CHAPTER 8

LINKAGES WITH OTHER PROGRAMS

8.1 As discussed in Chapter 4, the HACC Program operates within the context of a range of other programs. The relationship between HACC and these programs impacts on the capacity of HACC to provide positive outcomes for its consumers. The interface between HACC and the acute health sector was discussed in detail in Chapter 7.

8.2 The HACC Program provides the common ground for community and institutional or residential care but is also linked with other community based services for its target group, notably the Disability Services Program. These links give the potential for integration and cooperation or for fragmentation, cost-shifting and service gaps if strong linkages are not established.

8.3 The Commonwealth Department of Human Services and Health said of the interface between HACC and related programs:

> "This has led to some ambiguities and lack of clarity of boundaries of related programs. It has also led to considerable tension and pressure with regard to the types of services to be provided, as HACC strives to meet the often disparate needs of the three different groups that comprise its target population." (DHSH: Volumes of submissions, p 251)

DISABILITY PROGRAMS

8.4 The major interface between HACC and disability support programs occurs in relation to accommodation support services funded under the CSDA. The extent of linkages between the two programs varies significantly between States and Territories. In NSW and the ACT, for example, the two programs are closely linked in organisational terms and are administered within the same area of the same

department. In some other States, including Queensland and WA, the programs are administered by different departments. Of course, there are also important areas of interface between HACC and the disability employment and advocacy services which are the responsibility of the Commonwealth.

8.5 The NSW government spoke of the need for improved consistency between the programs:

> "One of the things I would say, having joint responsibility not only for HACC but a range of disability programs, is that the more commonality we can get between the two groups the better for the sector, because at the moment there are some slight variations. So it would be more useful if we could get a greater synergy between the two."(DOCS: Transcript of evidence, p 26)

8.6 The need for improved interface between the programs was also raised by an ACT service provider:

> "You need to consider that the disability services program, which is the source of funds in some areas, and the HACC need to communicate more readily with each other. There needs to be more conformity between the two areas. The community services sector in general needs to start communicating in a broader form and there needs to be some form of funding or source by which that communication can take place."(FABRIC: Transcript of evidence, p 3141)

8.7 Poor integration between HACC and disability programs has serious implications for consumers as it is likely to lead to gaps in the provision of services and leaves room for attempts to shift responsibility from one program to the other. The New South Wales Council of Social Service spoke of the boundary issues for the programs:

> "There is extraordinary confusion about the boundaries between HACC and disability programs at local levels in the program... There is a big gap between that program and what is available in the HACC program. A lot of people at local levels are not very clear about program boundaries... They are concerned about consumers' needs in the services, and the administrative issues are irrelevant to them. To try to explain where one program's boundaries begin and end is really of little interest to them. They want the services to exist and they want to find answers to the problems."(NCOSS: Transcript of evidence, pp 113-114)

8.8 The impact of these gaps on consumers of HACC services was raised by a COPs provider:

> "For a number of the people we are actually working with at the moment, training programs are part of their overall plan in terms of Community Options. We are having a very difficult time finding appropriate people to actually provide the training because they are needing some very specific skills themselves."(Blue Mountains Community Options: Transcript of evidence, p 2683)

8.9 The Committee believes that if recommendation 5.72 is adopted, identification of gaps and integration of services will be addressed.

8.10 **It is also recommended that the Commonwealth Department of Human Services and Health in consultation with States and Territories and local government develop and implement improved linkages between the programs at the planning and service delivery level.**

AGED CARE PROGRAMS

8.11 The HACC Program has been a key part of the Commonwealth's Aged Care Reform Strategy. This strategy recognised that changing the balance of care between residential and community care would require an effective community care structure. Stage 1 of the Mid-Term Review of Aged Care noted that the containment of nursing home growth had yielded significant savings which would grow to $400m per year by 1995-96 and that the balance of care framework provides an integrated means of making these adjustments in aged care.[1] Put simply, the adjustments in the balance of care for the frail elderly have contained the growth of nursing homes, increased the ratio of hostel beds compared with nursing home beds and increased provision of community care.

8.12 The boundaries between residential and community care are fluid. Improved assessment for and targeting of residential care means that individuals who would, some years ago, have been admitted to nursing homes are now residing either in hostels or in the community with the support of HACC services and

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1 Commonwealth Department of Health Housing and Community Services, "Aged Care Reform Strategy Mid-Term Review 1990-91 - Report", AGPS, 1991, p 9.

informal carers. The intersection of community and residential care is evident in a number of initiatives introduced in both sectors.

8.13 Community Options Projects, for example, are funded under the HACC Program to provide integrated packages of community care for high level need consumers, including those assessed as requiring nursing home levels of care. Within the residential care sector, methods of providing hostel and nursing home levels of care in other settings have been developed. Community Aged Care Packages (CACPs) have been developed, as noted in Chapter 4, to provide packages of care to hostel eligible clients in their own homes while new initiatives are being trialled to provide nursing home levels of care in settings other than nursing homes, including in hostels and in the community. The Commonwealth Respite for Carers Program is yet another area of intersection, providing respite services in the community to benefit carers who are part of the HACC target group, with funding provided generally to existing HACC providers.

8.14 There is no doubt that this blurring of boundaries provides improved scope for innovation, improves choices for consumers and challenges service providers in both residential and community care to reconsider traditional views about their capacity to provide services in different ways. It has led, however, to a level of confusion in the community about the boundaries and relationships between the two sectors.

8.15 The overlaps are demonstrated clearly by the following comments from a CACP provider:

> "The people we are accessing are people who would normally enter a residential hostel-... Community Options-for the frail aged-would access people at the higher level of care who were at risk of entering a nursing home... If our clients get to a level where they require nursing homes, we refer them on to Community Options".(Anglican Retirement Villages: Transcript of evidence, p 309)

8.16 Confusion is inevitable in this situation where community care providers, under HACC, are supporting people whose level of dependency is too high for a program funded under the residential aged care program and operated by a residential care provider and are taking referrals from those services.

8.17 While this flexibility is desirable and creates greater choices for consumers it may also make access more difficult if consumers are unable to identify the appropriate gateway for the services they need and if community care providers are not sufficiently familiar with the range of appropriate services. That this confusion exists is indisputable. One COPs provider said of CACPs:

> "To date the feedback has been positive. However, there has been some confusion between the roles of the community options program as opposed to the roles of the community aged care packages... It is very confusing for the consumers, for people in the community who do not fully understand our jargon."(Port Stephens/Great Lakes Community Options: Transcript of evidence, p 1569)

8.18 The Committee believes that the assessment agency approach recommended in Chapter 9 of this report will assist consumers and service providers by reducing the confusion between community care, residential aged care and other Commonwealth funded aged care services and providing a single point of entry to the range of services.

8.19 The Commonwealth Department of Human Services and Health stated in its submission that the Mid-Term Review of the Aged Care Strategy focused on adjustments to the balance of care in favour of community care and recommended an integrated framework for planning and financing aged care, within a single budget structure. (DHSH: Volumes of submissions, p 251) While the Committee, as noted in Chapter 5, does not support the proposal to split the Program, which would enable greater integration of aged care services, the current structure does allow for a level of integration. Issues relating to planning for community care are covered in Chapter 12.

8.20 **The Committee recommends that the Commonwealth Department of Human Services and Health define the boundaries and relationships between HACC and other aged care programs to minimise confusion among service providers and consumers, to eliminate gaps in service provision at the boundaries of the programs. It is also recommended that the Commonwealth Department of Human Services and Health promote consistency in administrative requirements between HACC and residential aged care programs, particularly where organisations are funded to provide services under more than one program.**

HOUSING AND RELATED ACCOMMODATION PROGRAMS

8.21 Issues in relation to the links between HACC and housing and other accommodation programs fall into two major categories: those arising from the importance of adequate secure housing for members of the HACC target group; and issues about the eligibility of residents of various forms of supported housing for HACC services.

Adequate and Secure Housing

8.22 The Commonwealth Department of Human Services and Health described the importance of adequate and secure housing for the HACC target group in the following terms:

> "... frail older people are more likely to be prematurely admitted to residential care if their housing is insecure and unpredictable and does not allow continued provision and maintenance of HACC funded services."(DHSH: Volumes of submissions, p 253)

8.23 The Commonwealth Department of Human Services and Health also commented on the need for further development of the links between the HACC Program and housing programs:

> "There is an extensive area of work for us in terms of linkages between care programs... That is a large part of what the government has been trying to achieve through the new community housing program. There is the relationship between that and some of the things being done through the Commonwealth-State housing agreements these days in terms of actually providing people not only with secure housing but also with some sort of secure and predictable link to care and support services. What we have to do there should not be underestimated. That is a big area of work but a very important one."(DHSH: Transcript of evidence, p 635)

8.24 The Committee has received little evidence in relation to the broader issues of the relationship between the HACC Program and most concern in the community has focused on the need for members of the HACC target group to have access to effective home maintenance and modifications services and the factors within the HACC Program and State housing programs which impact on

maintenance and modifications. There are significant differences within and between States and Territories in the way in which the HACC Program responds to this need and the role of State government housing departments.

8.25 In the ACT, for example, home modifications are not funded under the HACC Program. Home modifications are carried out in public housing by the Housing Trust and minor modifications, up to $1 500, are provided through mobile rehabilitation services. Home maintenance is funded under the HACC Program. The ACT Housing and Community Service Bureau acknowledged that this presents some difficulties for the target group:

> "The Housing Trust is probably the most significant agency involved in modifying homes and during the course of the last financial year it spent $473,000... on modifying houses for clients who needed more appropriate housing within their system... There is a problem where... clients are in their own homes or in private rental and they do not have assistance."(ACT Housing and Community Services Bureau: Transcript of evidence, pp 3071-3072)

8.26 In South Australia, there appear to be three programs involved in home maintenance and modifications. A community organisation described the SA approach in the following terms:

> "My understanding of the way that it works in this state is that there are three layers of schemes. There is the HACC one, which only provides for minor maintenance type things or addition things like grab rails and raises on toilet seats. The most expensive program is the disabled persons' equipment scheme, which has in the last few years been handed over to the states. Most of that budget goes to things like electric wheelchairs, scooters and things like that, which are made for a particular individual. There is a small percentage of that budget that goes to major modifications like bathrooms... DPES is implemented by Domiciliary Care so HACC is involved in actually implementing the program but the funds are not HACC funds."(Housing and Disability Forum: Transcript of evidence, p 2017)

8.27 The differences between States were summed up by the ACT Association of Occupational Therapists:

> "The main issue for the association was that there appeared to be inequities and a whole variety of schemes throughout Australia for people to access funds to assist with home modifications which are an

essential part of a person being independent or safe."(ACT Association of Occupational Therapists: Transcript of evidence, p 3090)

8.28 Apart from approaches to home modifications, it was suggested to the Committee that other services, if operated flexibly, could enable problems with housing adequacy to be overcome:

> "If we could even have money to provide transport for those people to come into the Midlands Multipurpose Health Centre to have a shower once a week, or even once a fortnight, it would be better than putting them in a hostel, because they then feel that they cannot cope... Because I am in the country, I have people with tin toilets. They have to be emptied. They have dirt floors. They do not have power. They have taps outside... The people who set the guidelines sit in town in their airconditioned offices with toilets that flush. I have a lot of people who do not have anything at all like that. That is the way they have lived... They are no longer capable of filling up a bucket, putting it on a fire inside and trying to have a bath."(Derwent Valley Lower Midlands District Health Forum: Transcript of evidence, pp 1205-1206)

8.29 The evidence available to the Committee suggests that access to adequate home modification and home maintenance assistance can be critical to the capacity of members of the HACC target group to remain in the community. The significant variations around the country in terms of the availability of such assistance raise serious equity problems. **The Committee recommends that the Commonwealth Department of Human Services and Health examine the current provision of home maintenance and modification services to develop an equitable approach across the Program to ensure that members of the target group have access to these services.**

8.30 **The Committee recommends that the Department of Housing and Regional Development, ensure that the needs of people with disabilities and frail elderly people are taken into account in future Commonwealth State Housing Agreements.**

Access to Community Care

8.31 It is clear to the Committee that there is an inconsistent approach both within and between States to eligibility for HACC services of people living in certain types of supported accommodation, including retirement villages, hostels, group homes for people with disabilities and special residential services. In Victoria, for example, the Office of the Public Advocate made a submission to the Inquiry which noted that the proprietors of supported residential services have complained that their residents (frail aged and disabled persons) are often excluded from local HACC services (Office of the Public Advocate: Volumes of submissions, p 487). Similar concerns have been raised by people involved in other forms of supported accommodation.

8.32 Of particular concern is the apparent inconsistency in the approach of different HACC service providers to this issue. An organisation which operates a number of residential facilities, including retirement villages, made the following comments in relation to the provision of HACC services to retirement village residents:

> "It varies from experience to experience. The view of most HACC providers... is that their resources are fairly stressed in particular areas. Their basic attitude would be that a retirement village should have its own facilities. They are more keen to care for the person who is lonely and isolated. Therefore, they would care for that person... It does not prevail in all cases. There are some cases where HACC people come into some of our villages, but certainly it would be on the basis of priority for the person who is at home."(Anglican Retirement Villages: Transcript of evidence, p 318)

8.33 The Commonwealth Department of Human Services and Health made the following comments in relation to the provision of HACC services to hostel residents:

"There is not an absolute policy exclusion in this area. The range of nursing support needed by hostel clients is tremendously diverse... Through an independent review, we are looking at the range of nursing services provided in hostels, and the range of ways in which hostels meet that-either through employing nurses or buying in nurses on contract. There would be cases where we would not object to home nursing services providing nursing into hostels. There is no problem with that. There would be other cases where a hostel should just organise it for itself. It depends on the case. It is not an area where you can write in tablet a policy guideline that will be easily transparent and applicable universally."(DHSH: Transcript of evidence, pp 637-638)

8.34 Clarification of the eligibility for HACC services of people living in forms of supported accommodation is required. This would ensure equity for consumers and assist service providers to make decisions. **The Committee recommends that the Commonwealth Department of Human Services and Health give consideration to extending HACC services into the area of supported accommodation where these are not currently funded at Federal or State level.**

TRANSPORT PROGRAMS

8.35 It is apparent from evidence received by the Committee that community transport is a critical service in the HACC Program. It has been raised consistently as a gap in service availability. Community transport is a valued service among HACC consumers and providers. A number of issues in relation to the operation and funding of community transport under HACC have been raised with the Committee. These include: a multiplicity of funding sources; varied eligibility criteria; inconsistent regulation; exclusion of private operators; efficiency of existing approaches and supply of and access to services. Community transport under the HACC Program takes a number of forms including mini-buses, wheelchair accessible buses and cars. The services may utilise paid drivers or may have a paid coordinator and be supported by volunteers. In some cases, volunteer drivers may provide services using their own cars.

8.36 The area of community transport is complex and has been the subject of extensive work by the National Accessible Transport Committee (NATC). This Inquiry has not attempted to canvass the full range of issues related to transport but will report on some key issues in terms of the relationship between HACC and State transport authorities and the relationship between HACC and the private sector.

The needs based planning issues canvassed in Chapter 12 are relevant to the reported unmet needs for community transport. **The Committee recommends, however, that the Commonwealth Department of Human Services and Health and State and Territory governments examine the material produced by the NATC in order to improve the provision of community transport under the HACC Program and to facilitate the access of HACC consumers to mainstream transport where appropriate.**

Relationship with Transport Departments

8.37 Linkages between HACC and State government transport programs are an important factor in addressing the current difficulties in community transport. The Community Transport Organisation (CTO) of NSW noted in its submission that major funding sources in that State are HACC, the Community Transport Program and the Area Assistance Scheme. Some groups also receive funding from local government and service clubs. HACC is the major source of funding and the CTO believes that HACC funding is the best basis for the operation of community transport groups (CTO: Volumes of Submissions, p 1183).

8.38 A report prepared for the NATC concluded, in relation to integration between HACC transport and other transport services, that:

> "The short response to this question is - very little to none at all. With the exception of NSW, HACC transport (and community transport in the wider context) is not included in State/Territory transport policy, planning and organisation."[2]

8.39 That report went on to recommend that integration be achieved through the establishment of Community Transport Units (CTU) in State transport departments with a broad role in community transport, including the joint assessment of HACC funding for community transport by the CTU and HACC and the management of HACC Transport funds by the CTU to meet identified HACC requirements.[3]

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2 Department of Transport/RUST PPK, "Research Project, Community Transport Brokerage Schemes for the National Accessible Transport Committee", June 1994, p 37.

3 ibid, p v.

8.40 The Committee supports greater integration of HACC community transport with other community transport and with broader transport services. The current approach in NSW, where HACC community transport funding is administered by the Transport Department, appears successful and has the support of the NSW CTO, despite some reservations about the commitment of that Department to community transport. The CTO said:

> "In honesty I would say that there is a lack of commitment on the part of the department of transport to community transport. An attempt was made to transfer responsibility for community transport from the department of transport to the department of community services. This was very rigorously opposed by the community transport organisation and its member groups because we feel that that would marginalise the transport of our passengers."(CTO: Transcript of evidence, p 284)

8.41 **The Committee recommends that the Commonwealth Department of Human Services and Health liaise with the NATC and State transport departments to improve integration in the manner suggested by the NATC and to ensure that adequate safeguards are in place to ensure the appropriate allocation of HACC funds to community transport in line with needs based planning principles.**

8.42 **The Committee also recommends that the Commonwealth Department of Human Services and Health and the State and Territory governments establish regional pilots aimed at coordinating underutilised HACC transport assets. The pilots should emphasise a regional network of HACC transport services and their connections with suitable mainstream transport capacity.**

Mainstream Transport Services

8.43 It is apparent that for many members of the HACC target group, existing mainstream transport options do not present a viable alternative. Public and privately operated bus services, for example, are not sufficiently flexible in the location of stops and taxi services are expensive. In rural areas, public transport is non-existent and distance compounds the cost of taxis. The difficulties were described by a consumer in a non-metropolitan area of NSW:

> "If I was not limited by transport, I could be a lot more independent and, therefore, need less support; and my carer would need less respite because I could be an independent person. Wheelchair taxis in this area

are very limited–about two for all the regions. They are unreliable. If you are meant to get to something on time, you would be lucky if you got there on time, even if you booked two days ahead... The cost is prohibitive, even despite the taxi subsidy scheme. For a friend in the disabled action group to come to my place for lunch... the whole cost for her is $24–$24 out of a disability pension... "(Macarthur Disabled Action Group: Transcript of evidence, p 445)

8.44 The Australian Bus and Coach Association and the Australian Taxi Industry Association gave evidence to the Committee about moves to improve the accessibility of mainstream transport and described initiatives by State transport departments:

"... they are spending large sums of money on classifying certain railway stations as being wheelchair accessible; and that is a very large proportion of their budget. They are putting kneeling buses in Sydney on virtually all bus routes. In Melbourne they have just introduced a new design standard for urban buses which all operators... must adhere to... There are a number of initiatives, and the taxi subsidy scheme in New South Wales is growing. In other words, the expenditure by the state government is growing. In all facets of their expenditure on transport for the disadvantaged their expenditure is growing as well."(Australian Bus and Coach Association and Australian Taxi Industry Association: Transcript of evidence, p 2776)

"In an urban area, the 4.38 from Circular Quay to Abbotsford has as much chance of helping people... as flying to the moon... He has got a schedule to meet. If he is not there he will be chastised. It needs a separate service with a bus that has that capacity. The department of transport in New South Wales last year allocated funding–it might have been HACC funding; I do not know–for people to put wheelchair lifts on buses that were going to do that sort of work. In other words, to start getting–not mainstream and not completely separate–a slower scheduled urban service that could take people to exactly where they wanted to go, at the right time and at that slower pace... With consultation between the HACC providers and the bus operators, that would be the way to go. The same could apply to taxis. You could find out when people require the service... and get some taxis and drivers specifically allocated for those services... I do not think you can expect every taxi driver or every Abbotsford bus to provide that sort of service."(Australian Bus and Coach Association/Australian Taxi Industry Association: Transcript of evidence, pp 2786-2787)

8.45 The Committee accepts that there have been moves toward increasing the accessibility of mainstream transport services. It is clear from evidence to the

Committee that these improvements have not yet reached a stage where mainstream transport is a viable or affordable alternative to community transport for the HACC target group.

8.46 **The Committee recommends that the Commonwealth Department of Human Services and Health and appropriate State and Territory departments monitor developments in mainstream transport and highlight the transport needs of HACC consumers to State transport departments to ensure that HACC community transport services are targeted to those members of the target group who are unable to access mainstream services.**

Private and Community Sector Interface

8.47 Private transport provider concerns focus on competition between HACC community transport and commercial operators. This is a particular issue in rural areas where private buses, for example, are not in use at all times and have the capacity to contract for community transport. The Australian Bus and Coach Association said:

> "The thrust of our submission was, in reality, that we do not like to see resources duplicated as many community transport projects throughout the state utilise private buses when they are not doing anything else, in between their peaks. Those services are generally given at a marginal cost and are of benefit. I can think of 27 operators between the Oxley community transport and the Coffs Harbour area that basically supply services on that basis. Where we do get concerned is in areas such as Bathurst and Orange where the operator is given a contract, an obligation to provide services commercially, and he has got to survive out of the fare box. Basically the targeted population for HACC funded things has expanded and they have competition in those
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> areas with the buses virtually running one in front of the other." (Australian Bus and Coach Association: Transcript of evidence, pp 2778-2779)

8.48 While the Committee has received limited evidence from other sources about the interface between HACC and the private sector, it appears sensible that the HACC Program should investigate the scope for more effective use of available transport funds through better coordination with the private sector. This view is supported in a recent study conducted for the National Accessible Transport

Committee which supports the development of brokerage models for the provision of community transport.

8.49 **The Committee recommends that the Commonwealth Department of Human Services and Health conduct an examination of the extent to which HACC community transport services coordinate with both the private sector and with other HACC transport services, to make best use of existing infrastructure.**

8.50 **The Committee further recommends that the HACC Program trial transport brokerage models to assess the effectiveness and efficiency of the approach.**

CHAPTER 9

ASSESSMENT

9.1 Effective assessment of the community care needs of each individual seeking access to HACC services is essential to the provision of appropriate services to each individual. It is also a pre-requisite for service providers in making judgements as to the relative needs of potential consumers where demand for their services exceeds their capacity to respond and for planning the delivery of care.

9.2 Assessment in the HACC Program presently is characterised by the same fragmentation which occurs in service delivery. In most instances, potential consumers of HACC services are assessed by each service provider they approach for assistance regardless of whether or not assessments have already been conducted by other HACC services.

9.3 Commonwealth and State governments and many HACC service providers have recognised that there is a need to streamline the assessment process within the Program. Governments initiated a recently completed trial of a common assessment record known as the Aged Care Assessment Record (ACAR). At the same time, attempts have been made by groups of service providers at the local level to rationalise the assessment process and introduce common documentation and approaches.

EXISTING ASSESSMENT MECHANISMS

9.4 Concerns about assessment processes in the HACC Program were evident as early as 1988. The First Triennial Review of the HACC Program identified assessment and coordination as important factors in fulfilling the aims of the HACC Program and noted that the HACC assessment system needs to be broader than any single service and, indeed, should extend beyond the boundaries of the HACC Program so that consumers are assisted in accessing the most

appropriate services for their needs, whether or not these fall within the HACC Program. The Review made a number of recommendations to improve assessment within the HACC Program by developing standards and principles for assessment and providing links between assessment, case management and service provision.[1]

9.5 While current attempts to address assessment issues generally reflect the spirit of the Triennial Review, they do not respond fully to the problems faced by consumers and service providers.

