital allocation at the current level of around 1.2% of recurrent funding. For this project the key question is whether the current submission-based processes for allocating these funds should be retained, or whether other options should be considered.

A separate project is currently underway within the Rural and Regional Health and Aged Care Services Division of DHS (RRHACS) to establish an integrated approach to the funding of capital earmarked for 'annual provisions' and one option is for the HACC minor capital funding round to occur as part of that process. The benefit of this is that it would create the opportunity to look at HACC capital funding in the context of the broader capital funding needs of agencies, and asset management priorities of DHS. This project has developed from a need to improve the focus on asset management requirements of State public sector agencies, and it would be essential to ensure the HACC-related capital needs of local governments and non-Government agencies were also clearly addressed if this approach was adopted. The accountability requirements of the HACC Agreement would also need to be met in a more integrated Divisional approach.

Planning and funding role of local government

As well as providing more than a third of all HACC services, local government in Victoria has played a key role in the development of the HACC program since its inception. It provides substantial funding from own-source revenues to the aged and disability services system. Estimates of the total amount vary according to the data source, with an upper estimate, based on the annual financial survey by the Victoria Grants Commission, of over $70 million.

In 2000 the Municipal Association of Victoria (MAV) published a major report, the *HACC Status Report for Local Government* outlining a range of specific actions that should be pursued to improve the planning and delivery of HACC and related services in Victoria. Some of these matters, like HACC unit prices, are outside the scope of this review. Other matters will need to be addressed through discussions at a national level between the States and Territories and the Commonwealth.

Councils are the entry point to the HACC service system for most clients, and a key source of information about service availability. *The Local Government Act* provides the statutory framework for each local government to plan for services within its municipality, and this includes planning for aged and disability services. Local Government is a key partner in all the State's Primary Care Partnerships. Many local governments are also funders of small community-based agencies that may be involved in the provision of HACC services. And most provide 'in-kind' support to local agencies as well, such as assistance with funding applications and planning information[14].

In summary, Local Government occupies a unique position amongst HACC stakeholders in terms of both the planning and funding elements covered by this paper. In recognition of this, the Municipal Association of Victoria and DHS are currently negotiating the scope and content of a *HACC Program Partnership* with both short- and medium term dimensions.

The kinds of questions relevant to HACC planning and funds allocation and currently being canvassed in the development of the *Program Partnership* include the following:

- how can we best collect and disseminate comprehensive data on services delivered by local government to inform planning processes?
- how might we capture data on HACC services subsidised or funded by local government from own source revenue to complement existing data on DHS-funded HACC services?
- what agreement might be reached between State and local government on maintaining respective effort in HACC?
- how can local government's role in integrated local area planning best be brought to bear in HACC planning without generating any conflict of interest with their role as a funded HACC provider? and
- how can local government's collective view (as expressed through the MAV) on priorities for the HACC Program best be incorporated into the Ministerial priority setting process?

More consistent, transparent and accessible planning and funding information

The prospect of a simpler, more formulaic and longer-term approach to funding does not mean that regional planning is no longer required or that strong consultation processes will not continue to be an important part of the HACC program. Rather, the move to a multi-year planning horizon, if adopted, would still require an effective regional planning capacity as the planning decisions would be guiding the allocation of several years' growth. However, the extensiveness of regional planning and consultation processes, and the balance between these and statewide processes, will depend on

how much regional flexibility the formulaic approach ultimately adopted provides for.

Determining the scope of the information underpinning the non-formulaic elements of the process, and how it should be developed, synthesised and presented forms part of this review.

As part of the 2001-02 growth-funding round, information packages were prepared by each region, including information on statewide priorities and the outcomes of regional planning, to guide providers who were seeking additional funding. For the 2002-03 planning process, one region (Loddon Mallee) published a detailed *HACC Information Resource Kit* profiling the regional HACC service system at an LGA level to assist service system planning and the regional consultation process. It included data principally on HACC service type and mix, but also in other relevant areas including client profiles, service provider identification and the distribution of related services[15]. The assembly of this kind information in a common format and its publication as a multi-year HACC plan for each region would be an important way of improving the transparency and wider usefulness of HACC planning processes.

Such plans would need to be more than just data tabulations. They would need to describe how the program priorities, quantitative analyses and provider feedback had been translated into a firm forward funding plan.

However it would also be important for the plan not to be overly detailed. For example, a stronger role for HACC central office in preparing, analysing and publishing more quantitative data on client profiles (based on the HACC MDS), national and international service trends and other factors could largely replace the need for that information to be covered in regional plans, and would allow the data content and analysis in the plan to better focussed on those areas that are unique to that region.

The development of the HACC Regional Plan could represent the vehicle for a strengthened regional planning process under which draft plans prepared by regions were used as a consultation vehicle with stakeholders prior to the plan being finalised.