9.6 The Committee has serious concerns about the current approach to the assessment of individuals for access to HACC services. Multiple assessment of individuals raises a number of issues for the Program. First, it is apparent that being assessed by a number of service providers is stressful for consumers and may not lead to appropriate provision of services. A further concern is whether or not it is efficient for each service provider to conduct its own assessment, particularly where assessments have already been carried out by other providers. Finally, the assessment process lacks any formal links with the related sectors of residential aged care, disability programs and acute health.

9.7 Despite efforts to reduce multiple assessment, evidence before the Inquiry indicates that it remains prevalent and places stress on frail elderly people, younger people with disabilities and carers. As stated by the New South Wales Department of Community Services (DOCS) for example:

> "The individuals can undergo five or six different assessments, often covering the same ground in many instances."(DOCS: Transcript of evidence, p 11)

9.8 The existing assessment process was described in the following terms by the NSW Community Options Representatives:

> "Within the whole community care situation, there are demarcation disputes and pecking orders. Health will say, 'I have assessed this person and why won't Home Care do what I tell it to do?'. They will say, 'But I am the professional nurse' - or the OT or the doctor - 'and these wretched people will not do a thing I tell them to'. Home Care says, 'We have our own fine assessment tool. We are professionals; we can do it.'"(NSW COPs Representatives: Transcript of evidence, p 186)

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1 Home and Community Care Review Working Group, op cit, pp 26-35.

9.9 A further area of concern has been the lack of consistent involvement of general practitioners in the HACC Program generally and, more particularly in the referral and assessment process. As most members of the HACC target group, particularly frail elderly people, have contact with a GP, increased involvement of GPs in referral to HACC services and in the assessment process would offer potential benefits for consumers and carers. The Committee has seen no evidence of any formal or consistent attempts to forge links between the HACC Program and GPs. The Committee is aware that the Divisions of General Practice may offer some scope for developing more formal links.

9.10 The Australian Pensioners' and Superannuants' Federation (APSF) noted in relation to general practitioner involvement in HACC:

> "One thing people say a lot to us is that they are surprised how little GPs seem to be knowledgeable or seem to pass on information about HACC services... we certainly could see a role for improving the role of GPs in that respect. Whether or not one would want to give them a formal assessment role is another matter."(APSF: Transcript of evidence, p 91)

9.11 The Commonwealth Department of Human Services and Health advised the Committee that GPs do have a role in assessment for HACC services and in helping clients access services:

> "Assessment traditionally in HACC has been agency based so that individual agencies have had responsibility for assessing a client's needs and determining the level of service to provide... It has not meant that GPs have not played a role: GPs have often played a quite significant role, but that role has never been formalised either."(DHSH: Transcript of evidence, p 566)

9.12 The Department also described efforts being made to involve GPs in the pilots of the common assessment record:

> "The Royal Australian College of General Practitioners, which is also supporting the project, has sent a copy of the form to every GP who is registered to practice in each of the five pilot regions."(DHSH: Transcript of evidence, pp 569-570)

9.13 The Alzheimer's Association of Australia also pointed to the need for strong links between GPs and HACC assessors:

> "We would like to see those two areas work very closely together. Obviously the aged care assessment team picks up the social needs as well as the medical needs, which we would not expect the GP to do. But we do expect the GP to be aware of the social needs and to know where to refer the person, particularly for the carer to get support during what is a very long and arduous caring career."(AAA: Transcript of evidence, p 244)

9.14 **The Committee recommends that undergraduate medical courses and continuing education courses for GPs incorporate material regarding community care programs.**

EXTENT OF MULTIPLE ASSESSMENT

9.15 Some doubt has been expressed about the extent of the problem of multiple assessment. The Australian Council of Community Nursing Services, for example, said:

> "There has been tremendous comment about people being assessed on a number of occasions... [I] have not seen any research that demonstrates this. I think it is anecdotal and has taken on a life of its own. There are some people that do have four and five services but, from our experience, they are not the majority of HACC clients." (ACCNS: Transcript of evidence, p 74)

9.16 The New South Wales Council of Social Service (NCOSS) expressed a similar view:

> "Most consumers only receive one or two services, so I think we do have to question whether multiple assessments are a big issue for a large number of consumers. I am sure they are for a small number of consumers, but we should not translate that problem to everybody." (NCOSS: Transcript of evidence, p 118)

9.17 NCOSS did acknowledge, however, that the number of services received does not necessarily indicate the number of assessments undertaken, only the number where access to a service resulted, and went on to express concern about the

lack of knowledge in the Program regarding the number of consumers not receiving services and the reasons for these decisions:

> "I think there is a big problem with not being able to identify the number of people who are missing out on services. That is something that we need to look at in much more detail... and what happens to them? *Do they go on a waiting list, are they referred to another* service? How many of them are likely to be falling through the gaps... because there is nowhere for them to go?"(NCOSS: Transcript of evidence, p 119)

9.18 It is evident from an examination of the data on the services used by HACC clients that multiple assessment is an issue for significant numbers of HACC clients, even leaving aside the proportion for whom assessment does not lead to access to a service. The HACC User Characteristics Survey 1990 reveals that the average number of service types used per person is 2.8 and that almost half of all clients receive three or more services. The number of service types received by HACC consumers can be summarised as follows:

Number of Service Types	Percentage of Clients
One	23.6
Two	28.6
Three	20.7
Four	12.9
Five	7.3
Six	3.9
Seven or more	3.1

9.19 More than 76% of HACC clients use more than one HACC service and some 47% use three or more.[2] It must be acknowledged that multiple assessment is a significant issue for these individuals.

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2 Department of Health, Housing, Local Government and Community Services, "Service Development and Evaluation Report No. 3, HACC User Characteristics Survey 1990", AGPS, Canberra, 1992, p 38.

9.20 The Community Options Projects model of managing a package of care for the individual client would appear to offer an opportunity for a more streamlined approach to assessment. However, there is evidence that the potential of COPs in this regard has not been fulfilled and that individual HACC services continue to conduct a full assessment of client need prior to accepting clients already assessed by COPs. A COPs coordinator acknowledged:

> "It is still the case that most organisations provide at least to some level their own assessment, and to some extent they need to do that because they will have limited resources that they are responsible for."(Hunter Area Health Service: Transcript of evidence, p 1415)

REASONS FOR MULTIPLE ASSESSMENT

9.21 The prevalence of multiple assessment in the HACC Program has a number of causes. Firstly, the structure of the Program is not conducive to a single or shared assessment process. The Program consists of a large number of diverse projects providing separate services. These projects range from professional services like nursing through to small voluntary groups providing delivered meals. Some organisations are small, local groups which do not have the capacity or need to develop sophisticated assessment procedures, others have professional requirements which must be built into their assessment tool, while still others are part of a larger organisation, such as the Home Care Service of NSW, and are bound by the requirements of that organisation. As noted above, many consumers use a number of these services in order to have their community care needs met.

9.22 There is a tendency, among HACC service providers, to mix the process of assessing needs with the subsequent steps of comparing relative needs, assigning priority, referral to other services and developing care plans. The Commonwealth Department of Human Services and Health noted in its submission that:

> "Access... is based on the assessed need of the individual. This assessment is conducted by the full range of HACC funded agencies as well [as] the Aged Care Assessment Teams (ACATs) in States and Territories. Current practice in assessment varies considerably, with some agencies conducting an initial assessment to determine the level of need for services, and others conducting an assessment which also takes into account the resources available and priority of access. This variability in assessment has led to situations where access to services

is inconsistent both between and within States and Territories."(DHSH: Volumes of submissions, p 274)

ASSESSMENT AND SPECIAL NEEDS GROUPS

9.23 The existing agency-based approach to assessment presents particular difficulties for members of identified special needs groups. In particular, it has been suggested to the Committee that people of non-English speaking backgrounds and people with dementia are poorly served by existing assessment practices due to the inability of every service provider to acquire the expertise, skills and sensitivity to assess these groups effectively. While members of these groups are subject to the range of difficulties identified above, they also have particular needs which must be acknowledged in the assessment process. As assessment is the key to the provision of appropriate services, it is essential that assessment mechanisms are able to respond adequately to the needs of these groups.

9.24 As discussed in Chapter 6 of this report, people of non-English speaking backgrounds are apparently under-represented among HACC clients. The role of the assessment process in this under-representation must be investigated. While many services employ bilingual workers for the major ethnic groups they encounter, it clearly is impossible for every service provider to employ staff with appropriate language skills and cultural backgrounds or understanding for all ethnic groups which may require the service. The Ethnic Communities Council of Queensland gave evidence that:

> "If you get just one bilingual worker, what are you trying to achieve? You really need someone with some significant awareness of the cultural and linguistic issues that are available... you have to have a good knowledge and framework for assessing non-English speaking background people and then start pulling in the resources that are required."(ECCQ: Transcript of evidence, p 1698)

9.25 While the Committee received limited information about the experience of Aboriginal and Torres Strait Islander people in being assessed for HACC services, it is not unreasonable to assume that similar difficulties occur. All HACC services do not have access to Aboriginal workers or people with an understanding of Aboriginal culture.

9.26 Indeed, it would not be reasonable or efficient to expect that every HACC service provider have access to the range of cultural and linguistic resources needed to assess members of the range of cultures represented in Australia. A regional approach to assessment, employing a single agency may assist in addressing this issue.

9.27 Similarly, people with dementia may be disadvantaged by agency-based assessment due to a lack of specific expertise among many service providers in relation to dementia. The Alzheimer's Association of Australia pointed out to the Committee the need for a combination of medical diagnosis and an assessment of community needs:

> "We are very keen that the person be properly medically diagnosed. That can be done by either the GP or, of course, the aged care assessment team, which has a medical component to it."(AAA: Transcript of evidence, p 244)

STRATEGIES TO IMPROVE ASSESSMENT

9.28 The HACC Options/Discussion Paper released by the Committee as part of this Inquiry contained three options for an approach to assessment in the HACC Program. These were:

- Implement a common assessment approach within existing structures through the introduction of a common assessment, referral and service provision record following evaluation of the trial of the ACAR;

- HACC assessments conducted through Aged Care Assessment Teams on the basis of established eligibility criteria for HACC services. To meet the needs of people with physical, intellectual and psychiatric disabilities, separate agencies would need to be established or the staffing profile of ACATs changed to enable them to assess all groups; and

- Fund an assessment service in each region under the HACC Program to act as the gatekeeper for all HACC services in that region. It would assess all potential consumers and refer them to existing HACC services.

9.29 The views of the HACC community regarding the best approach to assessment are diverse. Opinions range from those who consider that an assessment by the individual service provider is essential, to those who advocate the use of a gatekeeping agency or team to assess all HACC clients. An example of the former view is that of the ACCNS, which said:

> "I believe that, irrespective of what sort of centralised information you have in relation to assessment, it will not negate the professionals' responsibility to do their own assessments. As a group of professionals within the program, nurses will always have to undertake a nursing assessment to assess the person's need and plan their care... we have an absolute duty of care to do a professional assessment."(ACCNS: Transcript of evidence, pp 72-73)

9.30 It must be noted, however, that ACCNS states that nursing services have a close relationship with ACATs and do accept ACAT assessments (ACCNS: Transcript of evidence, p 75).

9.31 *The Northern Regional Office of the Tasmanian Department of* Community Services and Health, on the other hand, responded to problems of ownership of clients, access difficulties and lack of information, by suggesting that "the establishment of a multidisciplinary access/intake team to service the target groups would be one strategy to address these issues."(Community Health Regional Office, Northern Region, DCHS TAS: Volumes of submissions, p 910)

Common Assessment Agencies

9.32 The concept of a single agency assessing all potential consumers of HACC services in an area has been raised by a number of organisations. Several ways of developing the concept have been suggested including expanding the role of Aged Care Assessment Teams to include assessment for HACC services and establishing separate community care assessment agencies. There is general agreement, among those who support the concept, that any move toward assessment agencies would need to be done on a regional basis. The assessment agency proposal was also the subject of extensive comment at the Public Forums conducted by the Committee to consider the HACC Options/Discussion Paper.

9.33 Concerns about the implications of a common assessment agency for HACC services have been expressed in evidence to the Committee and in discussion at the Public Forums. It should be noted, however, that most of these concerns are from service providers, rather than consumers, and stem from potential service provision difficulties. While these concerns are legitimate, the Committee considers that the needs of consumers and carers are paramount and every effort should be made to overcome structural difficulties which limit the capacity of the HACC Program to deliver positive outcomes.

9.34 The main argument expressed to the Committee against common assessment agencies has been the need for each service provider to conduct its own assessment to enable care planning and decisions about priorities.

9.35 The Committee considers that this problem can be addressed within a common assessment agency approach by ensuring that the assessment is community oriented and includes professional input as required and by making it clear that the responsibility for care planning and decisions on priorities remain with the individual service provider. In effect the assessment agencies would become gatekeepers for the Program in the way that ACATs currently perform the role for residential facilities - establishing eligibility and level of need. In discussion at the Public Forums there was a level of acceptance for such a proposal. Some positive aspects of the proposal, as identified in the Forums, included:

- Concentration of expertise in assessment and avoidance of assessment by inappropriate staff;

- A single entry point to the Program for consumers;

- Highlighting gaps between community need and availability of HACC services, thereby providing an improved information base for the Program and better needs based planning;

- Facilitation of the assessment of clients on the basis of their needs rather than on what the Program or individual service providers can offer; and

- Enhanced efficiency for services by freeing resources for service delivery and reducing travel time.

9.36 The Committee considers that, in addition to resolving difficulties in relation to assessment, common assessment agencies would address a number of other concerns identified in the course of this Inquiry. A single point of entry would improve the visibility of community care and, hence, access for consumers and carers. It would enhance equity by ensuring a consistent interpretation of HACC eligibility criteria. It could improve linkages between HACC and related sectors. A regionally based common assessment agency would be well be placed to concentrate expertise in assessing members of special needs groups.

9.37 The role of existing assessment agencies, notably ACATs, in a common agency approach to assessment must also be resolved. The Mid-Term Review of Aged Care noted that ACATs (known at that time as Geriatric Assessment Teams or GATs) already have a significant role in community care:

> "The most common outcome, 36%, was for community care, this outcome indicates that GATs already have an extensive role in the community care network..."[3]

9.38 Concerns about the appropriateness of ACATs to assess the HACC target group have been raised by a number of groups. In general these included concern about the appropriateness of ACATs, the feasibility of adapting ACATs to meet the needs of younger people with disabilities, the possibility of a medical approach by ACATs and the increasing government intervention if a government body were the assessor for HACC services.

9.39 There is, on the other hand, some support for the use of ACATs as the assessors for HACC services. The Social Policy Research Centre (SPRC) for example, said:

> "I would say almost without hesitation that the geriatric or aged care assessment teams, as they are now called, as being appropriate... I do not feel that they are too highly qualified, incredibly expensive or inappropriate to send in in lower intensity cases. In our study - other research confirms this - we found that people who present with apparently low levels of need very often have a high risk of and very high rates of institutionalisation..."(SPRC: Transcript of evidence, p 225)

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3 Department of Health, Housing, Local Government and Community Services, "Aged Care Reform Strategy Mid-Term Review 1990-91: Report", AGPS, 1991, p 101.

9.40 The Returned Services League of Australia (RSL) also supported the involvement of ACATs, while noting some concerns:

> "The Aged Care Assessment Teams already established within the Community are a viable working option. While the RSL has some concerns about some elements of documentation and policy applied to ACATs, nonetheless the teams are already established and should be developed rather than scrapped and redesigned."[4]

9.41 The Committee considers that a broadly based assessment team which crosses program boundaries is essential to achieving positive outcomes for consumers across a range of aged care and disability services.

9.42 A natural extension of the concept of a common assessment agency for community care is an agency to assess for a range of related services. In the aged care sector, for example, an appropriately staffed and independent agency to assess frail elderly people would be able to assess eligibility and level of need for nursing homes, hostels, Community Aged Care Packages and community care, including but not restricted to, HACC funded services. The agency would then refer consumers to appropriate services. It could also, if suitably constituted, assess for the range of disability services. A single agency of this nature is an essential component of the model recommended for post acute and palliative care discussed in Chapter 7.

9.43 The Committee recognises that this would constitute a major change in assessment practice and that it will be essential to trial the concept prior to widespread implementation.

9.44 **The Committee recommends that the Commonwealth Department of Human Services and Health, in consultation with State, Territory and local governments and related programs in aged residential care and disability services, pilot a common agency approach to assessment for community care, aged residential care, post acute care, palliative care and accommodation related disability services. It is recommended that the pilots cover a number of metropolitan and non-metropolitan regions, are jointly funded by the relevant programs and test the following model:**

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[4] June M Healy, National Secretary, Returned Services League of Australia Ltd, Correspondence in response to HACC Options/Discussion Paper, 3 March 1994.

- Adequately resourced and appropriately staffed Regional Community Assessment Agencies to conduct gatekeeping assessments in line with the eligibility criteria of the relevant programs. The agencies must have flexibility in staffing and location(s) and should consist of a core team of staff with the capacity to contract in specialist staff as required and to contract organisations to conduct assessments on behalf of the agency in certain circumstances, such as in outlying areas of geographically large rural regions;

- Each Regional Community Assessment Agency to be independent of service providers and governments. The agency would be accountable through normal Program channels with administrative details to be negotiated among the programs concerned prior to commencement of the pilot;

- In relation to general HACC services each agency will be responsible only for the assessment of need against the criteria. As described in Chapter 7, the regional assessment agency would have the authority to determine amounts of service for consumers requiring post acute and palliative care services in conjunction with hospital discharge planners. In the case of residential aged care, the regional assessment agency would have the same powers as existing ACATs which would be replaced. For disability services, the agencies would subsume the powers of any existing assessment mechanisms;

- Individual HACC service providers should retain responsibility for deciding on relative need, in line with priority of access guidelines as recommended in Chapter 5, for developing care plans for individual consumers, for ongoing monitoring of consumers and for reassessment and minor adjustments of service levels. Major changes would be referred to the Regional Community Assessment Agency for re-assessment;

- The Regional Community Assessment Agencies should be responsible for follow-up to ensure that referrals are acted upon and to pursue alternatives when HACC agencies are unable to assist;

- The Regional Community Assessment Agencies should be subject to all HACC quality assurance requirements and to additional requirements regarding response time to ensure that the initiative does not lead to delays in assessment and provision of services and is able to respond to emergencies;

- **The Regional Community Assessment Agencies should be staffed with recognition of particular needs within the region, such as ethnic populations and dementia, and have the capacity and resources to bring in experts in special need areas such as interpreters or experts in brain injury;**

- **An avenue of appeal against an assessment, should be established as part of the complaints mechanisms recommended in Chapter 11;**

- **The pilot projects should incorporate a data collection model consistent with the data required under the draft HACC Program Outcome Indicators to assist in an assessment of the effectiveness of both the role of assessment data in identifying unmet need and of the draft Indicators as a tool for monitoring Program effectiveness; and**

- **The pilot projects should be run for 12 months concurrently with the other pilots recommended in this report.**

9.45 In order to obtain maximum benefit from these recommendations, the boundaries of the regions used must be compatible with other relevant regions including the Program's planning regions, aged residential care and disability services planning and service delivery regions, local government, State government health regions and statistical regions used by ABS in its collections. **The Committee recommends, therefore, that the Commonwealth Department of Human Services and Health in conjunction with States, Territories and local government negotiate consistent regional boundaries for these related service delivery areas and based initially on existing area health boundaries. Within the HACC Program consistent regional boundaries should be applied for all regionally based functions.**

Common Assessment Record

9.46 The HACC Program has recently completed a pilot of a common assessment record for use by HACC service providers. The aim of the project was to provide a common basis for the assessment of need for service for each consumer and a common referral mechanism. The Commonwealth Department of Human Services and Health also notes that issues regarding availability of resources and priority of access will be decided by the individual provider after the level of need has been established (DHSH: Volumes of submissions, p 275).

9.47 This Inquiry found that there is considerable support among both consumers and service providers for the continued development of a common record. The Royal District Nursing Service (RDNS), while not supporting fully the content of the ACAR as trialled, expressed support for the concept:

> "I have been a strong advocate of the need for some core information that we can all share, so I am very much in favour of the concept."(RDNS: Transcript of evidence, pp 873-874)

9.48 There have been some negative responses to the concept of a common record. Many of these relate to privacy concerns. It appears, however, that concerns about privacy are held mainly by service providers while consumers are less worried about confidentiality and more concerned with the potential benefits to themselves

of improved coordination and more streamlined assessment. The Victorian Consumer Forum for the Aged, for example, said in relation to privacy issues:

> "Could I say that I found that to be the least of the consumers' problems... It was the professionals' concern, it was not the consumers' concern. I found the consumers much more interested in the way they were approached by professionals, particularly in the caring situation." (Victorian Consumer Forum for the Aged: Transcript of evidence, p 734)

9.49 It should be noted that the trials of the Aged Care Assessment Record required that information could be recorded and shared only with the agreement of the consumer.

9.50 The pilot of the common record has now been completed and evaluated and an implementation strategy has been developed. The evaluation found a very high level of support for the record among consumers. The vast majority of clients and carers had no difficulty in providing the information required and valued being able to retain the record in their own homes. Most assessors were also supportive of the record with 66% finding that the core information required for Program data collections was included in the form, 68% finding the form easy to complete and 41% reporting that the use of the record increased their awareness of consumer and carer rights.

9.51 It is interesting, in view of concerns often expressed by providers in the course of this Inquiry about privacy issues, that no major difficulties were reported

in obtaining client/carer consent to the referral of client information to other services. The evaluation found, however, that the actual rate of referral was surprisingly low with only 28% of assessors making a referral. Of those assessors who did receive a referral, the majority found the record an improvement on previous referral methods and that it reduced the number of questions they needed to ask the client.

9.52 The evaluation concluded that it was feasible to extend the use of the record nationally to all HACC services and ACATs with some alterations to the documentation and adequate support to service providers during the transition to the new approach. A two stage implementation process is proposed, with initial implementation occurring in 25 regions across Australia and full implementation occurring from the end of 1994.[5]

9.53 The Committee is not convinced, however, that a common assessment record will address fully the difficulties in the area of assessment. Individual service providers will continue to conduct separate assessments, although they will be able to draw on information already collected. The assessment record will not ensure consistency or equity in the way needs are assessed or provide the Program with information about justified non-provision of services. Finally, the common assessment record will not resolve the confusion between assessment as a process for determining eligibility and establishing the level of need and the separate process of care planning and priority setting by individual service providers.

9.54 The implementation of a common assessment record as proposed by the Program will go some way toward addressing the problems the HACC Program and its clients face in regard to assessment. It will reduce the number of times a consumer is asked for basic information and will encourage effective referral and sharing of information among service providers, where the client wishes this to occur. It will also empower consumers by allowing them greater ownership of and access to their own service records. Holding a record, in the home of the consumer, of basic personal details and of services provided may also facilitate improved coordination among service providers.

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5 Department of Human Services and Health, "Aged Care Assessment Record Project Stage 3: Pilot Evaluation and Feasibility Study - A Summary", prepared by Brian Elton and Associates, Planning, Housing and Social Policy Consultants, March 1994.

9.55 The Committee acknowledges that significant resources have been put into the development, evaluation and early stages of implementation of the common assessment record. As detailed above, however, the Committee considers that the implementation of a regionally based assessment agency is the most effective approach to assessment. In view of the generally positive results of the evaluation of the assessment record, it is desirable that it form the basis for assessment under the proposed Regional Community Assessment Agency structure. In this context the existing common assessment record would be adapted for use as the record of assessment by the Regional Community Assessment Agency, the referral form from the agency to HACC and other providers and the care plan and service delivery record of individual providers. In filling these functions the record would continue to be held in the home of the client.