The kinds of areas that the multi-year regional Plan would cover include:

- The operations and outcomes of the formulaic processes for distributing the growth funding at an LGA level.
- Adjustments to the outcomes of the formulaic approach to take account of the Ministerial priorities, the outcomes of local and statewide consultation processes, sub-regional service models, locally accessible data, and access to specified HACC-related services.
- The extent to which adjustments to agencies' base recurrent funding, and the expiry of fixed term recurrent funding (if any), will used to address the Ministerial priorities and planning benchmarks.
- How service accessibility barriers faced by particular sub-groups within the target population will be addressed.
- Service development priorities for the region and how the service coordination initiative will be implemented
- How block-funded services are to be applied, and the basis of allocations to these and other service types that may not be subject to planning benchmarks.
- The impact and nature of cross-regional boundaries and service flows, where applicable.
- The extent and nature of existing Local Government contributions to HACC service provision.
- For each LGA, the providers whose catchment falls within that LGA and the services they are funded to provide.
- How the various funds allocation methods are to be applied.

A view of how some of the formulaic tables in a plan might look and how the general approach would operate is shown as Appendix 3.

APPENDICES

Appendix 1: Origins of Home and Community Care

The following brief history of the origins of the HACC program has been drawn largely from the Aged and Community Services Australia Fact Sheet: Community Care[16]:

> *"Community care has been provided in some shape or form for more than a century and began with the home (or district) nursing services at the end of the 1800's.*
>
> *Domestic assistance or 'home help' services tended to emerge later. For example, the Home Care Service of NSW (Australia's largest community care service) commenced in the 1940's.*
>
> *The late 1960s saw the introduction of legislation to encourage the development of community based services for the elderly, providing an alternative to residential care. Housekeeper, home help and services such as physiotherapy, chiropody and occupational therapy were jointly funded with the States.*
>
> *In 1970, the Federal government enacted legislation to provide direct financial assistance to voluntary organisations and local government bodies for the provision of delivered meals.*
>
> *In 1972-73 the Whitlam government made more funds available to community groups providing home care and continued to push for the expansion of community care services.*
>
> *As the number of services grew, so did the number of separate funding arrangements. The Commonwealth Home and Community Care Act 1985 consolidated four community care funding streams into a single program. Responsibility for the HACC Program was shared between the Commonwealth and State/Territory Governments, with the Commonwealth providing on average 60% of the funding.*
>
> *The HACC Program was part of the Commonwealth's 1980s aged care reforms, aiming to expand community care and reduce access to, and expenditure on, nursing homes. Under HACC, the range of community care programs was expanded significantly. New service types, such as community transport, community options (Linkages), home modifications and respite care, were introduced. National HACC expenditure increased from $154m in 1984/85 to a budgeted $945m in 2000/01.*
>
> *During the 1990s, the Commonwealth Government began to develop a range of new programs for community care. The first (and currently largest of the newer programs) was Community Aged Care Packages. CACPs were designed to provide low-level care in an older person's own home.*
>
> *The last few decades has seen the emergence of private sector services delivering community care. In some instances private organisations have been contracted to provide services on behalf of other organisations (eg local government HACC services). Individual consumers may choose to purchase all, or additional, support services from this source. The strength of this growing sector is demonstrated by the 1998 ABS Disability, Ageing & Carers Survey which shows that approx 65% of all people receiving assistance from formal providers do so from private (profit making) organisations. This study also shows that people tend to use private services in combination with others – 47% also used Government services while 13% also used the services of not-for-profit organisations."*

Over the past few years many significant changes have occurred to the management of the program, both nationally and in Victoria, with a particular bearing on this Review. Some of these are set out below.

1997 Focus on output levels and productivity increased following removal by the Commonwealth of the flexibility to use some funding allocated for service expansion to cover cost increases, if these were in excess of the indexation allowance.

1998 Replacement of the original HACC Agreement with the HACC Amending Agreement eliminating joint Commonwealth and State Ministerial approval for new funding for individual projects replacing it with a requirement for both Ministers to approve a detailed plan for the allocation of new funds at a regional level

Introduction of output-based funding and standard unit prices and new activity definitions, giving all providers (except the Royal District Nursing Service) the same funding for per unit of service for the various service types regardless of the size or type of providers, or client location.

Ending of the annual centrally-managed funds recoupment process and associated end of year minor capital funding round

Waiver of the requirement for Local Government to match 20% of expenditure on Home Care as a condition of attracting growth funding for Home Care services.

2000 Introduction of the HACC Minimum Data Set (MDS) and electronic data repository replacing the annual client characteristics survey, and giving a firm empirical basis on which future program planning can build.

Primary Care Partnerships established, with key objectives including more integrated local area planning and improved service coordination.

2001 New Regional Resource Equity Formula (RREF) implemented with factors and weightings designed to take better account of the health status, socioeconomic status, rurality, aboriginality and ethnic background of the DHS regions.

Improved guidance given in preparing funding submissions through the publication of detailed specification of services, target groups and catchment areas resulting from the regional planning process.

Veterans Home Care program implemented.

2002 Initial Needs Identification (INI) tool implemented to enable more streamlined intake and improved service coordination for clients.

Appendix 2: Departmental Advisory Committee on Home and Community Care

The Department of Human Services (DHS) has established a Departmental Advisory Committee on the Home and Community Care Program to provide a central point for statewide planning and integration of DHS-managed community based services for older Victorians, younger Victorians with a disability and carers.

The membership of the Committee includes representatives of a range of peak bodies, carer and consumer bodies, the Municipal Association of Victoria, providers and senior Commonwealth and State officials.

The Committee will consider issues, provide information and advise the Department about policy, planning, service coordination and service development in relation to community care for older people and younger people with disabilities and their carers in Victoria, with particular reference to:

- Older people and younger people with disabilities with special needs such as those living in rural areas, people from culturally and linguistically diverse backgrounds, indigenous people, people at risk of homelessness and low-income people.
- Quality improvement, including national and international examples of best practice in community-based service provision.
- Preventative and early intervention strategies to maintain independence and participation of older people and younger people with disabilities in their local communities.
- Appropriate mechanisms for consultation with consumers, carers, industry bodies and providers
- The interface between community care services and the acute, sub-acute and residential care sectors.
- Future development of the Home and Community Care (HACC) Program in Victoria and similar services and activities, including:
  - Targeting in the HACC Program
  - Implementation of a consistent dependency measure
  - Implementation of the HACC National Service Standards
  - Integration of service delivery across service types and sites
  - Workforce Issues
- Implications for Commonwealth and State policy and administrative arrangements for relevant programs.

Appendix 3: Hypothetical formulaic approach to LGA and activity funds distribution

Note: The following example is based on funding data at an LGA level as set out in the HACC Resource Information Kit 2002 prepared by Loddon-Mallee region. However it is used here for illustrative purposes only since there is more than one way that the elements in each step could work. For simplicity's sake the illustration only shows the effect for all years in Step 1, but under a multi-year plan the same process would apply across all years.

Step 1: Determine estimated base population (e.g. all over 70s, plus all under 70s with a profound severe or moderate disability less veterans and people in residential care) weighted for socioeconomic and health status

	RREF base population weighted for socioeconomic and health status							
	Numbers				Share			
	Base	Year 1	Year 2	Year 3	Base	Year 1	Year 2	Year 3
Buloke	2,031	2,039	2,065	2,079	4%	3.5%	3.5%	3.5%
Campaspe	7,686	7,887	8,073	8,265	14%	13.7%	13.8%	13.8%
Central Goldfields	3,171	3,221	3,239	3,276	6%	5.6%	5.5%	5.5%
Gannawarra	2,740	2,773	2,811	2,830	5%	4.8%	4.8%	4.7%
Greater Bendigo	15,459	15,728	16,003	16,329	27%	27.3%	27.3%	27.3%
Loddon	2,219	2,254	2,278	2,288	4%	3.9%	3.9%	3.8%
Macedon Ranges	4,800	4,906	5,001	5,109	8%	8.5%	8.5%	8.6%
Mildura	10,561	10,830	11,131	11,380	19%	18.8%	19.0%	19.1%
Mount Alexander	3,703	3,756	3,803	3,853	7%	6.5%	6.5%	6.5%
Swan Hill	4,266	4,275	4,270	4,298	8%	7.4%	7.3%	7.2%
	56,637	**57,670**	**58,674**	**59,707**	**100%**	**100%**	**100%**	**100%**

Step 2: Determine existing LGA level relativities based on existing funding

	Existing funding (fully allocated to LGA) $'000	Funding share	Modified RREF share	Relative equity position	Relative equity deficit position
Buloke	1,259	6%	4%	55%	
Campaspe	2,695	12%	14%	-12%	24%
Central Goldfields	1,270	6%	6%	0%	
Gannawarra	1,288	6%	5%	18%	
Greater Bendigo	5,971	26%	27%	-3%	7%
Loddon	1,319	6%	4%	49%	
Macedon Ranges	2,031	9%	8%	6%	
Mildura	3,699	16%	19%	-12%	25%
Mount Alexander	1,150	5%	7%	-22%	44%
Swan Hill	1,963	9%	8%	15%	
	22,644	**100%**	**100%**		**100%**

Step 3: Regional growth funding allocation determined according to RREF

Assume regional recurrent growth of $0.58m in year 1, $0.60m in year 2 and $0.62 m in year 3 of the triennium.