9.56 It is likely that the pilots and evaluations of Regional Community Assessment Agencies will take some time. Use of a common assessment record, in the interim, will reduce problems for consumers and, with service provider training, will begin to bring about the cultural change necessary for effective common assessment. **The Committee therefore recommends that the Commonwealth Department of Human Services and Health and relevant State and Territory governments:**

- **Adopt the common assessment record, with revisions as necessary, as the basic assessment and referral document for the pilot Regional Community Assessment Agencies and the care planning and service delivery record of HACC services in the pilot regions;**

- **Continue the implementation of the common assessment record and associated training pending the implementation of the recommendations above and evaluation of the pilots; and**

- **Retain the principle by which basic assessment information and service provision records are held in the consumer's own home and shared, with the agreement of each consumer, between service providers for ongoing use as a care planning and coordination tool following implementation of Regional Community Assessment Agencies, should the recommended pilots support the model. The use of the common record in this way should be made mandatory for projects subject to the agreement of the consumer.**

CHAPTER 10

SERVICE DELIVERY AND COSTS

10.1 During the Inquiry a range of issues about service delivery, service costs and staffing issues have been raised with the Committee.

SERVICE DELIVERY

Organisation Size

10.2 The diversity of HACC service providers leads, inevitably, to discussions of the most appropriate size and structure of the service provision unit. The Committee has heard arguments that large government and non-government providers are bureaucratic and inflexible, that they are not client focused and that their administrative expenses are high. On the other hand, it is sometimes claimed that these organisations are able to achieve economies of scale, bring about intra-State equity and provide more effective training and professional service.

10.3 Small community based organisations are viewed by many as the traditional and appropriate community service provider. They are seen as flexible and responsive, client driven and focused on the community they serve. Conversely, however, it has been suggested that the proliferation of small community providers contributes substantially to the fragmentation and lack of identity of the HACC Program, that it makes it difficult for consumers to find and access services and that it is inefficient as each provider maintains its own administrative structure thereby increasing the scope for duplication of resources and effort.

10.4 The Home Care Service of NSW commented on the perception that it may be too large to be responsive locally:

"We are large, and I think the perception of the bureaucracy is based on the fact that any organisation that is large and has some central aspects has some bureaucracy. But the actual service provision which comes out of our local branches, local areas, local networks, I do not believe to be very bureaucratic. I believe that it is well integrated as part of the local area's services... You can quite easily get access to anybody in Home Care."(HCS: Transcript of evidence, p 127)

10.5 A small community based service provider in SA stated the advantage of being small in the following terms:

"... one of the advantages of managing a small program is that I am in constant contact with my consumers. I hear a lot of things that people perhaps would not be prepared to say in a formal evaluation or a formal review because the truth is that people are very fearful of losing a service if they are in any way critical... I would have to say that I hear more criticisms about the inflexibility of a program like a dom care program as opposed to the flexibility of a COPs program."(Regional Carer Support Project: Transcript of evidence, p 2022)

10.6 The same service provider subsequently pointed out some difficulties faced by smaller organisations:

"... the managers of the smaller programs, many of which only have 1.5 staff, are not qualified nor trained to handle the legal issues of setting up contractors in brokerage situations. All of us have been very committed to doing that, but we have actually found it a very tiresome road and one that we still do not feel very confident about."(Regional Carer Support Project: Transcript of evidence, p 2026)

10.7 There is insufficient empirical data collected by the HACC Program to allow the Committee to draw conclusions about the financial efficiency or otherwise of large and small organisations.

10.8 It is likely that the very diversity of organisations in the HACC Program is one of the factors which has contributed to its success. One organisation addressed the question in the following terms:

"If you are trying to decide on the basis of an organisation, you are probably going the wrong way about it. If you start by looking at the needs of those clients and the needs of that community, you are much better placed to make a good decision about whether it would be better

to have a large organisation with regional units or a small, locally based organisation."(WACOSS: Transcript of evidence, pp 2131-2132)

10.9 **The Committee recommends that the HACC Program retain the current diversity of service provider types. It is further recommended that the Commonwealth and the States monitor the costs and effectiveness of service provision by different types of organisations to ensure efficiency and provide appropriate support for service providers.**

For-Profit Providers

10.10 Existing policy in the HACC Program precludes the direct funding of for-profit service providers under the Program. COPs and Linkages projects do, however, purchase services from the private sector. The Committee has received evidence, primarily from the private sector and from governments supporting the involvement of for-profit service providers in HACC. There has also been significant opposition to the concept from consumer and service provider groups.

10.11 For-profit providers have argued that they are able to provide high quality services as efficiently, or more so, than existing HACC service providers. Some State governments have supported this view and argued for a more competitive approach to funding under the HACC Program. For-profit providers have stated their hourly rates for home nursing, for example, at between $17 and $25 per hour. HACC Program data does not allow derivation of an hourly cost for service provision. The HACC Program Unit Costs Study found that among the services included in that study, the cost of home nursing ranged from $44 to $51 per hour. It must be noted, however, that the consultants who conducted that study have warned that the data can not be extrapolated to other services.[1]

10.12 It has also been suggested that the HACC Program is inconsistent in its approach to the private sector in allowing case management projects to purchase services from the sector while not allowing direct funding of these services

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[1] Department of Health, Housing and Community Services, "Aged and Community Care, Service Development and Evaluation Report No. 7, Home and Community Care Program Unit Costs Study", March 1993, p x.

10.13 The Western Australian and Victorian governments are among those who support allowing for-profit operators to receive HACC funding. Both these governments, however, stated that effective quality assurance and accountability measures would be essential. The Health Department of WA for example, said:

> "... if we are actually measuring outputs and the quality of those outputs and outcomes for people against the amount of dollars going into that, then we are able to compare much clearly like with like... Whereas at the moment if all we can do is measure the inputs and not really be able to calculate and be accountable for the outputs and outcomes, then there obviously is some concern about letting this go to the full for-profit sector."(HDWA: Transcript of evidence, p 2097)

10.14 The Victorian government expressed a similar view:

> "I think there is a range of things you need to do to make sure that any providers, in fact–not only the for-profit ones–do not cut corners. I think that having a uniform way of assessing people's needs is a useful step in that process... Regular reporting of the level of services and the mix of services that is provided to different people should be part of that system... But I think in terms of having contractual arrangements between suppliers and funders... it would be one of the planks. An efficient method of getting feedback from consumers about the services that they are receiving is another important part of it, and that is not just about complaints."(DHCS VIC: Transcript of evidence, pp 666-667)

10.15 The for-profit providers which spoke to the Committee had been involved in providing services under a purchase arrangement through COPs projects and one was operating a CACP project. All spoke of the high quality of their services, pointing out that they would not be able to continue in business if the product they provided was not of a high quality. One private provider of nursing and home care made the following comments about quality:

> "In other words, if you stay in business it is because you are doing it right. If you are not doing it right it will soon come to somebody's attention, particularly when you are dealing with the government and insurance companies et cetera. It took years for us to get accreditation. We had to be doing something right."(AP Care: Transcript of evidence, p 379)

10.16 A private nursing agency, which operates as an employment agency for self employed nurses who provide a range of nursing, personal care and home help services, described its quality assurance approach in the following terms:

> "Because we are the first private nursing agency to be going for accreditation in Australia, we have built in all the systems for a decent quality assurance program. Any organisation that has a quality assurance program has those results. We have a client quality appraisal assessment which is delivered to every single client every three months."(Southern Cross Home Nursing: Transcript of evidence, p 2634)

10.17 A private sector home care agency told the Committee that its quality assurance measures are consistent with the requirements of the HACC National Service Standards:

> "The approach we have would mean that our agency certainly complies with all the national standards, and the framework we have developed clearly reflects the national standards. That is a clear statement of client rights and client responsibilities... We have a clear grievance and complaints mechanism and we have built in the concepts of both individual choice and flexibility..."(Silver Circle Home Support Services: Transcript of evidence, p 3051)

10.18 There are serious concerns among many consumer and service provider groups about the involvement of for-profit providers in delivering HACC services. The concerns centre mainly around quality, the employment practices of the private sector, accountability and a perception that private providers may focus on 'easy' consumers in easily serviced metropolitan areas.

10.19 The Department of Veterans' Affairs (DVA), which has significant experience in purchasing home nursing services from both the private and public or community sectors questioned the perception that the private sector is more efficient. DVA said, of public or community sector providers:

> "Our view is that most, if not all, of those organisations are very well run. They are quite often cheaper. We do not have any problem of underqualified or unqualified people being employed in some of those agencies, as we do with some private agencies. We have not had any experience of questioning bills that they have given us. We can use those services at a cost of something between $9 and $23 per session,

compared with a much higher figure that we would get from a private organisation."(DVA: Transcript of evidence, pp 2471-2472)

10.20 Consumer organisations, while not ruling out the private sector as HACC providers, are concerned that the HACC Program does not have a sufficiently rigorous approach to quality and accountability to enable proper monitoring of private providers. The Council on the Ageing (Victoria), for example, said:

> "We are not keen on using for-profit operators unless we have already agreed standards of care. So they would have to be in place and be agreed as okay before we would want to go in that direction."(COTA VIC: Transcript of evidence, p 727)

10.21 These views were echoed by the Victorian Consumer Forum for the Aged, which said:

> "We have to preserve quality, accountability, and the rights of consumers always in this process. I do not know if there is any real attention being given to this... I was at a casemix funding conference... We heard two members of the panel who spoke very fashionably about privatisation and corporatisation as the answer to everything. But when I asked the question of where the consumers came into this, they were fumbling and mumbling at that time, because they answered the question very inadequately in my view and that of others."(VIC CFA: Transcript of evidence, p 739)

10.22 Finally, a COPs manager with experience in purchasing services from the private sector, while not suggesting that private sector services lack quality, said:

> "We would argue very strongly... that the private sector involvement in HACC needs to be scrutinised very carefully–the pros and cons needs to be looked at very carefully..."(South West Metropolitan Social Development Council: Transcript of evidence, p 2265)

10.23 The Committee considers that the involvement of for-profit providers in the delivery of HACC services is both inevitable and could be beneficial to the HACC target group by increasing choice. Arguments for the continued exclusion of the private sector can be overcome by the implementation of mandatory service standards, effective complaints mechanisms and outcome focused service agreements. It is significant that the case management projects have not reported major quality

problems through their experience in purchasing services from the private sector and have continued to make use of those services.

10.24 It is impossible, however, in the absence of any definitive cost information to make judgements about the relative efficiency of private and non-profit providers. Nor is it possible to compare the quality of services provided by the two sectors.

10.25 **The Committee recommends that the Commonwealth Department of Human Services and Health in conjunction with States and Territories examine the relative efficiency and quality of for-profit providers and traditional HACC providers. This will require implementation of a unit cost framework for HACC as recommended later in this Chapter.**

10.26 **The Committee recommends that the Commonwealth Department of Human Services and Health investigate any legislative barriers to the participation of the private sector in the provision of HACC services and work with States, Territories, local government, providers and consumers to develop a coherent policy to enable for-profit providers to seek funding to provide HACC services. This recommendation is conditional upon examination of the relative efficiency of these services and the implementation of recommendations regarding mandatory service standards, external complaints mechanisms and accountability for outcomes and outputs.**

Service Models and Funding Arrangements

10.27 The HACC Program provides services using a range of models. To some extent these models are driven by the funding arrangements of the HACC Program. The predominance of projects providing a single service type results from the history of the Program and from the ongoing practice of funding on the basis of service types. There are, however, projects which are funded to provide a range of HACC services and others where a number of services have collocated to share accommodation and, in some instances, administrative resources. In addition, the case management model of the COPs and Linkages projects is now being more widely adopted.

10.28 Apart from the range of models already in existence, the HACC Program continues to explore new approaches to service delivery. In NSW, demonstration projects are being established to test a variety of approaches to service delivery and funding. The approaches include area budget holders, mandated cooperation and one-stop shops. The WA Government has indicated that it is keen to pursue a purchaser-provider split approach to service funding and delivery with a reduced emphasis on inputs and a greater focus on outcomes and outputs. The Victorian government has shown some enthusiasm for a competitive tendering approach to funding HACC services.

10.29 Some States have already adopted a more flexible approach to the funding of services with the intention that this will lead to more flexible service provision. The Health Department of WA, for example, described its approach to funding services on a more integrated basis to promote integration of service delivery:

> "So an agency will receive funding to allow it to provide a range of services—maybe respite, home maintenance, transport—and it will not be required to account separately for funds for each of those. It can... respond in an integrated way to the client's need... But part of the aim of that, obviously, is that... HACC services as a whole are, hopefully, following that strategy of coming more towards looking at clients' needs on an integrated basis and responding to them."(HDWA: Transcript of evidence, p 2092)

10.30 The Victorian government has also opted for a more flexible and output oriented approach to funding with the implementation of a four stage reform plan which will give service providers greater flexibility in terms of service types and the capacity to carry over a small proportion of unspent funds across financial years, while at the same time improving accountability through revised service agreements.[2]

10.31 The Committee proposed a number of options for service delivery in the HACC Options/Discussion Paper. These were discussed at the Public Forums held during the Inquiry. The overwhelming feedback from the Forums was that the HACC Program must retain a range of service delivery models to enable it to respond to local and individual needs.

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2 Mr W Bruen, Assistant Secretary, Community Care Branch, Department of Human Services and Health, Correspondence, 9 December 1993.

10.32 The Committee accepts that there is value in retaining the current diversity of service delivery models. **It is recommended that the Commonwealth Department of Human Services and Health monitor the outcomes of service delivery models being trialled in States and Territories and continue to encourage innovation in service delivery.**

10.33 **It is also recommended that the Commonwealth Department of Human Services and Health implement flexible approaches to service funding to remove limitations so that an agency may provide a range of services while maintaining adequate accountability standards with a focus on outcomes and outputs.**

10.34 **Finally, the Committee recommends that the Commonwealth Department of Human Services and Health and the States and Territories actively encourage collocation of services and sharing of administrative resources as the opportunity arises (for example, when funding new projects or when changes in accommodation are required).**

COORDINATION AND CASE MANAGEMENT

10.35 The coordination of HACC services has been raised on numerous occasions during the Inquiry. While the implementation of the recommendations in Chapter 9 will largely address those concerns to the extent that they inhibit access to HACC services by the target group, the Committee considers that improved coordination between service providers at the local level will enhance consumer outcomes.

10.36 The responsibility for coordination of services at the local level falls largely to service providers. The extent to which service providers are able to work cooperatively and to achieve coordination has been due in the main to the efforts of service providers, although the HACC Program has made efforts in this area through the establishment of mechanisms like the HACC Forums and the recent development of the Cooperative Workstyles training package which gives service providers training in achieving a more cooperative and coordinated approach to service delivery.

10.37 **The Committee recommends that the HACC Program continue to foster improved coordination of service provision at the local level. Mechanisms to achieve this may include increased support for local forums and identification and promotion of best practice in coordination and cooperation.**

10.38 Coordination of services is of most importance for those consumers with very high level or complex needs who may find it difficult to approach and deal with a number of services which are required to meet their needs. It is for these clients which case management services have been most successful and have the most support. The national evaluation of the COPs found that:

> "Community options can care for people who prefer to remain at home, but for whom residential care would be an appropriate alternative if they did not receive suitable community care services. They include the most highly dependent people living in the community, and people who have a combination of intense, complex and changing needs."[3]

10.39 There is a generally high level of support for the case management approach of these projects in the community and a feeling that they have been a catalyst for change in the broader service provision community, helping to bring about a more client focused approach. A group of NSW COPs representatives spoke about this broader role in the following terms:

> "In a sense, Community Options as a program was about a change of service provision as much as it was about increasing coordination. From all over the state we can give examples of where we really have brought about change in the way people work... A good deal of time in Community Options is spent having discussions about service provision and acting as an advocate for our clients. It leads to much angst."(NSW State COPs Representatives: Transcript of evidence, p 179)

10.40 While the Committee accepts that the COPs/Linkages approach has played an important role as a catalyst for change and as a case management service for people with complex needs, it has been suggested that these projects are providing a luxury service for a few clients at the expense of others. ACCNS for example, suggested:

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3 Department of Health, Housing and Community Services, "Aged and Community Care Service Development and Evaluation Report No 2, It's Your Choice: National Evaluation of Community Options Projects", AGPS, April 1992, p 96.

"The welfare model has been very successful with the innovative programs, such as the community options and linkages... But we should not lose sight of the fact that those programs are only servicing a very, very small percentage of the total number of people that are requiring HACC services. They are servicing those people at a very high level–a luxury level–which we cannot afford to give everybody. I see that that raises all sorts of issues in relation to equity and access..."(ACCNS: Transcript of evidence, p 78)

10.41 The evidence available to the Committee suggests that the best use of resources will be achieved if case management is targeted to those who will most benefit from it - people with complex needs. **It is, therefore, recommended that the Commonwealth and the States/Territories expand coverage of case management services to ensure that consumers with complex needs in all areas of Australia have access to case management. It is also recommended that these services continue to be targeted to consumers with complex needs. As recommended in Chapter 6, rural and remote areas should be excepted from the requirement that case management is targeted only to high level need consumers.**

10.42 Some issues have been raised about the practices of case management projects in contracting individuals to provide services. A private provider, for example, raised the following issue:

"We find, particularly in the Orange area, which we now do exclusively for the Community Options program, that they were using people and paying them direct cash in hand. There was no PAYE tax, there were no super payments being made, there were no insurance policies, so if something happened the government would have had to carry the can for them."(AP Care: Transcript of evidence, p 374)

10.43 Similar concerns were raised in the submission of a Union with coverage of parts of the HACC field:

"Of more recent times the Union has become concerned about the operation of the Community Options program mainly because of the way it has tended to use services which are unregulated by awards, or in some cases, advising the clients to employ their own carers."(Australian Liquor, Hospitality and Miscellaneous Workers Union: Volumes of submissions, p 6)

10.44 **The Committee recommends that the Commonwealth Department of Human Services and Health investigate the industrial and legal issues associated with the purchase of services by case management projects, particularly where those services are provided by an individual.**

SERVICE COSTS AND EFFICIENCY

Existing Cost Data

10.45 The Committee has found that comprehensive data on the costs of providing community care services is not available.

10.46 Many service providers have given the Committee details of their costs. While interesting, this data does not allow conclusions to be drawn about the costs of service provision, the relative efficiency of the various approaches which may be employed in delivering services or cost variations between rural and urban areas.

10.47 The Commonwealth Department of Human Services and Health provided information on the average cost to the Program per unit of service for the main service types in each State and Territory. This data showed some large variations between States but, once again, does not allow any conclusions to be drawn. The costs were derived by applying service provision information to the expenditure on each service type. It is subject to various errors including the accuracy of the service provision data and the way in which States and Territories record expenditure against service types. In any event, it shows only the cost to the HACC Program rather than the actual cost of providing services.

Improving Cost Data

10.48 The HACC Program has recognised that it does not have adequate data on which to base analysis of the cost of community care and the factors involved in cost variations.

10.49 In 1991-92, the Commonwealth Department of Human Services and Health commissioned a study of unit costs in the HACC Program. The study

examined the costs of a small sample of services across three service types (home help, home nursing and delivered meals) in NSW, Victoria and Western Australia and sought to identify the cost of provision of HACC services, variations in costs and the reasons for these variations. It also set out to develop a framework to identify all relevant costs in the provision of HACC services.[4]

10.50 The study noted that:

> "This Study provides an extensive view of the costs and service delivery patterns of seventeen HACC services. The cost results should not be generalised to other service providers, locations or times. It was not within the scope of the study to make any connection between costs and quality of outcomes for consumers. This remains a future challenge for HACC service providers, funding bodies and researchers."[5]

10.51 The major value of the study has been the development of a framework for collecting cost and service provision information from service providers and calculating the costs of a unit of service. The study recommended that the framework be tested further and then implemented across the Program. The authors of the study saw the framework as having potential application in a number of areas:

> "The framework may be used in a variety of situations in the future, including
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> - costing new services
> - estimating the costs of other HACC service types
> - aiding consistency in project acquittals
> - analysing the impact on unit costs of particular service attributes
> - costing benchmark levels of service
> - costing 'packages' of service for individual consumers
> - calculating unit costs for measuring Program outcome indicators
> - providing a consistent framework for Program evaluations and project reviews

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4 Department of Health, Housing and Community Services, "Aged and Community Care, Service Development and Evaluation Report No. 7, Home and Community Care Program Unit Costs Study", March 1993, p 1.

5 ibid, p xi.

. allowing variations in costs to be identified and to an extent explained."[6]

10.52 The Commonwealth Department of Human Services and Health advised the Committee that plans are in place to test further the framework proposed in the Unit Costs Study and to implement the framework to improve the capacity of the Program to analyse cost issues.

10.53 **The Committee recommends that the Program proceed with the implementation of a unit costs framework. Once implemented, it is recommended that the framework be utilised to examine the relative efficiency of a range of service delivery models and to identify factors which cause cost variations.**

STAFFING ISSUES

10.54 A range of issues related to staffing of HACC services have been raised with the Committee. The key issue which has been raised in this area is the role of volunteers in the HACC Program.

Volunteers

10.55 Issues about the role of volunteers in the HACC Program fall into two categories. First, there are concerns about the extent to which the Program recognises the contribution of volunteers and assists volunteers through appropriate training and day to day support and reimbursement of expenses. Second, issues have been raised with the Committee about the need for guidelines to ensure that volunteers are not asked to perform tasks which are not appropriate for volunteers or for which they are not properly trained or qualified. Comments on the latter category revolve around protecting the interests of the volunteers, of consumers and of paid staff.

10.56 The Committee has heard of significant variations in the level of reimbursement of out of pocket expenses for volunteers. Meals on Wheels is delivered with a huge contribution by volunteers. The National Meals on Wheels

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6 ibid, pp ix-x.

Association is concerned about the level of reimbursement of expenses for volunteers. The Queensland Meals on Wheels Association presented the following statement to the Committee on behalf of the National Association:

> "Having regard to the increasing cost of fuel, the decreasing income of retirees, and the enormous contribution of both retirees and other persons of limited income, in the delivery of Meals on Wheels; that Home and Community Care (HACC) guidelines provide for the reimbursement of actual out-of-pockets paid by individual Meals on Wheels services in respect of volunteers."(Queensland Meals on Wheels Association: Transcript of evidence, p 1788)

10.57 The Queensland Meals on Wheels Association cited the following example of variations in reimbursement of volunteer vehicle expenses:

> "... Meals on Wheels deliveries in the ACT are being reimbursed at the rate of 49c a kilometre... in Queensland we get nothing."(Queensland Meals on Wheels Association: Transcript of evidence, p 1789)

10.58 In discussing reimbursement of out of pocket expenses, it must be noted that some volunteers do not seek reimbursement. A representative of the Volunteer Centre of WA, for example, said:

> "We pay the local government rate of about 35c a kilometre, depending on the engine size of the car. It has been my experience that only about two per cent of my volunteers actually want to take the reimbursement. However, HACC certainly gives me enough money to reimburse them for that."(Volunteer Centre of WA: Transcript of evidence, p 2365)

10.59 The Committee considers that, while many volunteers may not seek or require reimbursement of expenses, the HACC Program should ensure that they have access to a reasonable level of reimbursement, at a consistent level, should they wish to do so. **It is, therefore, recommended that the Commonwealth Department of Human Services and Health in consultation with State, Territories and local government and interested organisations, develop a national policy on the reimbursement of volunteer out of pocket expenses and fund projects which involve volunteer input accordingly.**

10.60 The more general question of support and recognition of volunteers has been raised by many organisations. There is a general feeling that the value of volunteers to the HACC Program is not acknowledged and that services which are supported by volunteers are not always funded appropriately to provide the support and training which volunteers need.