Step 4: Determine amount to be set aside for base equity adjustment pool

For year 1, assume 80% is set aside for distribution according to population share (modified RREF) and 20% according to each LGA's below equity position. However as base equity is gradually addressed, assume base equity pool reduces each year (to 15% in year 2, and to 10% in year 3)

Step 5: Determine formulaic amount for each LGA

Apply the "modified RREF share" and the "under equity share" for each LGA to the total funding available in each of the two pools to determine the funding attributable to each component. The additional funding allows the starting equity position for subsequent years to be determined for input to that year's funding calculations.

	RREF pool	Equity pool	Total Growth (FYE)	Total Funding (FYE)	Relative equity position at end of year	Relative equity deficit position at end of year
Buloke	16		16	1,275	70%	
Campaspe	63	28	92	2,787	-4%	21%
Central Goldfields	26		26	1,296	9%	
Gannawarra	22		22	1,311	28%	
Greater Bendigo	127	8	134	6,105	5%	
Loddon	18		18	1,337	61%	
Macedon Ranges	39		39	2,071	15%	
Mildura	87	29	116	3,814	-4%	22%
Mount Alexander	30	51	82	1,231	-11%	57%
Swan Hill	34		34	1,997	27%	
	464	**116**	**580**	**21,227**		**100%**

Step 6: Incorporate non-formulaic outcomes of local planning and consultation processes

Adjust formula outcomes for local factors and 'top-slice' amounts for sub-regional activity types (e.g. Linkages) and sub-regional services for special needs groups. Discuss, or refer to the section of the plan where reasons for adjustment to the formulaic approach are identified, and on what basis amounts have been 'top-sliced' for allocation at a sub-regional level.

Also refer here to the bringing forward of any growth funds to create larger funding parcels (although this will only be determined after the particular service types that are to be expanded over the period are determined). For the purposes of this analysis no inter-year growth funding transfers are proposed.

Assume for illustrative purposes that 10% has been set aside for sub-regional and other exceptional services.

Step 7: Present final LGA level and regional recurrent allocations

	Year 1 FYE	Year 2 FYE	Year 3 FYE
Buloke	16	18	19
Campaspe	92	89	93
Central Goldfields	26	28	31
Gannawarra	22	24	26
Greater Bendigo	134	139	153
Loddon	18	20	21
Macedon Ranges	39	43	48
Mildura	116	117	126
Mount Alexander	82	84	63
Swan Hill	34	37	40
Total	**580**	**600**	**620**

Step 8 (Model 1): Use formulaic model to distribute funds by service type across each LGA

In this example the following assumptions have been made:

a) The Minister has specified that a group of services comprising Home Care, Personal Care, and Respite (Home and Community), termed "HACC basic' for the purposes of illustration, should be accorded funding priority

b) The Minister has indicated that at least 50% of the growth funds directed toward each LGA should be indicatively allocated to those service types.

The formulaic approach to the operation of this hypothetical model has been implemented as follows:

1 The planning benchmark for 'HACC basic' is taken to be 6 hours per capita per annum, where the measure of 'per capita' is the same reference population as is used to distribute HACC funding across LGAs (in this case the RREF base population weighted for health and socieconomic status).

2 The existing hours for the three component activities are summed to compare existing provision levels with the planning benchmark

3 If the existing 'HACC basic' provision level is above the planning benchmark, the half of that LGA's growth funding that would otherwise have been applied to those services is distributed pro-rata among the below benchmark LGAs for application to the priority services. In the worked example, provision levels in Loddon and Macedon Ranges are above the hypothetical benchmark and 50% of the formulaic distribution attributed to these two LGAs is distributed to the other 8 LGAs

4 If the existing 'HACC basic' provision level is below the planning benchmark, half the growth funds for that LGA, plus any funds redistributed from any above-benchmark LGAs, are distributed to the component services in proportion to the gap between the benchmark and existing provision levels.

5 The 'under benchmark' service types are boxed and bolded.

6 The remaining 50% not earmarked for the priority activities is then distributed.

7 A formulaic approach is used only for those service types for which a planning norm or statistical benchmark has been specified. In the example shown, benchmarks have been specified only for those service types that are unit-priced.

8 As for the 'HACC basic' benchmark, the reference population used is the RREF base population weighted for health and socieconomic status.

9 Of the 50% to be distributed, 60% is allocated to service types for which a benchmark has been specified, with the balance (ie the block-funded services) left for determination in the planning process. This means that 80% of the regional growth funds are subject to initial formulaic distribution.

10 If the existing service provision level is more than 20% below the specified benchmark, the remaining growth funds for that LGA subject to the formulaic process are distributed to the relevant services in proportion to the gap between the benchmark and existing provision levels.

HYPOTHETICAL MODEL 1 – MINISTERIAL PRIORITIES SET FOR PARTICULAR SERVICE TYPES

	Activity	PRIORITY BENCHMARK SERVICES			OTHER PLANNING BENCHMARK SERVICES									BLOCK-FUNDED SERVICES			
	Activity	Home Care	Personal Care	Home & Comm'ty Respite	Nursing	Allied Health	Linkages	Delivered Meals	Property Maint..	Overnight Respite	PAG Core	PAG High	Vol'teer Co-ordinat'n	Vol'teer Co-ordinat'n – other	Ass'ment & Care M''ment	Flexible Service Response	Service System Resource
	Unit	hours	hours	hours	hours	hours	packages	meals	hours	overnight blocks	hours	hours	EFT Hours	$	$	$	$
	Hypothetical planning benchmark (units per capita weighted reference population	- - - - - - - - - 6 - - - - - - - -			1.6	0.5	0.005	7.0	0.5	0.02	4.0	1.5	0.8	na	na	na	na
BULOKE	Existing provision level (FYE)	8,275	853	2,390	3,687	3,636	12	28,100	1,222	25	18,386	1,150	963	0	9,139	35,871	76,766
	Reference population numbers	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039	2,039
	Units per reference population	4.1	0.4	1.2	1.8	1.8	0.006	13.8	0.6	0.01	9.0	0.6	0.5	0.0	4	17.6	37.6
	Formulaic expansion, before adjustment	0	334	0	0	0	0	0	0	2	0	199	70	- - - - - - - - - -	3,282	- - - - - - - - - -	
CAMPASPE	Existing provision level (FYE)	22,770	4,592	4,274	10,303	3,965	33	53,367	2,737		15,687	7,977	2,149	400	77,105	103,265	81,275
	Reference population numbers	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887	7,887
	Units per reference population	2.9	0.6	0.5	1.3	0.5	0.004	6.8	0.3	0.00	2.0	1.0	0.3	0.1	10	13.1	10.3
	Formulaic expansion, before adjustment	903	465	502	0	0	0	0	85	11	1,121	272	294	- - - - - - - - - -	18,349	- - - - - - - - - -	
CENTRAL GOLDFIELDS	Existing provision level (FYE)	9,244	4,783	1,579	4,647	31	6	21,488	2,528		10,984	3,428	4,550	2,162	34,462	51,239	60,229
	Reference population numbers	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221	3,221
	Units per reference population	2.9	1.5	0.5	1.4	0.0	0.002	6.7	0.8	0.00	3.4	1.1	1.4	0.7	11	15.9	18.7
	Formulaic expansion, before adjustment	331	0	197	0	49	0	0	0	2	0	44	0	- - - - - - - - - -	5,183	- - - - - - - - - -	
GANNAWARRA	Existing provision level (FYE)	10,769	2,594	2,304	4,310	2,473	7	25,685	1,412	0	6,962	0	1,882	7,165	53,732	47,086	85,039
	Reference population numbers	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773	2,773
	Units per reference population	3.9	0.9	0.8	1.6	0.9	0.003	9.3	0.5	0.00	2.5	0.0	0.7	2.6	19	17.0	30.7
	Formulaic expansion, before adjustment	0	173	282	0	0	0	0	0	2	152	153	0	- - - - - - - - - -	4,463	- - - - - - - - - -	
GREATER BENDIGO	Existing provision level (FYE)	41,345	21,558	20,994	20,012	6,049	49	107,544	10,780	120	26,118	21,694	12,433	24,724	77,290	201,131	161
	Reference population numbers	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728	15,728
	Units per reference population	2.6	1.4	1.3	1.3	0.4	0.003	6.8	0.7	0.01	1.7	1.4	0.8	1.6	5	12.8	0.0
	Formulaic expansion, before adjustment	2,738	0	0	179	63	1	0	0	7	1,280	0	0	- - - - - - - - - -	26,869	- - - - - - - - - -	
LODDON	Existing provision level (FYE)	8,470	2,845	2,974	4,194	3,311	8	17,600	975	124	18,424	1,236	1,524	0	11,059	38,063	
	Reference population numbers	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254	2,254
	Units per reference population	3.8	1.3	1.3	1.9	1.5	0.004	7.8	0.4	0.06	8.2	0.5	0.7	0.0	5	16.9	0.0
	Formulaic expansion, before adjustment	0	0	0	0	0	0	0	0	0	0	176	0	- - - - - - - - - -	3,628	- - - - - - - - - -	
MACEDON RANGES	Existing provision level (FYE)	19,195	3,963	7,643	6,597	1,432	11	28,662	4,692	2	17,601	6,207	2,606	8,050	45,362	57,244	
	Reference population numbers	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906	4,906
	Units per reference population	3.9	0.8	1.6	1.3	0.3	0.002	5.8	1.0	0.00	3.6	1.3	0.5	1.6	9	11.7	0.0
	Formulaic expansion, before adjustment	0	0	0	0	45	1	0	0	4	0	0	58	- - - - - - - - - -	7,894	- - - - - - - - - -	
MILDURA	Existing provision level (FYE)	30,209	7,344	7,686	9,772	3,749	51	53,157	4,335		45,056	11,437	8,803	3,400	73,166	473,365	
	Reference population numbers	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830	10,830
	Units per reference population	2.8	0.7	0.7	0.9	0.3	0.005	4.9	0.4	0.00	4.2	1.1	0.8	0.3	7	43.7	0.0
	Formulaic expansion, before adjustment	1,362	517	478	376	83	0	1,128	0	11	0	239	0	- - - - - - - - - -	23,133	- - - - - - - - - -	
MOUNT ALEXANDER	Existing provision level (FYE)	10,677	3,327	2,169	3,262	107	9	29,632	3,113	131	9,303	3,108	1,407	718	19,463	55,585	
	Reference population numbers	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756	3,756
	Units per reference population	2.8	0.9	0.6	0.9	0.0	0.002	7.9	0.8	0.03	2.5	0.8	0.4	0.2	5	14.8	0.0
	Formulaic expansion, before adjustment	979	199	485	125	81	0	0	0	0	261	115	73	- - - - - - - - - -	16,322	- - - - - - - - - -	
SWAN HILL	Existing provision level (FYE)	12,140	4,841	5,432	6,665	2,466	7	33,500	5,438	32	19,189	3,911	4,243	3,460	46,317	94,558	
	Reference population numbers	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275	4,275
	Units per reference population	2.8	1.1	1.3	1.6	0.6	0.002	7.8	1.3	0.01	4.5	0.9	1.0	0.8	11	22.1	0.0
	Formulaic expansion, before adjustment	701	0	0	0	0	1	0	0	3	0	129	0	- - - - - - - - - -	6,879	- - - - - - - - - -	
REGION TOTAL	Existing provision level (FYE)	173,094	56,700	57,445	73,449	27,219	193	398,735	37,232	434	187,710	60,148	40,560	50,079	447,095	1,157,407	303,470
	Reference population numbers	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670	57,670
	Units per reference population	3.0	1.0	1.0	1.3	0.5	0.003	6.9	0.6	0.01	3.3	1.0	0.7	0.9	7.8	20.1	5.3
	Formulaic expansion, before adjustment	7,013	1,688	1,945	681	321	3	1,128	85	41	2,814	1,328	495	- - - - - - - - - -	116,000	- - - - - - - - - -	