10.61 A service which relies on volunteers and has a part-time paid coordinator said, on this issue:

> "The main thing is to give our volunteers the support and the resources they need and to build some sort of cohesive group rather than just using volunteers. We do not talk about `using our volunteers' but actually `working with our volunteers'."(Hunter Combined Caring Groups: Transcript of evidence, p 1576)

10.62 This view was supported by the Macarthur Community Care Forum, which said:

> "Funding needs to be put into the basic training of volunteers as to what is expected of a volunteer, what their rights are as a volunteer, what they can expect back from that service and how they can be part of that service... that does involve time and hours by the service coordinators and it is often hard to find that time.(Macarthur Community Care Forum: Transcript of evidence, pp 487-488)

10.63 The evidence regarding the need for recognition and support of volunteers within the HACC Program has been consistent. **The Committee recommends that the Commonwealth Department of Human Services and Health work with State and Territory governments to develop a policy on the funding of volunteer based services which recognises the need for adequate funding of service coordinators to enable appropriate support to be given to volunteers.**

10.64 The final issue in relation to volunteers is the lack of guidance for service providers and volunteers about appropriate roles for volunteers, duty of care and the liability of volunteers in certain situations. The Australian Liquor, Hospitality and Miscellaneous Workers Union stated its concerns in the following terms:

> "We have no philosophical opposition to volunteers. It is a question of the quality of service, the control over the work that is provided, the

employer-employee relationship, and who is responsible for things that go wrong. If I am a volunteer where do I stand in the pecking order in terms of whether I am responsible for damage–all those sorts of issues, workers compensation, et cetera? They are all issues that concern us about volunteers who in all good faith go in to do a good job and who have everyone's best interests at heart."(Australian Liquor, Hospitality and Miscellaneous Workers Union: Transcript of evidence, p 214)

10.65 The Volunteer Centre of WA raised a similar concern:

"Any community organisation that is authorising volunteers to undertake tasks has an obligation to ensure that those tasks are carried out correctly, without negligence and with all reasonable care... they have offered the client the service and the client sees the agency as providing the service, not the volunteer. If negligence occurs... then a common law duty of care exists. Coordinators and people authorising these things need to take reasonable steps to ensure that that duty of care is carried out."(Volunteer Centre of WA: Transcript of evidence, p 2352)

10.66 **The Committee recommends that the Commonwealth Department of Human Services and Health and State and Territory governments work with service providers and volunteer agencies to develop a protocol for the conduct of volunteers, guidelines for the types of tasks which volunteers may appropriately carry out and any legal issues, including insurance coverage and public liability, associated with volunteerism in the HACC Program.**

CHAPTER 11

QUALITY ASSURANCE

11.1 The HACC Program quality assurance strategy comprises of the Guidelines for the HACC National Service Standards, the HACC Program Statement of Rights and Responsibilities, the HACC Program Complaints Policy and associated service provider training.

11.2 The Commonwealth Department of Human Services and Health said:

> "A commitment to quality of care and consumer rights has been actively pursued in the HACC Program since 1988, when HACC Ministers agreed on the need for a quality assurance strategy... based on a two tiered approach of providing information and training for service providers to assist them to deliver a high quality service, and *providing information and education for consumers to help them* understand and exercise their rights in the Program."(DHSH: Volumes of submissions, p 290)

11.3 While there is a high level of community support for the HACC Program and an obvious commitment on the part of service providers to high quality services, issues relating to quality assurance have been raised by both providers and consumers. The major issues are: the extent of implementation of the HACC Program Statement of Rights and Responsibilities; whether or not service standards should be mandatory; the adequacy of existing complaints resolution mechanisms; and the role and availability of advocacy in the HACC Program.

CONSUMER RIGHTS

11.4 The HACC Statement of Rights and Responsibilities was released in 1990. It sets out the rights and responsibilities of consumers and the responsibilities of service providers within the HACC Program. In addition to the Statement, the Program has produced a brochure for consumers which explains the contents of the

Statement in plain English. Both the Statement and the brochure have been translated into community languages.

11.5 The Committee is concerned about the apparent lack of awareness of the Statement of Rights and Responsibilities among consumers and, in some cases, service providers. Few consumers or consumer representatives who contacted the Committee were aware of the Statement or its contents. Many consumer groups said that consumers are not aware of the Statement and that the consumer brochures are not readily available. This is of serious concern in view of the fact that the Statement was launched almost four years ago and large numbers of copies of both the Statement and the brochures have been distributed to State and Territory governments to provide to services and consumer organisations. A further issue is the lack of action to implement the consumer rights requirements beyond simply distributing the Statement. The Alzheimer's Association of Australia said, in relation to the implementation of consumer rights measures:

> "Related to that is the rights mechanisms and the complaints mechanisms. Again, we are fairly concerned because there has not been much progress in developing that so far."(AAA: Transcript of evidence, p 247)

11.6 The Alzheimer's Association went on to say of the user rights documentation:

> "We are aware that they are available but it is difficult to know how they are followed through... It is going to the service providers who will choose to do with it as they wish."(AAA: Transcript of evidence, p 247)

11.7 It is apparent that service providers in some cases are not fully aware of what is required of them in regard to consumer rights and the provision of information to consumers. One service provider said:

> "The whole service has the user rights policy. But, I guess, in some ways, we have our policies and we are supposed to make our clients aware about having the policies. Frequently, the type of client group that we are dealing with does not always think to ask the questions, so we do not always make them aware of what is available."(Lake Macquarie City Council: Transcript of evidence, p 1459)

11.8 Some of these difficulties are clearly related to the fact that the Guidelines for the HACC National Service Standards have not been implemented fully in all States. The Standards will provide a clear framework for the implementation of the user rights policies. In Tasmania, which has made considerable progress in the implementation of the service standards, there was a much higher level of awareness of consumer rights with a number of service providers demonstrating a commitment to consumer rights. A nursing service in the north of the State said:

> "As far as I am aware, anybody with a first referral to any HACC service in the north receives the HACC rights and responsibilities pamphlet."(Community Nursing, Northern Regional Health: Transcript of evidence, p 985)

11.9 A rural service provider in Tasmania, while using the consumer rights documentation, raised the issue of its appropriateness for consumers:

> "When I assess and accept clients, I always give them a copy of the rights and responsibilities. I find that they are really difficult for people to understand-even for me at times-and I think there is about one column on the last page that they would be able to sit down and really understand what it is all about."(Derwent Valley Lower Midlands District Health Forum: Transcript of evidence, p 1207)

11.10 While the Committee accepts that implementation of the National Service Standards will assist in the implementation of the Statement of Rights and Responsibilities, the Statement and brochure should at least be disseminated to service providers and consumers. The Statement has been available publicly since 1990 and consumers should be able to benefit from knowing their rights.

11.11 **The Committee recommends that the Commonwealth Department of Human Services and Health review the extent to which the HACC Statement of Rights and Responsibilities has been distributed to service providers and consumers and the extent to which service providers advise consumers of their rights. It is further recommended that the Commonwealth Department of Human Services and Health negotiate with States and Territories to ensure immediate dissemination of this material, where it has not occurred, and to ensure that service providers are aware of their obligation to inform consumers of their rights and to operate their services in accordance with the rights and responsibilities contained in it.**

COMPLAINT RESOLUTION PROCESSES

11.12 The question of mechanisms for resolving consumer complaints about HACC services was a major feature of the Inquiry. Concerns centred on consumer fears of retribution if they complain about services, lack of knowledge among consumers of their right to complain and lack of an independent mechanism to deal with consumer complaints.

Current Situation

11.13 All HACC service providers should have a policy for dealing with consumer complaints and consumers should be advised of this policy. The HACC Program released a Complaints Policy in May 1992. The policy is linked to the National Service Standards and is intended to "help ensure that consumers have access to fair and equitable processes for dealing with complaints and disputes in the Program."(DHSH: Volumes of submissions, p 291) The Program has also developed a service provider training package for managing complaints. The package is to be implemented by State and Territory governments as part of their training schedule for the standards implementation.

11.14 The Complaints Policy states that State and Territory governments are responsible for the development of independent procedures for dealing with complaints and for publicising these to consumers and service providers. The Policy also notes that where State and Territory agencies are the service provider, consumers may approach the State or Territory Minister or an independent body where such a body exists.[1]

11.15 There is, however, very limited knowledge of the existence of the complaints policy or of the right to approach the State or Territory Minister. Mechanisms which may be able to provide an independent complaint resolution avenue for HACC are being developed in a number of States. In some cases, such as the proposed Community Services Commissioner in NSW, these mechanisms have specific coverage of HACC complaints. In others, such as the health complaints tribunal being considered in Tasmania, HACC is not currently within the proposed scope. At present, most HACC consumers do not have access to independent

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[1] Home and Community Care Program Complaints Policy, 1992

complaints mechanisms and there is no consistent approach within the Program to ensure that they do.

11.16 There are concerns about the extent to which service providers have developed complaints procedures within the service itself, the effectiveness and accessibility of these procedures and the extent to which consumers are aware of them. An advocacy worker in Victoria, for example, supported the development of good grievance procedures by service providers and said:

> "As far as complaints procedures are concerned, not many places have them in writing stating quite clearly what the procedures are. Where they do have them the procedures can be quite onerous because they have to go through so many steps, et cetera... I do not think that service providers see the value that a good complaints policy can have as far as improving their service, making everybody's lot better and making life easier for both the consumer and the provider."(HACC Ethnic and Disability Advocacy Workers Group: Transcript of evidence, p 751)

11.17 The response of service providers to complaints made directly to the provider was raised by a consumer representative:

> "I know of instances where there has been a complaint about, say, a HACC worker where, when the home help supervisor has been rung about the problem, the answer has been, 'But I have only good girls'. So at that point it is cutting off the complaint, and I think that is the process that is very bad if we are looking at a system of allowing older people and disabled people to be able to express their concerns."(CFA VIC: Transcript of evidence, pp 736-737)

11.18 An advocacy service in Western Australia which deals with HACC services and residential aged care also spoke of problems with service provider level procedures:

> "We have had quite a few particularly difficult and protracted disputes that have arisen when a consumer has raised a complaint and the staff have become very defensive. In one case the union was brought in immediately. One of the cases that I cited was where a person demanded a retraction and an apology. Unfortunately, the way the place had been set up and incorporated it did not have appropriate structures in place to deal with the staff."(Older Persons Rights Service, WA: Transcript of evidence, p 2161)

Consumer Fears

11.19 The Australian Pensioners' and Superannuants' Federation stated that:

> "Something very dear to our hearts are the user rights and complaints mechanisms... There is a problem about complaining, particularly for older people complaining. They see that if they complain they might lose the service altogether, particularly if they have been talking to a neighbour who has lost it for some other reason. But not knowing where to complain, how to complain, in fact not even knowing that they can complain without retribution is something that needs to be addressed."(APSF: Transcript of evidence, p 85)

11.20 A representative of advocacy workers in Victoria also commented on the reluctance of consumers to complain:

> "I think they are apprehensive about what the outcome will be. And I think providers, in the main, do not look favourably on people who complain. They are seen as a nuisance more often than not... Where they do exist, a lot of written grievance procedures, for example, ask people to negotiate with the person with whom they have the complaint. Some people are too frightened to do that because of what might happen to them. If they do bring up something they might be shouted at so they prefer to go higher up."(HACC Ethnic and Disability Advocacy Workers Group: Transcript of evidence, p 751)

11.21 This fear of retribution for complaining was raised consistently by consumers, consumer representatives and some service providers across the country. It was also acknowledged by service providers, who are aware of the apprehensions of consumers but have not been able to find a solution to the problem. While the Committee has not seen any evidence of services being withdrawn or of consumers suffering retribution for complaining, the fear of consumers that this will occur can not be ignored.

Independent Mechanisms

11.22 There is overwhelming support among consumers for the establishment of independent complaints mechanisms. Service providers and State governments have also expressed support for the concept. There is a concern, however, that these mechanisms should not consume large amounts of resources, they should not be

bureaucratic, they should have 'teeth' and they should not duplicate existing mechanisms.

11.23 The views expressed to the Inquiry could be summed up by the comments of one Tasmanian service provider:

> "Given that people have fears that are real to them, the more options they have, the better. If I ring the supervisor, what will I get? Is it better to ring somebody who is outside the service? People ought to have a range of options if they have an issue or a complaint." (Community Nursing, Northern Regional Health: Transcript of evidence, p 985)

11.24 **The Committee recommends that the Commonwealth Department of Human Services and Health, in consultation with State and Territory governments, local government, consumers and service providers, ensure that HACC consumers have access to independent regionally based complaints mechanisms by building on existing mechanisms to ensure that they have a mandate to investigate complaints in relation to HACC and by establishing separate mechanisms where suitable institutions do not exist. The independent mechanisms should have the following features:**

- **they should be completely independent of HACC service providers;**
- **they should be accessible and non-threatening to consumers, be informal and be well-publicised;**
- **there should be no requirement that consumers approach the service prior to accessing the independent regionally based mechanism;**
- **they should have a conciliation and mediation focus but have authority to direct HACC service providers to respond to complaints and to make changes in service provision where necessary;**
- **they should have the capacity to respond quickly; and**
- **they should encourage and facilitate the involvement of an advocate (formal or informal) by the consumer.**

11.25 **The Committee also recommends that the Commonwealth and the States ensure that all HACC service providers have a formal complaints procedure in place, that it is accessible and understandable to the target group and that all consumers are made aware of it, including those who are refused access to a service.**

SERVICE STANDARDS

Current Situation

11.26 Issues raised with the Committee regarding the National Service Standards fall into several categories. There is a fear among service providers and consumers that implementation of the National Service Standards will involve a large amount of service provider time and resources, which will detract from service provision. On the other hand, there are concerns that the Service Standards are not mandatory and take the form of guidelines. There is a perception that the Program lacks a clear implementation strategy with individual States and Territories responsible for implementation.

11.27 The Guidelines for the HACC Program National Service Standards were launched in December 1991. According to the Commonwealth Department of Human Services and Health:

> "The standards build on the foundation of the Statement of Rights and Responsibilities by providing practical guidance to service providers on how to meet their responsibilities... The Standards are designed to help HACC funded services achieve both consistency and quality of service for consumers and monitor their progress in this regard."(DHSH: Volumes of submissions, p 291)

11.28 The implementation of the Standards is proceeding under the guidance of a Commonwealth and State and Territory Steering Committee which agreed that the Commonwealth would fund the development and publication of the Standards, associated documentation and training material. The States and Territories are responsible for the implementation of the Standards.

Implementation of Service Standards

11.29 The Commonwealth Department of Human Services and Health stated in relation to implementation of the Standards:

> "States and Territories are at different stages of implementation of the Standards. Some States and Territories (ACT, QLD, VIC, and TAS) have made considerable progress with training of service providers on the Standards, others, (NSW and SA) have taken some initial steps with introducing the Standards and others (WA and NT) are still working out their implementation strategy."(DHSH: Volumes of submissions, p 292)

11.30 State and Territory government action to implement the Service Standards is proceeding at significantly different rates. The Health Department of WA, for example, had developed an implementation plan to bring the Standards into effect in a staged manner over three years. However, the Department still has some reservations about the impact of the requirements of the Standards on service providers:

> "We have had a continuing concern, particularly with the smaller and less robust organisations, about bringing in the additional reporting standards which are so very important without being able to at least offer them the prospect, at the end of the tunnel, of actually being able to reduce some of the input reporting and controls... It would probably be ideal if we could flag to them that those input reporting standards may be relaxed when the outputs are more clearly defined in terms of quality and their outcomes."(HDWA: Transcript of evidence, p 2095)

11.31 Implementation in Victoria is much more advanced, as outlined by the Victorian Department of Health and Community Services:

> "The implementation of standards I think is progressing very well in Victoria. We started probably as early as anyone in Australia to do it. We are really working on a two- to three-year strategy to fully implement the standards in Victoria and the accreditation of HACC agencies could be one of the final steps in the process. We have not definitely formed a view as to whether accreditation is a necessary step but it will certainly be considered."(DHCS VIC: Transcript of evidence, p 663)

Guidelines or Mandatory Standards

11.32 The Service Standards as presently constituted take the form of guidelines for service provision to be supported by training for service providers and monitored through service reviews and a self assessment tool developed nationally. This causes considerable concern among consumer organisations.

11.33 The Commonwealth Department of Human Services and Health has advised that the Standards will be gazetted, which will give them a more formal status where the State or Territory government has a service agreement with service providers which requires the service to be provided in accordance with the HACC National Guidelines. The Commonwealth Department of Human Services and Health anticipates that the Steering Committee responsible for the implementation of the Standards will agree to the insertion of a clause in all service agreements which requires the incorporation of the Standards in the day to day operation of the service. There are no plans in place for accreditation of services.[2]

11.34 There is a strong and consistent view among consumer organisations and some service providers and governments that the HACC Program requires mandatory quality assurance standards with a reasonably rigorous monitoring system to ensure quality services and recognition of the rights of consumers.

11.35 The HACC Ethnic and Disability Advocacy Workers Group in Victoria supported the concept of mandatory standards and said:

> "... we think it is great to have a document that makes people look at those objectives and base a service about them. However, as advocacy workers we are concerned that they are not enforceable, and there needs to be some sort of accountability written into service agreements... to say that they have some sort of binding agreement so they have to make sure those standards are enforced... Currently there is no way that service providers are being made accountable for not abiding by the standards. We think it is a severe deficit within those standards."(HACC Ethnic and Disability Advocacy Workers Group: Transcript of evidence, pp 749-750)

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2 Mr W Bruen, Assistant Secretary, Community Care Branch, Department of Human Services and Health, Correspondence, 9 December 1993.

11.36 The Social Policy Research Centre of the University of New South Wales, which has conducted various studies and research into community care in Australia and overseas, stated:

> "With regard to standards of responsibility, we are talking about qualifications of staff and quality of care provided. It is a mystery to me why standards should be so emphasised in many areas of our society and absolutely absent in this particular field. I find it quite incomprehensible. I cannot say that we have uncovered a great deal of neglect or mistreatment because of this absence of standards. Nevertheless, I think that it would be offering a security to people to know that the standards were in place. I believe it would be a real enhancement of the system and would, in a sense, move the HACC program from its historical basis as a slightly amateurish sort of add-on to the system to being part of the system. I believe it is part of that evolution and would be very valid."(SPRC: Transcript of evidence, pp 230-231)

11.37 It is apparent that there is support for a stronger approach to service standards among service providers as well as consumer organisations. Aged Care Australia, a peak provider organisation which represents residential care providers as well as community care services, said:

> "We believe the better approach is to move towards a quality assurance model that would embrace the outcome standards for nursing homes and hostels as a basic minimum. We would think the same thing would apply in community based services-a quality assurance program based on minimum outcome standards."(ACA: Transcript of evidence, p 2931)

11.38 The NSW government also expressed cautious support for a mandatory approach leading to accreditation of service providers in the longer term:

> "I think to begin with we should get the sector skilled up and not threatened by the process, but we should certainly move down the path of accreditation and minimum service levels... so that consumers are guaranteed of adequate service delivery. But we need to be very sensitive about how that is implemented, recognising that a large proportion of people who provide service within this sector are volunteers. We need to make sure that we do not compromise that involvement as a consequence of some zealot-like approach to this issue."(DOCS: Transcript of evidence, p 27)

11.39 The Public Forums conducted during the Inquiry were generally supportive of mandatory standards. There was general agreement that some form of mandatory standards are desirable. The favoured approach was for mandatory minimum standards. Service providers could build on these to further improve service quality. Forum participants supported a gradual implementation process with training and education for service providers.

11.40 Comments in support of mandatory standards included:

- Consumers support mandatory quality assurance with sanctions for failure to comply;
- Mandatory standards promote consumer confidence as consumers know what they can expect from HACC services;
- Mandatory standards can also assist service providers by stating clearly what is expected of service providers;
- The HACC Program exists for consumers and implementation difficulties from provider perspective should not prevent effective quality assurance; and
- Quality does not depend on funding levels;

11.41 Concerns raised in the Forums about mandatory standards included:

- Quality assurance goes beyond the implementation of service standards;
- Mandatory standards must be unambiguous and there may need to be variations for different size and capacity of services otherwise flexibility may be reduced;
- Quality is related to resources;
- Outcome standards can restrict access for complex clients for whom positive outcomes are difficult to achieve;

- Residential care standards have produced an industry to interpret and find ways around standards; and

- It is inappropriate to consider introducing mandatory standards at a time when major change in the Program is likely.

11.42 On balance, the evidence available to the Committee suggests that the interests of consumers and the objectives of HACC would be best served by mandatory service standards. **The Committee recommends that the Program implement mandatory outcome standards. This implementation should proceed in a staged manner and build on the work already conducted to implement the Guidelines for the HACC Program National Service Standards. The implementation must include continued development and provision of service provider training and take account of the varied nature of HACC service providers and their capacity to implement the standards.**

11.43 **The Committee further recommends that sanctions, such as transfer of auspice or defunding, for non-compliance be available as a final option. The preferred way of dealing with failure to meet standards is through negotiation and training.**

Standards Monitoring

11.44 The monitoring of services against the Standards is the responsibility of State and Territory governments. The Commonwealth Department of Human Services and Health outlined the approach to monitoring in the following terms:

> "The Commonwealth is not responsible for monitoring the implementation of the Service Standards within States and Territories. However, the Commonwealth has developed mechanisms to assist with the monitoring of Standards in HACC funded agencies.
>
> These mechanisms include:
>
> - 'Measures of progress'... in the National Service Standards so that agencies can directly measure their progress with implementation of the Standards against consumer outcomes; and

> a review document for States and Territories to monitor implementation of the Standards... The Review Form requires detailed information about what individual agencies have been able to achieve, what remains to be done, and what the priorities are for the coming year...
>
> This Form incorporated into a reasonably rigorous service review process, will enable State and Territory governments to adequately
>
> monitor and review the quality of care provided through services to consumers."(DHSH: Volumes of submissions, p 292)

11.45 The Committee heard from the Tasmanian government and from the Australian Community Health Association (ACHA) about an approach to monitoring quality of HACC services which has been piloted in Tasmania. The approach uses a model of service review based on the Community Health Accreditation Standards Project (CHASP). The Tasmanian Department of Community and Health Services said of the CHASP approach:

> "So far we have conducted three evaluations with remarkable success by adopting the community health accreditation standards program, or CHASP, and adapting it for the HACC program. We use the national HACC standards and the CHASP process of working with organisational representatives and consumers of services to form a committee, go through the HACC standards and compare the services' progress against those standards in an interactive way... We believe that it has tremendous application. We hope that it will... be something of a model nationally."(DCHS TAS: Transcript of evidence, p 1128)

11.46 The ACHA which is responsible for the CHASP model and was involved in its adaptation for HACC and the Tasmanian pilot described the CHASP process as adapted for HACC in the following terms:

> "They require a review team to be with the service for about two days looking into all aspects of that service. The review team usually consists of three people, one... from the service itself, two... from outside that immediate service... Essentially these people are drawn from a pool of trained reviewers who are either volunteers with HACC services, who work in HACC services, who are on committees of management or in some way related with HACC... the review team comes in for a couple of days... and presents them with a report and a series of recommendations for improvement of that service. So we hoped to set up a cycle of continuous improvement, usually on a three-yearly basis." (ACHA: Transcript of evidence, pp 2861-2862)

11.47 A common concern about service reviews whether in the context of the service Standards or more generally is the cost of conducting reviews and the time consuming nature of the process for service providers. Many reviews are carried out by consultants and can be quite expensive, both in terms of the financial cost and the resources required to establish and supervise a consultancy. The ACHA discussed this issue:

> "The project actually arose because the HACC service in Tasmania got a number of complaints about the present evaluation process: that it was costly, time consuming and a fairly negative process for people involved. So they asked us to help design a process that would eventually be self-sustaining and is a positive development of the organisation. I think we have managed to do that to their satisfaction. Needless to say, you need some input of resources to get them started."(ACHA: Transcript of evidence, p 2862)

11.48 The Committee is impressed by the CHASP approach and its apparent success in Tasmania. **The Committee, therefore, recommends that the Commonwealth Department of Human Services and Health, in conjunction with States and Territories, service providers and consumers, pilot the CHASP model in other States and Territories with the view to implementing it as the service review model and standards monitoring tool across the Program.**

11.49 **The Committee also recommends that the aggregated results of service reviews form part of the measurement of the performance of the Program as a whole through the HACC Program Outcome Indicators.**

ADVOCACY

11.50 A number of witnesses have raised the issue of advocacy as being critical to quality assurance and consumer rights in the HACC Program. It is often asserted that consumers can not be assured of high quality services or of respect for their rights unless they have access to the support of an advocate.