Step 8 (Model 2): Use formulaic model to distribute funds by service type across each LGA

The formulaic approach to the operation of this hypothetical model has been implemented as follows:

1. Planning benchmarks are set based on actual and expected client profiles, to allow appropriate 'per capita' relativities for each service type. Thus, unlike the approach set in Model 1, different reference populations are used for each service type.
2. As in Model 1, 80% of the funds are subject to formulaic distribution, with the formulaic model applying only to unit-priced service types.
3. Where existing provision levels are more than 20% below the planning benchmark, funds are distributed to the relevant service types in proportion to the gap between the benchmark and existing provision levels.
4. The 'under benchmark' service types are boxed and bolded.
5. For comparative purposes, the final row of the chart shows the indicative proposals put forward by Loddon Mallee region as part of the HACC annual plan development.

Step 9: Adjust the formulaic results within the flexibility limits provided for.

Make any necessary adjustments for factors such as

- Ministerial target group priorities
- Specific local area needs
- Sub-regional service models
- Cross-regional service models
- Cross-boundary issues
- Statewide services
- Reallocation of services within base recurrent funding
- Impact of expiry of fixed term recurrent funding
- Adjustment, within guidelines, for nominated HACC-like service types

Step 10: Implement inter-year adjustments, if necessary, for each activity and each LGA

Make any necessary transfers between years and LGAs (without changing each year's growth funding amount for the region) to ensure that funding for activities to be expanded is at an optimum level.