11.51 The HACC Program does not have a statement of policy in relation to advocacy services or the role of advocates in the HACC Program. The Program does fund advocacy services but the role and function of these services vary, with some providing information or mediation rather than direct consumer advocacy support.

The HACC Program Statement of Rights and Responsibilities and the National Service Standards refer to the right of consumers to involve an advocate at any stage of their dealings with HACC services. An advocate may be a formal advocate provided through an advocacy service or an informal advocate, including a friend, a relative or a carer.

11.52 A number of witnesses spoke about the need for advocacy in the HACC Program. For example, a consumer organisation said:

> "The role of advocacy services is not peripheral to a service system, rather it is an integral part of it. Complaints mechanisms and information services have a role... The terms advocate... and advocacy needs to be clearly defined. The advocacy role is very specialised. The provision of information, advice or referral should not be considered advocacy. There have been claims that service providers have staff that perform the role of advocate, without consideration of the conflict of interest that this would generate: ie. there is often a conflict of interest where a staff member has obligations to fellow staff and to the employing body, so that they cannot perform as effectively as an independent advocate."(Council of Pensioner and Retired Persons Associations Inc: Transcript of evidence, p 1913)

11.53 The SA HACC Advisory Committee raises a similar view:

> "It immediately brings into question things like an adequate advocacy service—and I know that is mentioned in a lot of submissions. I believe an advocacy service ought not be a little thing over there. It should be an integral part of a package of user rights, because otherwise you have just got a piece of paper. I believe that things like assertiveness training for young disabled and the frail elderly... are an essential part of this package. I believe that adequate information about what user rights are—and it is better handled than any aspect of it, by the way—is also an essential part of a package."(SA HACCAC: Transcript of evidence, p 1901)

11.54 The Committee accepts that access to advocacy and acceptance by service providers of the consumer's advocate are essential to any quality assurance or consumer rights strategy. The HACC Program lacks a consistent approach to advocacy, or even consistent definitions of advocacy and the role of advocates.

11.55 **The Committee recommends that the Commonwealth Department of Human Services and Health, in conjunction with States and Territories, develop a HACC advocacy policy which includes:**

- **a clear statement of the role and definitions of advocacy to apply under the Program;**

- **a policy on funding advocacy services and the scope and functions of these services;**

- **a statement of the right of the consumer to choose and involve an advocate at any stage of their dealings with HACC services, not just in the context of a complaint or dispute; and**

- **the distinction between advocacy and other services like information, referral and mediation services.**

CHAPTER 12

SERVICE AVAILABILITY, PLANNING AND ADMINISTRATION

GAPS IN SERVICE TYPES

12.1 Witnesses have called for the HACC Program to be more responsive to community needs by introducing new service types and administering existing service types more flexibly. The issues associated with flexible service delivery were discussed in Chapter 5 and Chapter 10. The introduction of new service types has been canvassed at several public hearings.

12.2 While many witnesses identified gaps in the range of services available under the Program, there was also a recognition that the advent of the HACC Program had led to an increased and more responsive range of services. NCOSS, for example, said:

> "The advantages of the HACC program bringing it together, pulling it together, and looking at what the gaps were in service types have allowed that growth of new service types like community options that may never have sprung up if there had been a haphazard approach, a purely natural evolution to the whole system of home support services."(NCOSS: Transcript of evidence, p 106)

12.3 While many gaps in available service types were raised with the Committee, a number were highlighted as being particularly important to the capacity of members of the target group to remain living in the community.

12.4 A number of witnesses raised the need of many elderly people and younger people with disabilities for assistance in managing medication at home and the impact the absence of such support can have on the capacity of the individual to manage at home. APSF, for example, stated:

"And help with medications is also quite critical... Perhaps there is a need to look at that in the overall scheme of things. It might just be that the community nurse has an arrangement with a local pharmacist to fill in a week's supply in one of those boxes they can get with separate sections for every day for the tablets, or whatever. But something is necessary to help people ensure that they take the correct medicines at the correct time... The sorts of problems that can arise, when they do not take them correctly or have problems or there are adverse drug reactions, are really going to affect their ability to cook for themselves, or their ability to get out, or it will affect their level of confusion and depression."(APSF: Transcript of evidence, pp 102-103)

12.5 Medication management problems are not confined to the elderly. Younger people with disabilities also experience difficulties in gaining access to services to assist with medication. The HACC Ethnic and Disability Advocacy Workers pointed out:

"Those people are totally missing out on services because, if the general home care workers provided services to those people, if they have to administer medication, the home care worker is unable to do that. So they are unable to use that service. Some councils do have nurses who can come in and do that but not every council has that so those people are unable to access that sort of service."(HACC Ethnic and Disability Advocacy Workers: Transcript of evidence, p 753)

12.6 An Aged Care Assessment Team advised the Committee that in some instances, nursing services are being utilised for the supervision of medication:

"The frail aged mostly do need a domiciliary nursing service. We have domiciliary nurses that we ask to go in just to supervise medication, for example."(Gold Coast ACAT: Transcript of evidence, p 1648)

12.7 The Pharmacy Guild of Australia made a detailed submission to the Inquiry recommending a role for consultant pharmacists in medication management and review for members of the HACC target group. The Guild proposed that HACC fund such services which would be subject to accreditation and registration through a national pharmacy registration authority. In its submission, the Guild said:

"There is an urgent need for medication management and review services to be provided by consultant pharmacists, attached to community pharmacies and working in liaison with prescribing doctors, to the frail aged and the disabled living in the community in Australia."(Pharmacy Guild of Australia: Volumes of submissions, p 156)

12.8 The problems faced by the elderly in relation to medication have been well documented. The Committee supports the view that many HACC consumers could benefit from assistance in this area. The Committee considers that the development of HACC services of this nature would further both the existing HACC objective and the revised objective recommended in this report.

12.9 **It is recommended therefore, that the Commonwealth Department of Human Services and Health, in conjunction with the States and Territories, develop a new service type under the HACC Program for the provision of medication review and management services. It is further recommended that the Commonwealth Department of Human Services and Health liaise with the Pharmacy Guild of Australia in developing this service type and fully investigate the legal aspects, relationship with existing HACC services, accreditation and training issues.**

12.10 The Inquiry has been told of a range of other service types which are needed by members of the HACC target group but are not within the scope of existing service types or only provided on a limited basis. These have included:

- Services to assist consumers with the installation and use of support systems, such as personal alarms or monitoring systems which enable the consumer to call for assistance in an emergency through a push-button pendant and a telephone or which allow regular contact by a service provider to monitor the health and safety of the consumer. The Committee is aware of a project in Victoria which is funded under HACC and provides the equipment required and maintains a monitoring service using volunteers during the day and links into the services of a commercial supplier of these services overnight. The project has achieved good results;

- Dental services in rural areas;

- Appropriate day time support for younger people with disabilities for whom neither existing respite arrangements nor the employment services available under disability support programs are suitable; and

- Evening and weekend services of various kinds including meals, respite, home help and personal care.

12.11 It is not possible to draw definitive conclusions from the evidence available to the Committee about the extent to which new service types are required to meet the community care needs of the HACC target group. It is apparent, however, that there are service needs which can not be met through the existing range of service types.

12.12 **The Committee recommends therefore, that the Commonwealth Department of Human Services and Health in conjunction with State and Territory governments, investigate the need for additional service types under the HACC Program. This investigation should make use of the input of the regional, State and national advisory structures recommended later in this Chapter.**

STRATEGIC AND NEEDS BASED PLANNING

Demand and Supply

12.13 Most concern about gaps in the availability of HACC services actually relates to the levels of service available and to the availability of service types in particular areas. There is a consistent perception among service providers and consumers that the HACC Program is inadequately resourced to meet existing needs for community care and that it is not well placed to respond to the challenges which are likely to arise from the ageing of Australia's population into the next century.

12.14 As noted in Chapter 4, there is an existing level of unmet need for HACC services. While the extent of that unmet need is difficult to assess on the basis of existing data, it is likely to grow as the need for HACC services increases, unless mechanisms are put in place to improve the Program's capacity to plan for and fund growth in services. The concerns of the community about the availability of HACC services are evident in the comments cited in Chapter 5 about targeting of HACC services, tightening of eligibility criteria and rationing of services.

12.15 It has been suggested that improved needs based planning and strategic planning are necessary to reduce unmet need and allow the HACC Program to improve the match between demand for and supply of community care and the distribution of that care. These improvements will also improve the quantification and visibility of unmet need, strengthening arguments for adequate resource levels

for community care. These improvements will be supported by the data which will be obtained from the Regional Community Assessment Agencies about the extent to which assessed needs are able to be met within each region.

Existing Approaches to Planning

12.16 In its submission to the Inquiry, the Commonwealth Department of Human Services and Health detailed the strategic and needs based planning approach adopted by the HACC Program. The Commonwealth Department of Human Services and Health said, of strategic planning:

> "The role of strategic planning at a macro level is to distribute the finite resources available against priority areas of need, on both a geographical and type of service basis. Strategic planning for the Program also aims to bring together a range of strategies to maximise the efficiency and effectiveness of the Program."(DHSH: Volumes of submissions, p 270)

12.17 The current strategic planning approach as described by the Commonwealth Department of Human Services and Health involves a National Triennial Plan, which provides a published statement of the goals and agreed directions and priorities for the Program nationally. The National Plan provides a framework for the development of State and Territory Triennial Plans and annual Business Reports. The annual Business Reports form the basis for funding decisions, policy implementation and service development activities in the Program to implement the jointly agreed objectives of the National Plan. This approach has been implemented from 1993-94. The Commonwealth Department of Human Services and Health went on to state in its submission that:

> "The Reports are also to include funding priorities identified through a needs-based planning methodology. The Reports will use data supplemented by information provided by the HACC Advisory Committee, and agreed by Commonwealth and State and Territory officers."(DHSH: Volumes of submissions, p 271)

12.18 The Commonwealth Department of Human Services and Health advised further that all States and Territories have developed needs based planning approaches and stated that:

"The focus of existing needs based planning models is to achieve financial equity between regions through the allocation of available growth funds. The purpose of this allocation is to address gaps that may occur between the existing distribution of HACC funds and the estimated ideal distribution of funds based on the HACC target group."(DHSH: Volumes of submissions, p 272)

12.19 These planning structures are supported by State level HACC Advisory Committees which advise governments on broad priorities and policy issues. Some States have established local and regional HACC Forums to advise on priorities, local issues and needs while others have not. The extent to which the local and regional structures influence the planning process is also variable. The role of advisory structures is discussed later in this Chapter. The Committee notes at this point, however, that local and regional level input into the strategic and needs based planning processes is essential.

12.20 There is, however, some doubt in the community about the effectiveness of existing needs based planning in the HACC Program and the extent to which they allow local or regional input from service providers and consumers.

12.21 Aged Care Australia spoke in the following terms of what is required in the development of effective needs based planning for HACC:

"We need to establish what we have got and where we should be heading. It is very hard at the moment, anywhere across Australia, to try to identify exactly what home help, nursing and personal care we have got. When we decide where it is we should be heading, it should only be used as a guide, and that is all a benchmark should be. It should not be a fixed thing because it might not be right. Once we have identified that, we should then look at getting a good balance. It would need to be based on prospective research and that may take two or three years to do. We can then ask: How are we going? Is it starting to meet the needs of people?"(Aged Care Australia: Transcript of evidence, pp 2941-2942)

12.22 A Regional HACC Forum expressed concern about a lack of feedback to the community in the planning process:

"... if it were an open planning process rather than what we have at the moment, which is a process where we are asked what we think and then we do not get feedback afterwards. We also do not get to view

what the regional plan is and what the priorities are."(South East Regional HACC Forum: Transcript of evidence, p 3170)

12.23 A common complaint from Regional Forums across NSW was that the work of Forums in identifying priorities is often ignored. The NSW Community Transport Organisation, for example, made the following comments about the identification of priorities:

> "... our chief means of doing that is through the HACC forums which, as you probably understand, are groupings of different HACC services which meet in their local area. We discuss, in cooperation with those people, the priorities for funding in those areas... Transport is generally seen by just about every HACC forum that I have heard of as being the No. 1 priority in the area. It is very puzzling to us to see that that is not reflected in the decisions made on funding."(CTO: Transcript of evidence, p 276)

12.24 The South Australian HACCAC gave strong support to the need for regional or local level input into planning processes:

> "We had very strong feedback from each consultation that there ought to be more regionally based planning. You heard Jan Lowe this morning describing the way that family and community services sees that happening. I do not know the details of it but I am damn sure that this state, in its HACC program, has to return to local input into the planning process."(SA HACCAC: Transcript of evidence, p 1890)

12.25 **The Committee recommends that the Commonwealth Department of Human Services and Health ensure that State and Territory needs based planning models incorporate effective local and regional planning mechanisms and opportunities for advisory bodies, to be established in line with recommendations later in this Chapter, to have an effective role in strategic planning and needs based planning.**

12.26 **The Committee further recommends that the Commonwealth Department of Human Services and Health ensure that State and Territory planning models provide for feedback to the community about the contents of State and National Plans and the outcomes of planning processes in which Forums have participated.**

12.27 **It is also recommended that needs based planning models take account of the range of data available including ABS data, local data collections including local government material and data from Regional Community Assessment Agencies. Planning must also take account of existing services which impact on the needs of the target group in each region including those provided under disability programs, other aged care programs, State government health and welfare programs, local government and voluntary projects.**

12.28 Despite the existence of needs based planning models and advisory mechanisms it appears that funding under the HACC Program continues to be largely submission based. In Tasmania, for example, the Committee was told consistently that transport services were a major need in the community. A local government community services officer in northern Tasmania, for instance, said:

> "It just seems to me that we have got over 700 people in a municipality who do not have a transport service or any service and who could be using a transport service. I cannot get it–it is not through lack of trying–and I do not think that what we are asking for is illogical or nonsensical. I do not understand why some can have it and others cannot."(Georgetown and West Tamar Councils: Transcript of evidence, pp 1023-1024)

12.29 Orana Respite Care, another northern Tasmanian service provider also pointed to the need for transport services in the area:

> "Transport up our way is a huge problem because we have 110,000 people or whatever scattered over a third of Tasmania. We have two or three major centres of population which have about only 25,000 or so, but we have a fairly scattered hinterland of people in areas that have 7,000, 10,000 or 15,000 people. Getting transport for these people to get to just ordinary daily services can be a very difficult thing, even to go shopping and things like that. Transport would be one of the biggest single issues because of the cost of it. With petrol at 77c a litre down our way, that becomes a very expensive item."(Orana Respite Care: Transcript of evidence, p 1099)

12.30 The Tasmanian government representatives spoke of the needs based planning approach in Tasmania and agreed that community transport had been identified as a priority for 1993-94:

"Transport is a priority within the existing strategic plan and therefore is a priority for growth funds within this financial year. The major issue in terms of transport is unmet need."(DCHS TAS: Transcript of evidence, pp 1143-1144)

12.31 In response to questions about growth funds allocated to transport, however, the Department said:

"My recollection is that there were not very many applications for transport. There were some very big applications for other projects, but I do not recall very many applications for community transport."(DCHS TAS: Transcript of evidence, p 1147)

12.32 The Committee is concerned that while the Program employs a needs based planning approach to identify priorities in terms of service types and the regional distribution of services, the actual allocation of growth funds continues to be largely submission driven. An effective needs based planning approach can not rely on submissions for funding but should include a community development element which encourages the development of services to meet identified needs at the local level.

12.33 **The Committee recommends that the Commonwealth Department of Human Services and Health work with State and Territory governments to ensure that effective needs based planning models are in place which include a community development element to assist communities in developing services to meet identified needs or encourages existing large service providers to extend to areas of need.**

Benchmarks and Planning Data

12.34 In conjunction with the development of improved needs based planning approaches, the HACC Program has also moved toward the development of benchmarks or planning targets for the Program. This initiative is consistent with the recommendation of the Mid-Term Review of Aged Care:

"That a benchmark be set for the total level of resources allocated to community care, and that this benchmark be linked to the benchmarks

already established for nursing homes and hostels and be used as a basis for establishing equity across geographic regions." [1]

12.35 The Commonwealth Department of Human Services and Health noted in its submission that the concept of benchmarks for community care was first advanced in the First Triennial Review of the Home and Community Care Program. The Department explained that the Triennial Review argued that benchmarks or planning targets for HACC would enhance the capacity of the Program to plan for the demographic changes expected into the next century. The Triennial Review also called for improved data on the supply of HACC services in the community. The Commonwealth Department of Human Services and Health said of the development of benchmarks for community care:

> "The development of benchmarks in the Australian community care environment is complex. This is due to the difficulty in applying the concept to a very diverse Program and, until recently, the quantity and quality of data on service use and service need... This situation is, however, changing. There has been a significant improvement in the availability of detailed data on service provision and consumer numbers by service type, and, importantly, on the cost of producing services."(DHSH: Volumes of submissions, p 273)

12.36 High quality data on existing service provision and service usage is essential to an effective planning mechanism and to the development of benchmarks. As discussed in Chapter 10, the Committee considers that there is still significant work to be done in improving community care cost data. Similarly, the Committee considers that service provision and consumer data requires further work. The most recently published data is drawn from collections in 1990 and, for NSW, 1989 and contains a number of caveats regarding data quality. This reduces the usefulness of the data and may lead to service provider resistance to participating in collections where feedback is not forthcoming.

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[1] Commonwealth Department of Health Housing and Community Services, "Aged Care Reform Strategy Mid-Term Review 1990-91 - Report", AGPS, 1991, p 198.

12.37 **The Committee recommends that the Commonwealth Department of Human Services and Health ensure that HACC data collections are reviewed regularly to confirm their appropriateness and that data is published within one year of the completion of each collection to ensure its currency and usefulness in the planning framework. It is further recommended that the Commonwealth Department of Human Services and Health continue to work with States, Territories, local government and service providers to ensure the availability of high quality data.**

12.38 The Committee considers that the development of benchmarks or planning targets will be a valuable component of HACC needs based planning approaches. Benchmarks or planning targets are essential in the establishment of a rational base for the future funding of the Program and for linking funding growth with population changes. There were, however, some words of caution regarding this initiative. A witness from the Social Policy Research Centre, for example, said:

> "We were commissioned by the then Department of Health, Housing and Community Services to propose benchmarks and we could not find any around the world that really operated."(SPRC: Transcript of evidence, p 234)

12.39 The NSW government also expressed some concern about the complexity of the task:

> "I think we are also confronting a threshold issue in terms of benchmarking for community support services. I am not sure whether that work has evolved to a sophisticated level in any country, at this stage. We are certainly on the precipice of doing a lot of work in that area but we are all coming to grips with the complexity of the program and the range of services and needs. I suppose it is not a lack of intent; it is more a case of being a bit overwhelmed by the complexity of the difficulties and the issues that we are confronting."(DOCS: Transcript of evidence, p 23)

12.40 The Commonwealth Department of Human Services and Health itself in evidence to the Inquiry accepted that the task of developing community care benchmarks is extremely complex. The Commonwealth Department of Human Services and Health described the challenge in the following terms:

> "With the nursing home and hostel ratios we were able to establish those benchmarks... by reference to existing provision, overseas data and so on. At the moment we have a consultant who is going to look

at trying to establish those benchmarks for us in regard to HACC. It is complicated because of the different mix of HACC services... I guess you could have a concept where that mix–if you could express it in some kind of unit–would add up to the same number of units per head of population. The difficulty is working out what all those units are and what weighting you would give to, say, an hour of home nursing, an hour of home care, a Meals on Wheels service, a day care centre, and all the other things that HACC funds. The consultant is also looking at the issue as to whether the HACC needs in a region will vary according to other services that are there, such as other disability services that are outside the HACC program or other residential aged care services."(DHSH: Transcript of evidence, pp 3208-3209)

12.41 **The Committee recommends that the Commonwealth Department of Human Services and Health, in conjunction with State and Territory governments, continue the development of community care benchmarks or planning targets which identify an appropriate level of community care services required per head of population. The benchmarks should be based on empirical evidence of the incidence of disability among the population and be capable of being employed at the regional and local levels.**

Local Government Role

12.42 The role of local government in the HACC Program has been canvassed extensively in the course of the Inquiry. According to the Commonwealth Department of Human Services and Health, local government plays an important role in the planning, development and delivery of HACC services. (DHSH: Volumes of submissions, p 245). Local government also provides funding for HACC services and this is recognised as part of the State contribution to the Program. As local government is not a party to the HACC Agreements, it is not bound by those agreements and has not been given the formal role in the Program it has sought from time to time. The area in which the local government associations have sought recognition in this Inquiry is through a greater involvement in planning.

12.43 In Victoria, the local government role in service provision, planning and financial contribution has been particularly strong and local government has been accorded a more formal role than in other States and Territories. The Municipal Association of Victoria is represented on the Joint Officers Committee and has

involvement in decisions on priorities and the development of recommendations for funding.

12.44 The Australian Local Government Association (ALGA) and the State level associations have argued for greater recognition of the capacity of local government for planning, developing and coordinating the provision of community services. The ALGA in its submission contends that the Commonwealth and State/Territory governments have failed to acknowledge the role of local government in HACC. As a consequence, the Association argues, there has been a failure to utilise alternative planning and service delivery processes which would lead to greater flexibility for consumers and improved efficiency. The ALGA submission goes on to suggest that the work undertaken by local government on Integrated Local Area Planning (ILAP) has demonstrated a model which would be useful for the HACC Program and would enhance flexibility and consumer outcomes. (ALGA: Volumes of submissions, p 190)

12.45 In evidence to the Committee the ALGA requested recognition of what it sees as the legitimate role of local government in the planning of HACC services at the local level:

> "... what we are saying is that, if you and the program were to acknowledge that role in terms of local planning–forget the structures; just let us make an advance in terms of recognising we do need to plan locally for services–then a lot of energy would be able to be put into how we do that and to moving towards ensuring that happened in each council." (ALGA: Transcript of evidence, p 2438)

12.46 The South Australian government has negotiated arrangements with the local government association in that State which gives local government a more formal role in the planning of services at the local level and in the setting of

priorities at the State level. The Department for Family and Community Services said of local government involvement in planning:

> "I think that the planning input is at the two levels. One is the local council in the local area in agreed ways with service providers, stakeholders and the community. That is one aspect of it. The other aspect is the Local Government Association, in planning with us about what future needs are and how these can be met. We will be looking to encourage that and do that enthusiastically. The Local Government

Association, of course, has the same kind of variety of views of its separate members as any other peak organisation."(DFCS SA: Transcript of evidence, p 1864)

12.47 In Victoria, local government has the most formal role of all States in the HACC Program. The Victorian Department of Health and Community Services described that role in the following terms:

> "Uniquely, in Victoria, the Municipal Association of Victoria is a member of the joint officers group that is responsible for making recommendations to the joint ministers. It is also a member of all the working parties and committees that that group establishes to develop things in the program. For example, it had a representative on the group that developed the next three-year strategic plan... So they are closely involved in the formal processes associated with the program. The one process where we have not yet worked particularly closely with them in a formal sense is in looking at options for the future of the program. But once we have developed a position in terms of an options paper we will naturally want to discuss it with them and get their reaction and so on."(DHCS VIC: Transcript of evidence, p 668)

12.48 The Committee considers that local government is well placed to make a significant contribution to the planning of HACC services. It has expertise in planning and demographics and has already developed a planning model for local services in the ILAP approach. Local government is not however, party to the formal HACC Agreements and the State and national level associations are not able to make commitments on behalf of member councils. While this means that it is not possible for the Associations to enter into a formal agreement with the Commonwealth and the States regarding the operation of the HACC Program, it does not prevent the recognition of the role of local government in the HACC Program. The Committee does consider, however, that decision-making powers are appropriately held by the Commonwealth and the States as the major funders of HACC nationally and the parties to the formal HACC Agreements.

12.49 **The Committee recommends that the Commonwealth Department of Human Services and Health in conjunction with State and Territory governments develop a formal role for local government, to be negotiated with the ALGA and the State local government associations, in the HACC planning process. This role should recognise local government as a partner in the planning and delivery of HACC services and acknowledge the significant financial and in-kind contributions of local government to the provision of community care, and should include:**

- involvement in broad planning issues including the development of HACC needs-based planning models and State and national strategic plans;

- membership of Regional Forums, State level advisory committees and the national policy advisory committee;

- encouragement of local councils to cooperate on a regional basis in order to facilitate involvement in the proposed regional structure of the HACC Program; and

- a key role in planning at the local and regional level including participation in Commonwealth/State committees responsible for considering priorities and developing funding proposals.

ADVISORY STRUCTURES

State and Territory Level Advisory Committees

12.50 The Commonwealth Department of Human Services and Health advised the Committee that the role of HACC Advisory Committees (HACCACs) is as follows:

> "HACC Advisory Committees (HACCACs) advise Ministers broadly about planning strategies, program development priorities, and more specifically about unmet community needs and feedback on Program performance. The Committees provide a forum for service users, service providers, community organisations and local governments to comment on these Program issues and facilitate the flow of information between Ministers and the community."(DHSH: Volumes of submissions, p 245)

12.51 While there is strong community support for advisory structures at the State and regional or local level, there is concern about the effectiveness of the existing structures. In a number of States the Committee was told that the HACCAC had not met for considerable lengths of time or that governments had failed to re-form committees as terms of members expired. In the ACT, for example, a witness appearing on behalf of the ACT Consumer Forum for the Aged had recently been

appointed Chairperson of the HACCAC which had been reconstituted after a lengthy hiatus, and said:

> "The appointments, as they were, terminated at the end of March. The departments took inordinately long times to decide what they wanted to do about it... The local minister had to get the concurrence of the federal minister. The election had been called. The federal minister took the view, as I warned that he would, that this was a new appointment and he could not do it under the terms of the normal rules governing an election. So nothing happened... It was sloppy in the way it handled this. Frankly, I almost came to the conclusion that it really did not want a consultative committee... Anyway, I am pleased to say that the committee has now been appointed. It had its first meeting on 29 November. But there was no advice for a period of nearly nine months. I think that was shocking."(ACT CFA: Transcript of evidence, p 3102)

12.52 A similar situation was reported in WA where the Committee was told that the HACCAC had not met in two years:

> "The ministerial advisory committee has not met for a very long time... It is two years. Even in the year prior to its demise it met only twice."(WACOSS: Transcript of evidence, p 2142)

12.53 The Committee pursued the issue of the Advisory Committee with the WA government and was advised that a new HACCAC was to be constituted in the near future and explained the lengthy period with no HACCAC in the following terms:

> "At the time when those terms of office expired, a number of changes were under way with the HACC program. Firstly, the jurisdiction issue was being raised which gave rise to a feeling that there might be substantial changes in the administration of the program. Secondly, we in the state have moved to this regionalised model. So the interregnum really has been the product of those changes occurring and the need to devise a structure which would more adequately reflect our administration under the new model and lead to more adequate community representation from the regions."(HDWA: Transcript of evidence, p 2071)

12.54 While the Committee accepts that there may be valid circumstances which would delay the appointment of new Advisory Committee members, it is not acceptable that the community should be without a voice for two years, as was the

case in WA, or even nine months, as in the ACT. Governments and the community invest significant resources in the operation of the HACCACs and it is essential that they are able to fulfil their role of representing the community and providing a community perspective on issues in the HACC Program.

12.55 **The Committee recommends, therefore, that the Commonwealth Department of Human Services and Health formalise a protocol with States and Territories to ensure that, under normal circumstances, new appointments to State level advisory Committees are confirmed prior to the expiry of terms of existing members. It is further recommended that the Commonwealth Department of Human Services and Health in conjunction with States and Territories, amend the guidelines for the HACCACs to ensure that in the event of unavoidable delays in reconstitution of Committees at the expiry of members' terms, existing members will continue to fill their positions until new appointments are made.**

12.56 A further area of concern is the role and representativeness of HACCACs. There is a level of frustration among HACCACs which the Committee spoke to regarding their role in the Program and the responsiveness of governments. The role of HACCACs appears quite broad, encompassing involvement in the development of strategic plans, consultation with consumers and service providers, identification on unmet needs and advice to governments on broad priorities for the Program.

12.57 In Victoria, for example, the Committee encountered a degree of frustration among the HACCAC representatives about the extent to which they are able to influence the direction of the HACC Program. The State government in Victoria noted that the HACCAC is involved in the development of the State Strategic Plan and the development of the State's needs based planning model. The official went on to say:

> "I think the role of the committee should be distinctively to represent consumers of the program. It is useful to have service providers as part of the group, but I think if there is one thing that the committee can do that no-one else is in a position to do, it is to represent the consumers of the program."(DHCS VIC: Transcript of evidence, p 647)

12.58 The HACCAC representatives themselves, however, had a slightly different view of their role and their influence with governments:

"Reflecting on our role, it is really one of commentary. It is a question of whether the senior officers in the department are interested in your opinions. I think that has varied tremendously in the time I have been involved."(HACCAC VIC: Transcript of evidence, p 804)

12.59 A consumer representative on the Victorian HACCAC described the HACCAC role from the perspective of a consumer representative in the following terms:

"... we take it very much to heart being on this advisory committee. We are representing people out there in our constituencies. In that sense, if we are picking that there are difficulties with a particular policy or a problem with something that is happening, we see it as our role to bring that through to the HACC advisory committee and question the department around that. We do that constructively, because I think we have a very good working relationship with them, but also to see that there is some accountability for the processes that are being following and what is actually occurring, and to raise issues that are of concern to the people actually using the HACC services."(HACCAC: Transcript of evidence, p 801)

12.60 The Committee considers that the HACCACs are an important part of making sure governments are accountable to the community for the performance of the HACC Program. It is obvious that the Program has access to a range of experienced and knowledgeable people in the community to advise on the directions and priorities of the HACC Program and it is essential that governments ensure that the Program, and hence consumers, benefit from that knowledge and skill.

12.61 **The Committee recommends, therefore, that the Commonwealth Department of Human Services and Health review the guidelines for the HACCACs, in consultation with members of the current Advisory Committees to clarify the role of the Committees and develop protocols for the passing of HACCAC advice to the Commonwealth and State Ministers and for governments to respond to that advice and provide feedback to the Committees. It is further recommended that the Program provide HACCACs with adequate resources to fulfil their role, particularly in terms of community consultation.**

12.62 The Committee further recommends that the role of State level HACCACs encompass the existing role but have a much stronger emphasis on consideration of policy issues. HACCACs should take a proactive approach and advise governments of areas where existing policy is lacking, where implementation is not proceeding effectively and where issues arising in the HACC community require a policy response on behalf of governments. In addition, HACCACs should be included in the consultation process for all major new policy initiatives.

12.63 It is also recommended that the Commonwealth Department of Human Services and Health ensure that the membership of HACCACs is representative of the communities they serve and includes a high level of consumer representation and people who are able to advocate for special needs groups.

Regional and Local Forums

12.64 In addition to these State and Territory level advisory structures, local and regional HACC Forums have been formed in some States, with NSW appearing to have the most formalised system. The Forums are intended to allow local or regional level input into the planning and policy development process by feeding information to State level bodies. The Committee heard evidence from a number of HACC Forums.

12.65 A local government representative in NSW summed up the potential value of regional forums in the following terms:

> "The forums can offer lots of things. They can provide a mechanism for participating at a local level, both for consumers and for service providers so that they feel that they are participating and having a say in what is going to happen in the future. They can offer accurate, or as accurate as possible, needs assessment for state and federal planners for service providers. They can also provide a link between the needs that are identified and the decisions that are made about where money goes. That is the key link that needs to be made. The people who decide where the money goes need to make that link with local needs. The forum can do that."(Campbelltown City Council: Transcript of evidence, p 357)

12.66 It was suggested to the Committee, however, that a single advisory structure at the regional level will not be effective in gaining the cross section of views which governments need:

> "If you want to look at consultation with consumers, service providers and other interested bodies, then setting up any one structure will not give you what you are looking for. It will provide only one mechanism. If you are looking for feedback from service providers and clients, then it is going to have to be multi-layered. It is going to have to involve a variety of formal structures as well as continuous informal structures."(WACOSS: Transcript of evidence, pp 2142-2143)

12.67 Some States which do not currently have regional advisory structures have indicated their intention to establish such mechanisms as part of regionalisation initiatives currently underway. These include Western Australia and Queensland.

12.68 The consistent message to the Inquiry has been that it is essential that regional level advice about priorities, consumer concerns, unmet need and service delivery issues is sought to ensure the effective operation of the HACC Program. The Committee accepts that this is the case and considers that the Program must develop and maintain effective structures to achieve this feedback.

12.69 **The Committee recommends that the Commonwealth Department of Human Services and Health in conjunction with States and Territories ensure the establishment and maintenance of regional HACC Forums in all States and Territories to advise on regional service needs, broad priorities for funding, consumer views and service delivery issues. It is further recommended that the advice of the Forums be forwarded to governments through the State HACCACs and that the Commonwealth Department of Human Services and Health ensure that mechanisms exist for feedback from governments to the Regional Forums.**

12.70 **The Committee also recommends that Regional Forums have a sufficiently flexible and informal structure to enable the Forums to be accessible to consumers. While this would include formal consumer representatives on the Forums, it should extend to informal consultative activities where consumers may feel more able to participate.**

National Advisory Council

12.71 The HACC Program lacks a formal mechanism for consultation with national peak organisations about major policy issues. The Program consults with these organisations on an ad hoc basis in relation to policy issues as they arise. The Committee considers that the effectiveness of the HACC Program would be enhanced through a more formal structure which enables policy issues and priorities to be discussed more broadly rather than simply in response to initiatives generated by the Program.

12.72 **The Committee recommends, therefore, that the Commonwealth Department of Human Services and Health establish a National HACC Advisory Council comprising the national peak organisations representing consumers and providers of HACC services. The Council should meet annually and have the capacity for special meetings to examine major policy initiatives as is currently the case. The role of the Council will be to:**

- **participate in the development of the National Strategic Plan, although the final decisions about the Plan will be made by governments;**
- **advise on community concerns and areas in which HACC performance requires improvement;**
- **have access to Program data, including the results of the monitoring of the HACC Program Outcome Indicators when they are implemented, to enable analysis and advice on the program's performance; and**
- **provide a two-way communication link between governments and the community in relation to the HACC Program.**

ADMINISTRATION

12.73 Planning for HACC services must also be considered in the context of the administration of the Program. Administrative structures must develop in a way which supports effective planning and community input into policy issues. Evidence to the Inquiry indicates that the current administrative structure is perceived as inefficient. The community is concerned about duplication between the

Commonwealth and the States and about complexities which arise from that relationship.

Duplication and Complexity

12.74 Discussion of the roles of the Commonwealth and the States/Territories in the administration of the Program has focused mainly on the appropriate form of Commonwealth involvement, the complexity of existing administration and perceived duplication between levels of government.

12.75 Service providers and consumers, while concerned about duplication, have generally supported continuing or increased Commonwealth involvement. State governments, on the other hand, have generally argued that the Commonwealth has too much involvement in the details of Program administration. States have argued for a reduced Commonwealth role and greater autonomy for State governments. As noted in Chapter 3, the States and Territories are nominally responsible for the day to day administration of the HACC Program.

12.76 The Commonwealth Department of Human Services and Health described the current relationship between the Commonwealth and the States/Territories in the administration of the Program in the following terms:

> "The administration of the HACC program is organised in a way that is generally fairly well accepted between the Commonwealth and the states, with the Commonwealth having a role which is fairly clearly distinct from the role of the states. The Commonwealth's role is in the setting of the national framework and the development of national policy. The state role and the administration of the program is not a duplication of that role... There has been a constant emphasis on the improvements and refinements... including contemporary discussions over areas in which we can refine or streamline administration of the program."(DHSH: Transcript of evidence, p 548)

12.77 State governments, however, have presented a slightly different view of the administration of the Program. They have generally argued that the Commonwealth should take a lesser role in the administration of the Program. Particular areas of concern are the approval of funding for HACC projects and accountability requirements. There is acceptance of the need for the Commonwealth

to maintain a strategic and policy role. The South Australian government, for example, said:

> "... we would like to see the streamlining of approvals because what is required now is extremely detailed and constricting and time consuming in terms of what has to be produced and how that process occurs. However, having said that, we would see no reason not to have the Commonwealth there. We would expect to be able to cooperate as well as we have over the past."(DFCS SA: Transcript of evidence, p 1850)

12.78 The Queensland Health Department called for a streamlined project approval process, while acknowledging the valuable role of the Commonwealth in the Program:

> "I am not saying for the Commonwealth to get out; I think the Commonwealth's direction for the program has been brilliant. They have done a marvellous job over the last eight years in building up the program to where it is. In terms of strategic and national planning, they should maintain a major role... My comments relate mainly to the approval process of projects in Australia. I think the state ministers should be able to go through the approval process without... the horrible administrative wrangle... The Commonwealth can oversight that from a strategic point of view, as they do now."(Queensland Health: Transcript of evidence, p 1599)

12.79 HACC service providers and consumers consider a strong Commonwealth role in HACC essential to ensure continued development of the Program and to guarantee that funds are allocated as required. There is concern in the community, however, about the complexity and duplication which is perceived to be inherent in the current arrangements. ACOSS, for example, said:

> "... we believe that it is important within this program to get national consistency in a number of areas, and we feel the only way you can achieve that is if the Commonwealth maintains a strong role. That is not to say they need to be involved necessarily in all the detailed administration of the program, but they need to have a strong role in driving the policy for the program... We feel that the Commonwealth's maintaining a strong role in the program at least gives it some security... both having an appropriate program infrastructure which allows consistency from state to state and from territory to territory, and also providing a greater insurance in terms of the future funding for the program."(ACOSS: Transcript of evidence, pp 55-56)

12.80 In the ACT, the Consumer Forum for the Aged presented a slightly different view and stated that the Program should be administered locally:

> "It is therefore best administered at the local level. I would think it would be unnecessary for the Commonwealth to try to get into that sort of program... I would see no difficulty in Commonwealth funding tied to Commonwealth outcomes, standards and accountability but administered by the states."(ACT CFA: Transcript of evidence, p 3104)

12.81 The Committee accepts that the existing administrative arrangements of the HACC Program are complex and resource intensive. In particular, the joint Ministerial approval of HACC projects appears cumbersome. The prevalence of complaints about the availability and distribution of HACC services, which were discussed earlier in this Chapter, indicates that Commonwealth involvement in the detail of project approvals has not guaranteed equity within or between States. Nor is there any evidence that it has contributed to the Program objective and consumer outcomes.

12.82 The strategic planning framework detailed earlier in this Chapter has the potential to enable the Commonwealth to influence and monitor the extent to which States and Territories are working toward agreed objectives and priorities regardless of its involvement in joint approvals. The implementation of Program Outcome Indicators to provide a framework against which to measure the performance of the Program as foreshadowed by the Commonwealth Department of Human Services and Health (DHSH: Volumes of submissions, p 238). The Committee is not prepared, however, to recommend a change in the Commonwealth role in the absence of improved accountability from States for equitable distribution of funds and for outcomes achieved.

12.83 **The Committee recommends that prior to any change to streamline administration, the Commonwealth Department of Human Services and Health evaluate the success of the strategic planning processes discussed earlier in this Chapter in terms of the level of cooperation by State and Territory governments, the extent of the match between nationally agreed objectives and State/Territory Triennial Plans and outcomes reported in State/Territory Business Reports.**

12.84 The Committee also recommends that the Commonwealth Department of Human Services and Health negotiate revised accountability measures with State and Territory governments to improve the capacity of the Program to measure the extent to which it achieves its objectives and ensure that HACC funds are applied to further HACC objectives. These arrangements are to include:

- Continuation of existing accountability for expenditure of HACC funds;

- A more focused approach to data collections in line with the data requirements of the HACC Program Outcome Indicators when finalised;

- Timely provision of other information required within the Outcome Indicators framework including unit cost information and aggregated results of standards monitoring; and

- A commitment by States and Territories to the timely provision of data to allow publication of data within one year of its collection.

12.85 The Committee further recommends, that subject to favourable findings from this evaluation and the implementation of accountability measures recommended, the Commonwealth Department of Human Services and Health and State and Territory governments implement the following streamlined administrative processes through revised HACC Agreements:

- Continued Commonwealth responsibility for the development, coordination and implementation of policy and strategic directions, initiation of innovative service models on an unmatched basis, initiation of research and development activities to advance Program objectives, data analysis and publication, national promotional activities, national financial monitoring;

- State and Territory governments to be responsible for the day to day administration of the Program, including funding decisions to be made at regional level with Commonwealth and State Ministers and Members advised simultaneously;

- Joint agreement to the quantum of funds to be available to the Program in each State and Territory; and

- **Continued joint responsibilities at a broad strategic level, including: joint agreement to national and State level strategic plans; joint agreement to policy initiatives and major program tools like needs based planning models, *standards monitoring mechanisms and service agreements; joint participation* in advisory structures; and joint involvement in program evaluation activities.**

REGIONAL FOCUS

12.86 The evidence to the Inquiry has supported strongly the need for HACC to have a much greater regional focus than is presently the case. The community perceives that the administration of the Program, its needs based planning

approaches and its advisory structures lack the regional focus and understanding needed to ensure the effectiveness of the HACC Program.

12.87 The Program is generally moving towards an enhanced regional focus with States and Territories implementing regional structures within the Departments responsible for the HACC Program. The Commonwealth is also moving toward regionalisation of the Commonwealth Department of Human Services and Health. While the Committee supports the increased regional focus which will arise from these initiatives, it is concerned that regionalisation is generally occurring in an uncoordinated manner.

12.88 Regionalisation of the government departments responsible for the HACC Program has the potential to bring significant benefits to the consumers of HACC services. In order to achieve this potential, however, there must be consistency between the regional boundaries selected by the Commonwealth and the States and Territories, those employed by related Programs and Departments and the planning regions for which data can be obtained through organisations like ABS which collect the information which forms the basis of HACC needs based planning. Consistency with local government boundaries, where this can be achieved in a way which is geographically appropriate, is also necessary.

12.89 **The Committee recommends that the Commonwealth Department of Human Services and Health monitor regionalisation initiatives which affect the Program and negotiate with States and Territories to ensure that this occurs in a coordinated way to promote the consistency discussed above.**

12.90 The Committee also recommends that the Commonwealth Department of Human Services and Health, in conjunction with State and Territory governments, pilot a regional administration approach to the provision of HACC services. The pilot regions must involve the selection of common regions both by the Commonwealth and State departments responsible for the HACC Program and related Programs. The Committee considers that State Health Regions may be the appropriate basis for the pilot regions, as they are well established in most States and have close links between HACC and the acute health sector. In order to test the total package of initiatives recommended in this report, the regions for these pilots should be the same as those for the Regional Community Assessment Agencies. It is recommended that the pilots have the following features:

- Commonwealth and State/Territory officers responsible for the HACC Program working in close partnership;

- A strong role for Regional HACC Forums in advising on priorities and examining the effectiveness of the Program;

- A regional funding allocation, developed on the basis of the priorities identified in the State Strategic Plan, with authority to distribute funds delegated to State government officers in the Region or to a regional community board;

- Commonwealth and State officers to attend key meetings of the Regional Forums in an ex officio capacity;

- Local government representatives to have a formal role in the Regional Forum, in needs-based planning and in the development of funding priorities; and

- A strategy for the formal evaluation of the Pilot.

CHAPTER 13

HOME AND COMMUNITY CARE: A NATIONAL MODEL

13.1 The Committee has made a series of recommendations in this report for the future directions of the HACC Program. The recommendations recognise the positive view held by the community about the value of the HACC Program and the need to retain its best aspects. They also address those areas identified in the evidence and submissions to the Inquiry as limiting the capacity of the Program to deliver high quality, responsive and efficient care to those in the community who require it and to build on the achievements of the Program.

13.2 The Committee is aware that the Program has experienced limited growth funding in recent years and that there are serious concerns about the capacity of the Program to meet existing levels of need in the community. In making recommendations for the future directions of the Program the Committee has sought to ensure that changes will lead to a more efficient and effective approach to the delivery and administration of the Program.

13.3 Due to the lack of detailed data about HACC Program costs, the Committee is unable to estimate the potential costs and savings arising from the recommendations. The Committee has, therefore, proposed that the implementation of a number of its recommendations proceed on a pilot basis. This will enable the effectiveness, costs and efficiencies of the proposals to be tested prior to widespread implementation. The Committee envisages that the implementation of its recommendations will proceed over a period of time.

13.4 The implementation of the recommendations in this report should lead to a coordinated and accessible system of community care for people with functional disabilities who need assistance to live in the community and their carers who need support in the caring role. It should have a greater regional focus and more opportunity for meaningful input from the community. In the longer term,

implementation of recommendations regarding planning and benchmarks should result in a better match between supply of HACC services and the level of need in the community for these services and provide a link between growth in the target group and growth in HACC funding.

13.5 This Chapter brings together the recommendations made throughout the report to describe the system of community care which should flow from their implementation. Figure 1 gives a schematic representation of the service delivery and administration model.

OBJECTIVE AND TARGET GROUP

13.6 The Home and Community Care Program should provide basic maintenance and support services to people of all ages with functional disabilities and their carers. The aim of the Program should be to assist members of the target group to continue living in the community and to maintain and **enhance their independence and quality of life**. Obviously, people in this group who are at risk of premature or inappropriate admission to residential care should continue to be an important part of the target group. The Program should define clear eligibility criteria for HACC services. Special needs groups should continue to be identified and improved strategies to improve their access should be implemented.