HYPOTHETICAL MODEL 2 – MINISTERIAL PRIORITIES NOT SET FOR PARTICULAR SERVICE TYPES

	Activity	Home Care	Personal Care	Home & Comm'ty	Nursing	Allied Health	Linkages	Delivered Meals	Property Maint..	Overnight Respite	PAG Core	PAG High	Vol'teer Co-ordinat'n	Vol'teer Co-ordinat'n – other	Ass'ment & Care M'ment	Flexible Service Response	Service System Resource
	Unit	hours	hours	hours	hours	hours	packages	meals	hours	overnight blocks	hours	hours	EFT Hours	$	$	$	$
	Hypothetical Reference Population	weighted HACC base (70+ only)	weighted HACC base	weighted HACC base (under 70 only)	weighted HACC base	weighted HACC base	*see footnote*	weighted HACC base (70+ only)	weighted HACC base (70+ only)	weighted HACC base (under 70 only)	weighted HACC base	weighted HACC base	weighted HACC base	weighted HACC base	weighted HACC base	weighted HACC base	weighted HACC base
	Hypothetical planning benchmark (units per capita weighted reference pop'n)	6.2	1.5	2.0	1.6	0.5	0.012	10.0	0.5	0.050	4.0	1.5	0.8	na	na	na	na
BULOKE	Existing provision level (FYE)	8,275	853	2,390	3,687	3,636	12	28,100	1,222	25	18,386	1,150	963	0	9,139	35,871	
	Reference population numbers	1,306	2,039	733	2,039	2,039	465	1,306	1,306	733	2,039	2,039	2,039	2,039	2,039	2,039	2,039
	Units per reference population	6.3	0.4	3.3	1.8	1.8	0.026	21.5	0.9	0.034	9.0	0.6	0.5	0.0	4.5	17.6	0.0
	Formulaic expansion, before adjustment		272							1		236	83		3,000		
CAMPASPE	Existing provision level (FYE)	22,770	4,592	4,274	10,303	3,965	33	53,367	2,737		15,687	7,977	2,149	400	77,105	103,265	
	Reference population numbers	4,601	7,887	3,286	7,887	7,887	1,981	4,601	4,601	3,286	7,887	7,887	7,887	7,887	7,887	7,887	7,887
	Units per reference population	4.9	0.6	1.3	1.3	0.5	0.017	11.6	0.6	0.000	2.0	1.0	0.3	0.1	9.8	13.1	0.0
	Formulaic expansion, before adjustment	572	719	228						16	1,575	383	413		18,000		
CENTRAL GOLDFIELDS	Existing provision level (FYE)	9,244	4,783	1,579	4,647	31	6	21,488	2,528		10,984	3,428	4,550	2,162	34,462	51,239	
	Reference population numbers	2,059	3,221	1,162	3,221	3,221	766	2,059	2,059	1,162	3,221	3,221	3,221	3,221	3,221	3,221	3,221
	Units per reference population	4.5	1.5	1.4	1.4	0.0	0.008	10.4	1.2	0.000	3.4	1.1	1.4	0.7	10.7	15.9	0.0
	Formulaic expansion, before adjustment	265		56		119				4		106			5,200		
GANNAWARRA	Existing provision level (FYE)	10,769	2,594	2,304	4,310	2,473	7	25,685	1,412	0	6,962	0	1,882	7,165	53,732	47,086	
	Reference population numbers	1,625	2,773	1,148	2,773	2,773	688	1,625	1,625	1,148	2,773	2,773	2,773	2,773	2,773	2,773	2,773
	Units per reference population	6.6	0.9	2.0	1.6	0.9	0.010	15.8	0.9	0.000	2.5	0.0	0.7	2.6	19.4	17.0	0.0
	Formulaic expansion, before adjustment		188							7	497	500			4,000		
GREATER BENDIGO	Existing provision level (FYE)	41,345	21,558	20,994	20,012	6,049	49	107,544	10,780	120	26,118	21,694	12,433	24,724	77,290	201,131	
	Reference population numbers	8,412	15,728	7,316	15,728	15,728	4,519	8,412	8,412	7,316	15,728	15,728	15,728	15,728	15,728	15,728	15,728
	Units per reference population	4.9	1.4	2.9	1.3	0.4	0.011	12.8	1.3	0.016	1.7	1.4	0.8	1.6	4.9	12.8	0.0
	Formulaic expansion, before adjustment	1,059			505	178				24	3,605				27,000		
LODDON	Existing provision level (FYE)	8,470	2,845	2,974	4,194	3,311	8	17,600	975	124	18,424	1,236	1,524	0	11,059	38,063	
	Reference population numbers	1,388	2,254	867	2,254	2,254	527	1,388	1,388	867	2,254	2,254	2,254	2,254	2,254	2,254	2,254
	Units per reference population	6.1	1.3	3.4	1.9	1.5	0.015	12.7	0.7	0.143	8.2	0.5	0.7	0.0	4.9	16.9	0.0
	Formulaic expansion, before adjustment											1,036			4,000		
MACEDON RANGES	Existing provision level (FYE)	19,195	3,963	7,643	6,597	1,432	11	28,662	4,692	2	17,601	6,207	2,606	8,050	45,362	57,244	
	Reference population numbers	2,082	4,906	2,824	4,906	4,906	1,655	2,082	2,082	2,824	4,906	4,906	4,906	4,906	4,906	4,906	4,906
	Units per reference population	9.2	0.8	2.7	1.3	0.3	0.007	13.8	2.3	0.001	3.6	1.3	0.5	1.6	9.2	11.7	0.0
	Formulaic expansion, before adjustment		342			103	1			14			133		8,000		
MILDURA	Existing provision level (FYE)	30,209	7,344	7,686	9,772	3,749	51	53,157	4,335		45,056	11,437	8,803	3,400	73,166	473,365	
	Reference population numbers	6,051	10,830	4,779	10,830	10,830	2,506	6,051	6,051	4,779	10,830	10,830	10,830	10,830	10,830	10,830	10,830
	Units per reference population	5.0	0.7	1.6	0.9	0.3	0.020	8.8	0.7	0.000	4.2	1.1	0.8	0.3	6.8	43.7	0.0
	Formulaic expansion, before adjustment		902		766	169				24		487			23,000		
MOUNT ALEXANDER	Existing provision level (FYE)	10,677	3,327	2,169	3,262	107	9	29,632	3,113	131	9,303	3,108	1,407	718	19,463	55,585	
	Reference population numbers	2,201	3,756	1,556	3,756	3,756	991	2,201	2,201	1,556	3,756	3,756	3,756	3,756	3,756	3,756	3,756
	Units per reference population	4.9	0.9	1.4	0.9	0.0	0.009	13.5	1.4	0.084	2.5	0.8	0.4	0.2	5.2	14.8	0.0
	Formulaic expansion, before adjustment	314	244	100	290	187					605	267	169		16,000		
SWAN HILL	Existing provision level (FYE)	12,140	4,841	5,432	6,665	2,466	7	33,500	5,438	32	19,189	3,911	4,243	3,460	46,317	94,558	
	Reference population numbers	2,116	4,275	2,159	4,275	4,275	1,057	2,116	2,116	2,159	4,275	4,275	4,275	4,275	4,275	4,275	4,275
	Units per reference population	5.7	1.1	2.5	1.6	0.6	0.007	15.8	2.6	0.015	4.5	0.9	1.0	0.8	10.8	22.1	0.0
	Formulaic expansion, before adjustment		290				1			14		462			7,000		
REGION TOTAL	Existing provision level (FYE)	173,094	56,700	57,445	73,449	27,219	193	398,735	37,232	434	187,710	60,148	40,560	50,079	447,095	1,157,407	0
	Reference population numbers	31,841	57,670	25,828	57,670	57,670	15,155	31,841	31,841	25,828	57,670	57,670	57,670	57,670	57,670	57,670	57,670
	Units per reference population	5.4	1.0	2.2	1.3	0.5	0.013	12.5	1.2	0.0	3.3	1.0	0.7	0.9	7.8	20.1	0.0
	Formulaic expansion, before adjustment	2,209	2,958	384	1,561	756	2	0	0	105	6,282	3,477	797		116,000		