13.7 The Program should have priority of access guidelines to assist service providers in making decisions about the relative needs of consumers and to improve equity. The guidelines should be based on research into the effectiveness of various points of intervention by community care services.

13.8 HACC should have a well developed marketing strategy to ensure that information about available services reaches all members of the target group and referrers. The marketing strategy should include appropriate measures to reach referrers and members of special needs groups. Importantly, it should include a strong focus on carers and the legitimate place of carers in the Program.

NO GROWTH SERVICES

13.9 *Post acute and palliative care and rehabilitation services should be the* responsibility of the health budget. To ensure that services are provided and continuity is achieved, particularly among the elderly, the Regional Community Assessment Agencies should assess all patients being discharged from public hospitals who are likely to require post acute care, rehabilitation or palliative care and should have the authority to determine in conjunction with hospital discharge planners the level of services to be provided. The hospital should be responsible for the cost of those services.

13.10 *The health system should fund community care of this kind under the* casemix mechanism. A method of costing the post acute, palliative or rehabilitation component should be developed, possibly through bundled DRGs.

ASSESSMENT FOR COMMUNITY CARE

13.11 Consumers who wish to access HACC services should have a single identifiable point of entry to the Program through Regional Community Assessment Agencies. These agencies would assess the community care needs of each consumer seeking HACC services to determine eligibility for HACC and the level and mix of services they require and refer the consumer to those services. Individual service providers would still decide whether they can meet the assessed needs of each consumer and would develop the care plan. Service providers would let the Regional Community Assessment Agencies know if they are not able to accept a referral.

13.12 Each Regional Community Assessment Agency would also assess potential nursing home and hostel residents, people being discharged from hospitals who require post acute care, people requiring palliative care and people with disabilities who wish to access disability services programs.

13.13 The other important function of the Regional Community Assessment Agencies could be the assessment of fees to be charged under a fees policy to be developed by the Commonwealth and the States/Territory after further community consultation. The agency could also collect these fees.

SERVICE DELIVERY

Delivery Mechanisms

13.14 Existing methods of service delivery should continue with the existing variety of organisation types and small and large service providers. The Program should, however, encourage change in some areas to improve flexibility, coordination and choice. These are:

- collocation should be encouraged and potential for collocation should be considered when new projects are funded or changes in location are required;

- different models of service delivery should continue to be explored as is currently occurring in NSW with the demonstration projects;

- for-profit providers should be permitted to provide HACC services once mandatory quality assurance and accountability measures are in place; and

- the Program should investigate and address demarcation problems which inhibit multi-skilling of workers to provide more than one service where this is appropriate taking account of professional standards.

13.15 The Program should allow greater flexibility in its funding by facilitating multiple service type outlets and giving greater flexibility to service providers in allocating funds to each service type. This flexibility should involve greater service provider accountability in terms of outputs and outcomes.

Case Management Services

13.16 The case management approach of COPs and Linkages projects should be extended to ensure full geographic coverage of the approach. These projects should assist only high need clients who are assessed as requiring case management support. In rural and, particularly, remote areas, case management should be available to lower level need consumers in order to facilitate the purchase of a range of services which may not be available under HACC or other programs in the area.

Service Types

13.17 The range of service types provided under HACC should be reviewed to identify services which are required and would contribute to the objectives of the Program and new service types should be added to those allowed under the Program. The Committee has recommended that these include medication supervision and has also noted gaps in the areas of personal alarms and monitoring systems, day time support for younger people with disabilities, dental services and evening and weekend services.

Volunteers

13.18 Volunteers should continue to have a key role in the delivery of HACC services. The Program should improve training and support for volunteers and should implement guidelines specifying any limits on the types of work which volunteers may carry out. This should provide protection for volunteers and ensure recognition of where volunteers fit into HACC.

13.19 Volunteer expenses should be reimbursed at a standard rate to be set in consultation with volunteers and service providers. Services which rely on volunteer input should be funded at an appropriate level to provide reimbursement and to meet legal and insurance requirements.

Quality Assurance

13.20 Consumers of HACC services should be assured of high quality services and respect for their rights as consumers through mandatory outcome standards. The standards should be introduced over a period of time and the implementation should be accompanied by a continuation of the service provider training which has been developed for the existing Guidelines for the HACC Program National Service Standards.

13.21 Monitoring of the performance of service providers should be carried out by State governments in a systematic way using a model which incorporates consumer views and peer review. Aggregated results of service reviews should form part of the measurement of the performance of the Program as a whole through the

HACC Program Outcome Indicators. Sanctions for non-compliance should be a last resort but should, after adequate training and full implementation of the standards, be available. Sanctions may include transfer of auspice to another organisation or defunding.

13.22 Complaints about HACC services should be dealt with through a two tier system. All service providers should have a complaints resolution policy and should advise consumers of this. The Program should establish accessible independent complaints mechanisms in each region. Consumers should have access to this mechanism regardless of whether efforts have been made to resolve the complaint at the service provider level. The independent complaints mechanism should also have the authority to deal with grievances about the Regional Community Assessment Agencies.

13.23 The quality assurance system should be supported by advocacy services to ensure that consumers of HACC services have access to support from an advocate in any situation. The role of an advocate is to stand beside the consumer and assist the consumer to present his or her view, not to act as a meditator between the parties. Advocacy should not be confined to situations of dispute between providers and consumers.

ADMINISTRATION AND ROLES OF GOVERNMENTS

Administration

13.24 The Program should continue as a joint Commonwealth and State/Territory Program. The roles of the levels of government should be streamlined to remove existing duplication. Most importantly, joint Ministerial approval of individual projects should cease and the State Ministers' approval powers should be delegated to State government regional offices or regional community boards. This change is, however, dependent on a greatly strengthened needs based planning and strategic planning process.

13.25 Under the new arrangements, the Commonwealth should continue its valuable role in the development, coordination and implementation of policy and strategic directions and may initiate innovative service models on an unmatched

basis. It should work with the States and Territories to develop needs based planning models and strategic plans but should not be involved in the examination of individual projects and approvals.

13.26 State and Territory government should be responsible for the day to day administration of the Program, including funding decisions.

13.27 Joint processes should continue to be a feature of the Program but these should be at a broader more strategic level, including: joint agreement to national and State level strategic plans; joint agreement to policy initiatives and major program tools like needs based planning models, standards monitoring mechanisms and service agreements.

Accountability

13.28 The States should continue to provide project by project financial acquittals within specified timelines. Accountability of service providers to State and Territory governments should be determined by State and Territory governments to meet State and Territory financial and audit requirements and their obligations under the HACC Program.

13.29 Other data requirements should be developed within the framework of the HACC Program Outcome Indicators. Data should be collected from service providers by State governments and provided to the Commonwealth for analysis. The Commonwealth should ensure that States and Territories, local government and services providers and consumers receive feedback as to the result of data collections and analysis. Data should be published on a regular basis using the Outcome Indicators framework.

Planning

13.30 The Program should develop service provision benchmarks which should specify the levels of service provision required to meet the needs of the target group. These benchmarks should give a basis for future growth in the Program and the allocation of growth funds both within and between States and Territories.

13.31 Advisory structures should be strengthened with the establishment of Regional Community Care Advisory Forums and State Advisory Councils. The Program should also establish a national advisory structure, comprising appropriate peak organisations, to consider both priorities for services and broader policy issues. The Commonwealth should take a greater role than is currently the case in advisory structures including representation in an ex officio capacity on Regional HACC Forums.

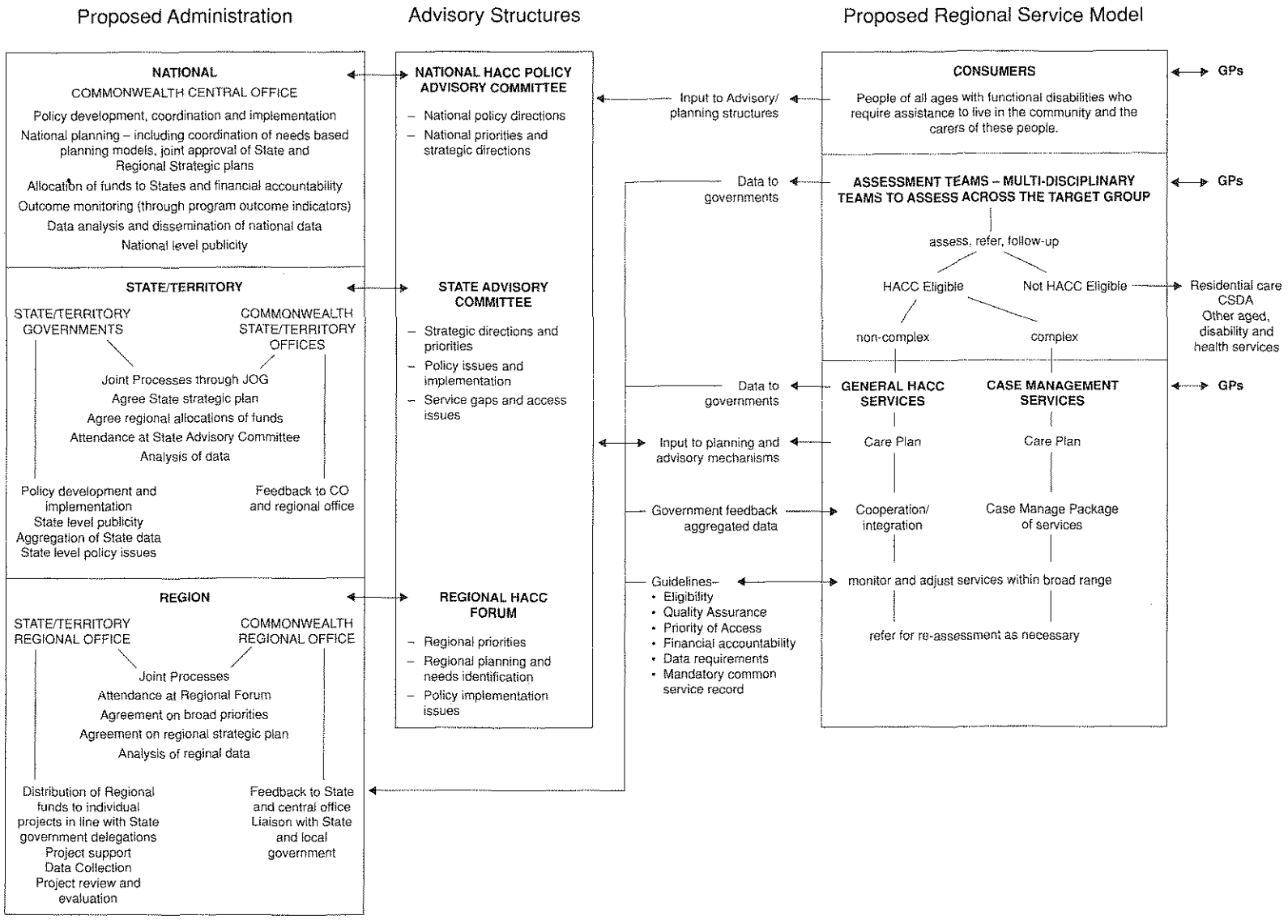
Local Government

13.32 Local government, while not a formal partner in the funding and administration of the Program should have a formal role in needs based and strategic planning. In particular, the expertise of local government in planning at the local level should be brought into local and regional planning processes.

Allan Morris MP
Chairman

26 July 1994

Figure 1 **HOME AND COMMUNITY CARE PROGRAM**



APPENDIX 1

LIST OF SUBMISSIONS

Individuals

Mr J Brett, Miranda, NSW
Ms M Buckley, Hawks Nest, NSW
Mr R Chalmers, Narrogin, WA
Ms M Covi, Townsville, QLD
Ms T Cox, Evatt, ACT
Ms T Curley, Newcastle, NSW
Mrs M Dissidomino, Noranda, WA
Mrs N Firrell, Burbank, QLD
Mrs D Grant, Malvern, VIC
Mr M Gunasekara, Dapto, NSW
Mrs F Hainge, Waroona, WA
Ms A Henderson, Windsor, NSW
Mrs J Hill, Ashfield, NSW
Ms H Jackson, Tregear, NSW
Ms B Kilotat, Holbrook, NSW
Mrs L Lawler, Queanbeyan, NSW
Mrs K Leslie, Queanbeyan, NSW
Mrs B May, Rooty Hill, NSW
Sister S O'Connell, Kalamunda, WA
Mr B Pascoe, Western NSW
Ms F Smith, Sawyers Gully, NSW
Mr P Spencer, Petersham, NSW
Ms W Tully, Quilpie, QLD
Mrs M Turner, Regents Park, NSW
Mr T Watkins, Woodville, SA
Mrs M Whelan, Midway Point, TAS
Mrs D Wilkinson, Turramurra, NSW
Mrs J Young-Smith, Darwin, NT

Organisations

Acquired Brain Injury Group
ACROD
ACT Association of Occupational Therapists
ACT Consumer for the Aged
ACT Council of Social Service Inc.
Action Group for Disabled Children
Activ Foundation Inc.
Adelaide Central Mission
Advisory Committee on Abuse of Older People
Aged Care Assessment Teams, South Coast Region
Aged Care Australia Inc.
Aged Rights Advocacy Service Inc.
Aged Services Association of NSW & ACT Inc.
Alice Springs HACC District Forum
Allora-Clifton Blue Nursing Service
Alzheimer's Association Australia
Alzheimer's Disease and Related Disorders Association of NSW Inc.
Alzheimer's Association of Tasmania Inc.
Anglican Homes for Elderly People, Diocese of Melbourne
Anglican Retirement Villages, Diocese of Sydney
Anne Caudle Centre
AP Care
Arthritis Foundation of Australia
Association of Supportive Care Homes
Attendant Care Coalition Inc.
Austin Hospital, Spinal Injuries Unit
Australian Association of Gerontology
Australian Association of Speech and Hearing, South Australian Branch
Australian Association of Speech and Hearing, Tasmanian Branch
Australian Association of Speech and Hearing, Victorian Branch
Australian Bus & Coach Association
Australian Catholic Health Care Association
Australian Catholic Social Welfare Commission
Australian Community Health Association
Australian Council of Community Nursing Services
Australian Council of Social Service

Australian Federation of AIDS Organisations Inc.
Australian Greek Welfare Society
Australian Hospital Association
Australian Liquor, Hospitality & Miscellaneous Workers Union
Australian Local Government Association
Australian Medical Association Ltd.
Australian Multiple Birth Association Inc.
Australian National University, National Centre for Epidemiology and Population Health
Australian Nursing Federation, Tasmanian Branch
Australian Nursing Federation, Victorian Branch
Australian Pensioners' and Superannuants' Federation
Australian Physiotherapy Association, National Office
Australian Physiotherapy Association, Victorian Branch
Australian Podiatry Association, Victoria
Australian Psychiatric Disability Coalition Inc.
Australian Red Cross, Tasmania
Australian Red Cross, Western Australia
Australian Society for Geriatric Medicine
Australian Taxi Industry Association
Bathurst City Council
Bathurst Handicare Inc.
Benalla Support Group for Children with Special Needs Inc.
Benevolent Society of NSW
Beresfield and District Meals on Wheels
Blue Mountains Community Options
Blue Mountains Food Service
Blue Mountains Home Modification & Maintenance Service
Blue Mountains Volunteer Carers Service
Blue Nursing Service, Warwick
Booringa Shire Council
Brain Injury Association of NSW Inc.
Brain Injury Network of South Australia Inc.
Bridges Disability Services, Management Committee
Brunswick Byron Health Service
Camden District Activity Centre Inc.
Campbelltown and District Aboriginal Cooperative Ltd.
Campbelltown City Council

Canterbury Council
Care Force, Anglican Home Mission Society
Carers Association of Australia Inc.
Caulfield Aged Care Assessment Team
Central Coast Disability Council
Cessnock HACC Forum
Charleville & District Community Support Association Inc.
Chigwell Support Programme
City of Fitzroy
City of Glenelg
City of Lake Macquarie
City of Malvern
City of Melbourne
City of Melville
City of Preston
City of Ringwood
City of Salisbury
City of Sandringham
City of Springvale
City of St Kilda
City of Unley
City of Wangaratta, Aged and Disability Services
City of Wangaratta, Wangaratta and District Linkages
Coffs Harbour District Hospital and Community Health Services
Combined Pensioners' and Superannuants Association of NSW
Community Health Accreditation and Standards Program
Community Health Regional Office, Northern Region, Launceston
Community Options, Albury and District
Community Options NSW State Representatives
Consumers' Health Forum of Australia Inc.
Consumers Association of Western Australia Inc.
Cook Consultancy Pty. Ltd.
Council of Pensioner and Retired Persons Associations (SA) Inc.
Council of Social Service of NSW
Council of the City of Armidale
Council of the Municipality of Camden
Council on the Ageing (Australia)
Council on the Ageing (Victoria)

Country Home Advocacy Project Inc.
Deloraine Radio Cabs
Department for Family and Community Services, HACC Advisory Committee (SA)
Department of Health, Housing, Local Government and Community Services
(now the Department of Human Services and Health)
Department of Veterans' Affairs
Derby HACC
Derwent Valley-Lower Midlands District Health Forum
Disability & Community Support Services Committee
Disability Advisory Council of Australia
Disability and Aged Services, NSW
Disabled Action Group
Drake International
Eastern Regional Geriatric and Medical Rehabilitation Service
Eastern Suburbs Geriatric Centre
Eastern Sydney Area HACC Forum
Eastern Sydney Ethnic Food Service
East Gippsland Municipalities Human Services Committee Inc.
Esperance Home Care
Ethnic Communities' Council of Tasmania Inc.
Ethnic Communities' Council of Newcastle and the Hunter Region Inc.
Ethnic Communities' Council of New South Wales
Ethnic Communities' Council of South Australia
Ethnic Communities' Council of Queensland Ltd.
Ethnic Communities' Council of Northern Tasmania
Ethnic Link Services
Eurobodalla HACC Forum
Family Based Care (South) Inc.
Family Link
Family Resource and Network Support Inc.
Family Support Services Association of NSW (Inc.)
Federation of Ethnic Communities' Councils of Australia Inc.
Frankston Community Health Centre Inc.
Geelong Community Health Services
George Town Taxi Service
Georgian Villages,Chatswood and North Sydney
Geraldton Home Help Inc.
Gilgai Aboriginal Centre

Glenorchy Easy Access, Community Options
Gold Coast Aged Care Assessment Team
Goondiwindi Blue Nursing Service
Government of the Australian Capital Territory, Chief Ministers Office
Government of New South Wales, Cabinet Office
Government of Northern Territory, Minister for Health and Community Services
Government of Queensland, Minister for Health
Government of South Australia, Minister of Health, Family and Community Services
Government of Tasmania, Minister for Community and Health Services
Government of Victoria, Minister for Aged Care
Government of Western Australia, Office of the Premier
Grafton Base Hospital and Health Service, Community Health
HACC Development Officers, New England Region
HACC Ethnic and Disability Advocacy Workers, Victoria
HACC Ethnic Liaison Project
HACC Home Modification Services, Hunter Area
Handyhelp ACT Inc.
Hastings Area Community Health Service
Hastings Community Transition Team
Hastings District Hospital
Hawkesbury Carelink
Hawkesbury HACC Forum and Aged Care Committee
Health and Community Services, Victoria
Health Department of Western Australia, Great Southern Health Region
Hobart District Nursing Service Inc.
Holland Park and District Meals on Wheels Inc.
Home Care Service, Newcastle West Branch
Home Help Service ACT
Homework - Home Modification and Maintenance Service
Housing and Disability Forum
Hunter Area Health Service, Community Aged and Mental Health Services
Hunter Brain Injury Group
Hunter Combined Caring Groups
Hunter Occupational Therapists
Hunter Volunteer Centre
Inner Metropolitan Regional Association
Inner West Community Shopping and Transport Service Inc.
Inner West Neighbour Aid Project

Intellectual Disability Services Council
Interchange Illawarra, Inc.
Interchange, Inner Urban
Interchange Respite Care (NSW) Inc.
Italian-Australian Pensioners Association of Tasmania Inc.
Katanning Community Options
Kingston Centre
Kogarah Community Aid and Information Centre Inc.
Kurri/Cessnock Live at Home Service
Lane Cove Community Aid Service
Local Government and Shires Association of NSW
Lower North Domiciliary Care and Rehabilitation Service
Lyell McEwin Health Service
Macarthur Community Care Forum
Maitland HACC Forum
Mandurah District Support Services Inc.
Mango Mini Bus
Manly Aged Care Assessment Team
Manly Warringah Pittwater Community Information & Service Centre
Marrickville Council
Meandarra Homes Nursing Service
Member for Newcastle (NSW), Mr Bryce Gaudry MLA
Member for South Metropolitan Region (WA), Ms C Davenport MLC
Mental Health Coordinating Council Inc.
Mercy Family Life Centre
Mersey Leven Community Care Association Ltd.
Metropolitan Municipal Association
Migrant Resource Centre, Preston-Reservoir Inc.
Milpara Inc.
Mole Creek Citizens and Friends Association
Mooroolbark-Croydon Community Health Centre Inc.
Mordialloc Aged Services Committee Inc.
Morrisett & District Meals on Wheels
Mosman Community Services
Motor Neurone Disease Association of Australia Inc.
Mountains Community Transport Inc.
Multicare Pty. Ltd.
Multicultural Advocacy and Liaison Service of SA

Multiple Sclerosis Society of Victoria Ltd.
Municipal Association of Victoria
Municipality of George Town
Municipality of West Tamar
Murray-Waroona HACC Inc.
Myrtle Cottage Group for the Physically Disabled Inc.
Nambucca Shire Council
Narellan Congregational Village Outreach
National Association of Nursing Homes & Private Hospitals
National Association of Nursing Homes, Western Australian Branch Inc.
National Centre for Ageing and Sensory Loss
National Meals on Wheels Association Inc.
National Women's Consultative Council
Nepean Community Transport Inc.
Newcastle City Council
Newcastle Elderly Citizens' Centre
Newcastle Out of Workers Ltd.
North Sydney Community Service Limited
North West Hospital
North Western Slopes Community Transport
North-East Metropolitan Regional HACC Forum Inc.
Northern Domiciliary Care Service
Northern Rivers Community Transport Inc.
Northern Territory Anti Cancer Foundation Inc.
NSW Community Transport Organisation
NSW Consumer Forum for the Aged
NSW Department of Community Services, Newcastle Area Office
NSW Health Department, North Coast Branch
NSW Meals on Wheels Association
NSW Nurses' Association
Office of the Public Advocate
Older Persons Rights Service Inc.
Older Persons' Action Centre Inc.
Orana Respite Care Centre
Para Districts Volunteer Service Inc.
Peninsula Hospice Service
Penrith City Council
Pensioners' Action Group Inc.