Footnote: *The hypothetical reference population for Linkages used here is the profoundly and severely disabled population (excluding veterans), not living in cared accommodation*

NOTES

1. Victoria Grants Commission database, measured as Local Government expenditure on 'aged and disability' less user charges, grants and other revenue
2. Commonwealth policy is for the program to grow at 6% nationally in real terms, but under its equalisation strategy which runs until 2010, those States with more base funding get a smaller share of the growth. This means that Victoria's share is only 4%.
3. At the inception of the Agreement in 1985, Local Government expenditure on certain services (home help, community service officers, and senior citizens centres), amounting to $2 million, was counted towards the State matching requirements and this amount has since grown in line with overall program growth.
4. Australian National Audit Office. Audit Report No.36. 1999-2000. *Home and Community Care*. See: **www.anao.gov.au**
5. Public Accounts and Estimates Committee. *Report On Department Of Human Services – Service Agreements for Community, Health and Welfare Services Parliament of Victoria*. 2002. See: **www.parliment.vic.gov.au**
6. National Community Care Advisory Committee. *Community Care Programs: "The Future"*. Aged and Community Services Australia. 2001. See: **www.agedcare.au/projects**
7. See: **http://www.health.vic.gov.au/agedcare/hacc/index.htm**
8. Cumpston Sarjeant Pty Ltd. *Options Paper for the Review of the HACC Relative Resource Equity Formula*. 2001. See: **www.health.vic.gov.au/agedcare/hacc/index.htm**
9. Cumpston Sarjeant Pty Ltd. *Final report Review of the Relative Resource Equity Formula for the Review of the HACC program in Victoria*. 2001 See: **www.health.vic.gov.au/agedcare/hacc/index.htm**
10. *The National Evaluation of the Cost-Effectiveness of Home Care.* See: **www.homecarestudy.com**
11. See RREF Final Report (footnote 9 above)
12. Commonwealth Department of Human Services and Health and the NSW Department of Community Services (1994), Service Provision Targets – A Report for the Home and Community Care Program, Aged and Community Care Service Development and Evaluation Reports No. 15, AGPS, Canberra
13. *Developing Service Provision Targets*. Commonwealth of Australia. 1999 See: **www.health.gov.au/acc/hacc/sptm**
14. City of Darebin. 2001. *Aged and Disability Strategy Future Directions*. See: **www.darebin.vic.gov.au/aged.html**
15. *HACC Resource Information Kit, Loddon Mallee*, 2002. Department of Human Services. See: **www.dhs.vic.gov.au/regional/loddon/publications**
16. Aged and Community Service Australia. *Fact Sheet 3. Community Care*. 2002. See: **www.agedcare.org.au/factsheets**