Perth Home Care Services Inc.
Pilbara HACC
Port Stephens/Great Lakes Community Options
Prince Albert Memorial Hospital Tenterfield
Queensland AIDS Council
Queensland Association of Occupational Therapists Inc.
Queensland Consumer Forum for the Aged
Queensland Health, Brisbane North Region
Queensland Health, Central Office
Queensland Health, Darling Downs Region
Queensland Health, Princess Alexandra Hospital
Queensland Health, South West Region
Queensland Meals on Wheels Services Association Inc.
Regional Carer Support Project Inc.
Resthaven Inc.
Rosalie Shire Council
Royal College of Nursing, Australia
Royal District Nursing Service, National Office
Royal District Nursing Service, Homeless Persons Program
South Australian Consumer Forum for the Aged
Sancella Pty. Ltd.
Shared Centre
Shire of Gnowangerup
Shire of Goomalling
Shire of Ravensthorpe
Shire of Swan
Shire of Swan Hill
Silver Chain Nursing Association Inc.
Silver Circle Home Support Services
Singleton Home Maintenance and Modification Service
Sontec Aged Care
South Australian Country Women's Association Inc.
South Perth Senior Citizens Centre (Inc.)
South West Metropolitan Social Development Council Inc.
South-West HACC Network
Southern Cross Home Nursing
Southern Domiciliary Care and Rehabilitation Service
Spastic Society of Victoria

St George HACC Forum
St John of God Hospital
St Vincents Hospital, Lismore
Statim Care and Communications Pty. Ltd.
Strata & Tenancy Commissioner's Office
Sydney Home Nursing Service
Tasmanian Consumer Forum for the Aged
Tasmanian Pensioners Union
Technical Aid to the Disabled Queensland Inc.
The Abbeyfield Society (Australia) Ltd.
The Australian Association of Social Workers Ltd.
The Australian Quadriplegic Association Ltd.
The Blue Nursing Service, Ipswich Centre
The Good Neighbour Council of Tasmania
The Kalparrin Centre
The Macleay Valley Health Service
The National Council of Women of Australia Inc.
The Pharmacy Guild of Australia
The South East Regional HACC Forum
The Uniting Church in Australia, Queensland Synod,
Division of Aged Care and Domiciliary Services
The Uniting Church in Australia, Synod of Victoria
The University of NSW, Social Policy Research Centre
The University of Sydney, School of Occupational Therapy,
Faculty of Health Sciences
The Victorian Hospitals' Association Limited
Townsville Regional HACC Forum
Tweed Heads Aged Care Assessment Team
Victorian Association for Hospice and Palliative Care Inc.
Victorian Association of Occupational Therapists Inc.
Victorian Bush Nursing Association
Victorian Consumer Forum for the Aged
Victorian HACC Advisory Committee
Victorian Municipal Community Services Association (VMCSA)
Victorian Older Adults Recreation Network
Volunteer Centre of Western Australia Inc.
WA Network of Community Based Home Care Services
Walcha Council

Wentworth Area Health Service, Community Health
Wentworth Area Health Service, Aged Care Assessment Team
Western Australian Consumer Forum for the Aged
Western Australian Council of Social Service Inc.
Western Australian Municipal Association
Western Domiciliary Care and Rehabilitation Service
Western Region Local Government, Aged and Disability Managers Working Group
Western Sydney Community Forum Inc.
Wollongong HACC Forum
Yooralla Society of Victoria

APPENDIX 2

DETAILS OF PUBLIC HEARINGS AND WITNESSES

CANBERRA - 3 SEPTEMBER 1993

Department of Health, Housing, Local Government and Community Services

- Mr Brian Edward Conway, Director,
  Community Care Strategies and Management Section
- Ms Elizabeth Ann Delaney, Assistant Secretary, Community Care Branch
- Mr Bob Eckhardt, Director, Community Care Management Section
- Mr Robert Griew, Acting First Assistant Secretary,
  Aged and Community Care Division
- Ms Jenny Hefford, Director, Community Care Branch,
  Aged and Community Care Division
- Ms Myee Michael, Assistant Director,
  Community Care Strategies and Management Section

SYDNEY - 22 SEPTEMBER 1993

Australian Council of Community Nursing Services

- Mrs Regis McKenzie, President

Australian Pensioners and Superannuants Federation

- Ms Sarah Fogg, Policy Officer
- Mrs Norah McGuire, National Secretary

Home Care Service of New South Wales

- Ms Beryl Jamieson, General Manager
- Ms Janett Margaret Milligan, Coordinator, Area Operations

New South Wales Council of Social Service

- Ms Lyn Gain, Director
- Ms Frances Parker, Policy/Liaison Officer (HACC)

New South Wales Department of Community Services

- Ms Elizabeth Ann Evans, Acting Principal Program Officer, HACC Unit

. Ms Elizabeth Jane Forsyth, Director, Ageing and Disability Services
. Mr Adam Luckhurst, Senior Program Officer,
Ageing and Disability Community Support Unit

Australian Council of Social Service
. Ms Lyla Joy Rogan, Deputy Director

SYDNEY - 23 SEPTEMBER 1993

Alzheimer's Association (Australia)
. Mrs Joyce Gook, Family Carer
. Ms Patricia Jones, Executive Director
. Ms Christine Rossiter, Policy Officer

Anglican Retirement Villages
. Mr Mark Caldwell, Manager, Village Operations
. Mrs Aileen Cumming, Manager, Hostel Options
. Mrs Pearl Price, Coordinator, Hostel Options

Australian Community Health Association
. Mr Ian Gregory Lennie, Executive Officer
. Ms Penny Ryan, National Director,
Community Health Accreditation and Standards Program
. Ms Shirley Ann Schulz, Chairperson, Hunter Branch of New South Wales

Federation of Ethnic Communities' Councils of Australia
. Ms Anne Catherine Hampshire, Deputy Executive Officer
. Ms Chris Livanos, National Disability Network Convenor

Liquor, Hospitality and Miscellaneous Workers Union, Miscellaneous Workers Division
. Mr Ian William West, Assistant Secretary, New South Wales Branch

Mental Health Coordinating Council Inc.
. Ms Gillian Church, Policy/Project Officer
. Mr Norman Ralph Webb, Delegate

NSW Community Transport Organisation

. Mr Charles Edward Richardson, Vice-President

NSW State Community Options Representatives, Eastern Suburbs Options Programs

. Mr Andrew Robert Clark, Senior Coordinator, Inner City Live at Home
. Ms Marika Kontellis, Senior Coordinator
. Miss Lisa McCann, Coordinator

South Sydney Community Transport

. Mr Jack Frederick Carnegie, Coordinator

University Of New South Wales

. Dr Michael David Fine, Research Fellow, Social Policy Centre

CAMPBELLTOWN - 24 SEPTEMBER 1993

AP Care

. Colonel Colin Lawson Bell Meredith, Chairman of Directors

Camden Council

. Mr Robert Ian Lester, Community Planner

Campbelltown and District Aboriginal Cooperative

. Mr Gavin Douglas Andrews, Board Member
. Mr John Delaney, Senior Member
. Ms Barbara Myers, Coordinator, HACC Program

Campbelltown City Council

. Mr John Warren Brookfield, Manager, Community Development
. Mr Ian Frederick Burns-McClintock, Community Services Coordinator

Families First

. Mrs Vicki Meadows, Parent
. Mrs Mandy Jo-Anne Sheppard, Parent

Macarthur Community Care Forum

. Mrs Lynette Ann Bright, Committee Member
. Miss Danielle Leigh Carriage, Committee Member

Macarthur Disabled Action Group

. Miss Rosemary Joan Gray, Member
. Ms Colleen Ruth Percival, Member

Myrtle Cottage Group for the Physically Disabled

. Mr Thomas Alfred Gilholme, Community Representative
. Mr Gary Henry Hudson, Administrator
. Mr Brian Francis Toby, Committee Chairman

CANBERRA - 1 OCTOBER 1993

Department of Health, Housing, Local Government and Community Services
(now the Department of Human Services and Health)

. Ms Anne Croft, Acting Director, Community Care Branch, Aged and Community Care Division
. Ms Elizabeth Ann Delaney, Assistant Secretary, Community Care Branch, Aged and Community Care Division
. Mr Bob Eckhardt, Director, Community Care Branch, Aged and Community Care Division
. Mr Robert William Griew, Acting First Assistant Secretary, Aged and Community Care Division
. Ms Jennifer Susan Hefford, Director, Community Care Development, Community Care Branch
. Ms Janet Anne Murphy, Assistant Secretary, Disability Planning and Review Branch, Disability Programs Division
. Mr Warren Ross Talbot, Acting Assistant Secretary, Casemix Branch

MELBOURNE - 12 OCTOBER 1993

Attendant Care Coalition

. Mr Geoffrey Alan Bell, Convenor
. Mr Phillip Edward Ripper, Outreach Worker

. Miss Anna Strezos, Outreach Worker

Australian Nursing Federation
. Ms Jill Clutterbuck, Industrial Organiser, Aged Care
. Mrs Judith Uren, Assistant State Secretary, Victorian Branch

Council on the Ageing (Australia)
. Mr Denys Edward John Correll, National Executive Director
. Ms Patricia Helen Morrison, Consultant
. Ms Patricia Doris Reeve, Policy Officer

Department of Health and Community Services
. Mr Gregory Philip Mundy, Assistant Director,
Community and Primary Care

HACC Ethnic and Disability Advocacy Workers Group
. Ms Jennifer Ann Ashby, Advocacy Worker
. Mr Richard Berger, Advocacy Worker
. Mrs Jennifer Anne McPhee, Advocacy Worker
. Mr Robert Edmund Reid, Advocacy Worker
. Mrs Carol Hobley-Smith, Coordinator,
Goulburn Valley Council for the Disabled Inc.

Preston-Reservoir Migrant Resource Centre
. Ms Katina Nomikoudis, Executive Officer
. Ms Malina Stankovska, Ethnic Aged and Disabilities Advocacy Worker

Victorian Consumer Forum for the Aged
. Ms Edith Joyce Morgan, Chairperson

Victorian State HACC Advisory Committee
. Dr Leonard Charles Gray, Member
. Dr Patricia Moynihan, Chair
. Mrs Christine Ruth Scott, Carer Representative

MELBOURNE - 13 OCTOBER 1993

Action Group for Disabled Children Inc.
- Mrs Nola Louise Horne, Coordinator
- Mrs Pamela Kruse, Coordinator, Interchange Program

Caulfield Aged Care Assessment Team
- Ms Kathlyn Gibson, Social Worker
- Ms Annette Madden, Nursing Coordinator

Inner Metropolitan Regional Association
- Ms Noelene Duff, Convenor, IMRA Human Service Managers Group
- Mr Nick Matteo, Coordinator, Aged and Disability Services, City of Fitzroy

Kingston Aged Care Assessment Team
- Ms Libby Owen, Director, Community Services

Metropolitan Municipal Association
- Mr Thomas George Hadkiss, Director, Aged and Disability Services, City of St Kilda
- Mr Michael William Ingram, General Manager

Municipal Association of Victoria
- Ms Jennifer Ann Wills, Director, Social Policy
- Ms Louise Margaret Kummrow, Aged and Community Care Policy Officer

Royal District Nursing Service
- Miss Beverley Armstrong, Director of Nursing
- Mr Frank Arthur Evans, Chief Executive Officer
- Ms Gail Miles, Policy and Planning Officer

The Multiple Sclerosis Society of Victoria
- Mrs Sheryl Coughlin, General Manager, Services
- Mr Lindsay McMillan, Executive Director

Victorian Bush Nursing Association
- Mr Eric Walter Puls, Honorary President of the Board
- Mr Andrew John Tsindos, Executive Director

LAUNCESTON - 14 OCTOBER 1993

Consumer Forum for the Aged
- Mrs Ailsa Gray Bond, Chairperson

Deloraine Radio Cabs
- Mr Douglas Robert Plevey, Proprietor

Ethnic Communities Council, Northern Tasmania
- Mrs Anne Cutler, Member
- Mrs Stella Goiser, Acting Secretary
- Mrs Irene Skira, Acting Treasurer

George Town Council
- Mrs June Smith, Community Officer

George Town Taxi Service
- Mr James Francis Deane, Manager
- Mrs Marion Faye Deane, Manageress

Good Neighbour Council of Tasmania
- Mr Edvins Baulis, President
- Mrs Jean Baulis, Member
- Mr John Lunstroo, Member

Launceston Community Health Centre
- Mrs Mary Vane-Tempest, Nurse Manager, Home Care Service

Northern Regional Health, Launceston
- Mrs Ann Domingues, Community Nurse Consultant, Community Nursing
- Mrs Marolyn Lou Seaman, Community Nurse Consultant Level Three, Community Nursing

Orana Respite Care Centre
- Mrs Norma Mary Jamieson, Registered Nurse and Manager

West Tamar Council
- Mrs June Smith, Community Officer

HOBART - 15 OCTOBER 1993

Department of Community and Health Services

- Ms Kathryn Barnsley, Principal Program Officer, Aged Care Support and Seniors Bureau
- Mr Timothy Mark Francis, State Program Coordinator, Aged and Disability Support Program

Australian Red Cross

- Mrs Joan Cope, Chairman
- Mrs Jacquie Tewes, Coordinator, Community Projects

Ethnic Communities Council of Tasmania Inc.

- Mr Alojzy Dziendziel, Member
- Mr Jozef Gala, Committee Member
- Mr Giuseppe La Rosa, Committee Member

Derwent Valley Lower Midlands District Health Forum

- Mrs Suzanne Peta Bailey, Coordinator
- Mrs Lynette Fisher, Community Representative

Family Based Care Inc. (South)

- Miss Mary Phyllis Guy, Secretary, Board of Management
- Mr David Bruce Pearce, President of the Board of Management

Glenorchy Easy Access Community Options

- Ms Lyn Elaine Armanasco, Coordinator Community Options

Tasmanian Pensioners Union

- Mrs Etheleen Veronica Guy, State Secretary

CANBERRA - 28 OCTOBER 1993

New South Wales Department of Community Services

- Ms Elizabeth Jane Forsyth, Director, Ageing and Disability Services
- Mr Adam Luckhurst, Acting Principal Program Officer, Ageing and Disability Community Support Unit

NEWCASTLE - 3 NOVEMBER 1993

Cessnock HACC Forum

. Mr Stephen Charles Gorton, Chairperson

Department of Community Services

. Ms Marilyn Louise Wright, Community Program Officer, *Newcastle Area Office*

Ethnic Communities Council of Newcastle and Hunter Region

. Mrs Christine Maria Jordan, Executive Member
. Ms Sonja Ann-Marie Lundquist, Ethnic Aged Services Coordinator, HACC
. Ms Violetta Johanna Walsh, President

Home Care Service of New South Wales

. Ms Wendie Bradley, Area Manager, Hunter

`Homework', Kurri Home Modification and Maintenance Service

. Ms Sharon Beeton, Office Administrator
. Mr Alan Meldrum, Project Manager

Hunter Area Health Service

. Ms Susan Fardy, General Manager, Community Aged and Mental Health Service

. Ms Nicola Mary Ross, Team Leader, Community Options, Newcastle/Lake Macquarie

Hunter Combined Caring Groups

. Mr Duncan Goh, Coordinator, Jesmond Friendship Club
. Mrs Yvonne Audrey Selby, Coordinator, Charlestown Caring Group

Hunter Occupational Therapy Group

. Ms Annie Lewin, Occupational Therapist, Wallsend Community Health Centre
. Mrs Elizabeth Jane Thwaites, President
. Mrs Jean Marion White, Occupational Therapist

Lake Macquarie City Council

. Mrs Jill Bogaerts, Community Worker, Aged and Disabled Services

Maitland HACC Forum

. Ms Diane Adnum, Chairperson

Member for Newcastle, NSW

. Mr Bryce James Gaudry MLA (appearing in a private capacity)

Member for Wallsend, NSW

. Mr John Charles Mills MLA (appearing in a private capacity)

Milpara Inc.

. Ms Josephine May Elizabeth King, Committee Member

. Ms Frances Joan Watt, Service Director

Newcastle City Council

. Mrs Valerie Marjorie Woodman, Community Worker, Aged and Disabled Services

Newcastle Out of Workers Ltd.

. Mr Christopher Phillip Dodds, Chairperson

Newcastle Pensioners Advisory Service

. Mr George Blackmore, Secretary

Port Stephens-Great Lakes Community Options

. Ms Lynne Maree Graham, Senior Coordinator

Raymond Terrace Community Health Centre

. Mrs Lorraine Kay Palmer, Nurse Unit Manager

BRISBANE - 4 NOVEMBER 1993

Queensland Health

. Mr Frederick Huckerby, Acting Director (HACC)

Gold Coast Aged Care Assessment Team

- Mrs Pauline Kay Cousins, Physiotherapist
- Mrs Cheryl Way, Social Worker

Uniting Church of Australia, Division of Aged Care and Domiciliary Services

- Mrs Lydia Elizabeth Kirby, Executive Officer, Administration and Development
- Mr Alexander Lobban, Chief Executive Officer
- Mrs Joyce Stephan, Executive Officer, Care Services

Queensland AIDS Council Incorporated

- Mr Ian Thomas Watts, Manager, Client Services and Support

Ethnic Communities Council of Queensland

- Ms Margaret Louise Hess, Coordinator, Home and Community Care Resource Centre

Brisbane North Regional Health Authority

- Dr Mervyn Cheong, Coordinator, Aged Health and Extended Care
- Mr Raymond John Whitta, HACC Regional Development Liaison Officer

Technical Aid to the Disabled Queensland

- Mr John Williams, General Manager

BRISBANE - 5 NOVEMBER 1993

National Meals on Wheels Association Inc.

- Mrs Lois Catherine Baker, Secretary/Treasurer
- Mrs Mary Lowe, National President

Princess Alexandra Hospital

- Miss Sue Margaret Cumming, Social Worker in Charge
- Mrs Patricia Ann Dorsett, Social Worker, Spinal Injuries Unit
- Ms Margo Frances Newman, Senior Social Worker, Geriatric and Rehabilitation Unit

Queensland Consumer Forum for the Aged

. Ms Valerie Thelma French, Chairperson

Queensland Meals on Wheels Association Inc.

. Mrs Lois Catherine Baker, Treasurer

. Mrs Mary Lowe, State President

ADELAIDE - 8 NOVEMBER 1993

Dr Ludomyr John Mykyta

Adelaide Central Mission

. Mr Ian Frederick Thomas Bruce, Research Manager-Consultant, Services for Seniors

City of Glenelg

. Ms Camilla Mary Kinnane, Senior Community Services Officer

City of Salisbury

. Ms Elizabeth Joan Dalston, Aged Care Officer and Acting Community Development Coordinator

. Mr Peter Eric Hall, Manager, Community Services

City of Unley

. Ms Kerry Anne Symons, Senior Community Services Officer

Council of Pensioner and Retired Persons Associations Inc.

. Mrs Mary Patricia Miller, President

Department for Family and Community Services

. Mr Alan Clive Lohf, Principal Project Officer, Development and Funding Administration Unit

. Ms Janis Lynette Lowe, Director, Family and Community Development

. Mr Christopher Ross Millington, Acting Principal Project Officer, HACC Support Unit

. Mr Michael Gregory Szwarcbord, Manager, Development and Funding Administration Unit

Eastern Regional Geriatric and Medical Rehabilitation Service

- Dr Robert Keith Penhall, Executive Officer/Medical Director

Ethnic Communities Council of South Australia Inc.

- Ms Laima Bogens, Vice-President
- Mrs May Lee, Asian Aged Care Project Officer
- Mr Michael Zdenek Schulz, Vice-President
- Ms Sabina Spaan, Senior Ethnic Aged Care Project Development Officer

Ethnic Link Services

- Mrs Franca Antonello, Coordinator, Southern Region
- Mr Ross Hamilton Barnett, Coordinator, Eastern Division
- Mrs Iwona Glowinski, Coordinator, Northern Region
- Ms Gosia Skalban, Coordinator, Western Region

Housing and Disability Forum

- Ms Tricia Hensley, Project Officer

Intellectual Disability Services Council

- Mr Richard Norman Bruggemann, Chief Executive Officer
- Ms Bronwyn Mary Webster, Executive Officer,
  Community Support Incorporated

Lower North Regional Domiciliary Care and Rehabilitation Service

- Mrs Mavis Elizabeth Martin

Multicultural Advocacy and Liaison Service of South Australia

- Mrs Guiseppina Agostino, Consumer
- Ms Popi Amanatidis, Systems Advocate
- Mr Moschos Politis, Executive Officer
- Mrs Betty Vasilogiannakopoulos,
  Member of Management Committee

Northern Domiciliary Care Unit

- Mr Everard John Altus, Acting Director

Regional Carer Support Project

- Mr John Cronin, Member, Management Committee

. Ms Patricia Smytherman, Manager
. Ms Carolyn Stead, Member, Management Committee

South Australian Home and Community Care Advisory Committee
. Mr James Ramsay Giles, Chairperson
. Mr Neville Kennedy, Consumer Member, HACC Support Unit

Southern Domiciliary Care and Rehabilitation Service
. Dr Elizabeth Rose Hobbin, Director, Clinical Services

PERTH - 9 NOVEMBER 1993

Australian Association of Social Workers Ltd.
. Mrs Leanne Maree Wood, Member of Older Persons Subcommittee

City of Melville
. Ms Jane Benn, Human Services Officer
. Mr Ron Hurst, Community Development Coordinator

Geraldton Home Help Inc.
. Mr Alan Frank Mascall, Coordinator
. Mrs Elgin Marga von Kehler, Chairman, Board of Management

Harold Hawthorn Day Centre
. Ms Cheryl May Davenport, Chairperson, HACC Subcommittee
. Mrs Pamela Ann Pope, Coordinator

Health Department of Western Australia
. Mr Stephen Edward Anderson, Assistant Commissioner for Health Policy
. Mr Michael William Robinson, Program Support Officer, Central HACC Unit

Older Persons' Rights Service and Disability Rights Service
. Mrs Megan Patricia Benier, Advocate

Pilbara HACC
. Mrs Ailish McGovern, Regional Manager

Silver Chain Nursing Association

. Mr Wayne Laurence Belcher, Manager, Home and Aged Care Policy Development
. Mr Ross Edmund Bradshaw, Chief Executive

Shire of Swan

. Ms Jacqueline Gillespie, HACC Coordinator, Swan Caring Centre

South West Metropolitan Social Development Council, Standing (Subcommittee) on Age and Disability (SCAD)

. Mr Andrew Gordon Sanderson Allsop, Member
. Mrs Ann Barclay Kelly, Member
. Mr Peter James Murley, Member
. Ms Louise Verden, Member

Western Australian Consumer Forum for the Aged

. Mrs Deborah Catherine Kirwan, Chairperson

Western Australian Council of Social Service

. Ms Charlotte Ellen Stockwell, Deputy Director

Western Australian Municipal Association

. Ms Gillian Frances Palmer, Project Officer, Community Development

Western Australian Network of Community Based Home Care Services

. Ms Helen Mary Dullard, Secretary
. Mrs Elaine Olley, Chairperson

PERTH - 10 NOVEMBER 1993

National Association of Nursing Homes, Western Australian Branch (Inc.)

. Mr Dennis Albert Dorricott, Vice President
. Mr Victor Fisher, President
. Mr Keith Douglas Glew, Executive Officer

Perth Home Care Services Incorporated

. Mrs Gloria Jean Jones, Chief Executive Officer

Volunteer Centre of Western Australia Inc.

- Mrs Sallie Elizabeth Davies, Executive Director
- Ms Lindy Godfrey, Agency Member, Board of Management
- Mrs Susan Patricia Limbert, Agency Member, Board of Management

CANBERRA - 15 NOVEMBER 1993

Australian Council for Rehabilitation of Disabled Limited

- Mrs Helen McAuley, *Policy Officer*
- Mr David Robert Plant, Executive Officer,
  Australian Psychiatric Disability Coalition
- Mrs Susan Margaret Taylor, Deputy Executive Director

Australian Local Government Association

- Councillor Elaine Armgard Cassidy, Member,
  Community and Economic Development Standing Committee
- Councillor Graeme Frecker, Immediate Past President
- Ms Louise Anne McDermott, Development Officer,
  Home and Community Care Services
- *Ms Jacqueline Ohlin, Policy Manager,*
  Community and Economic Development
- Ms Jennifer Ann Wills, Director, Social Policy,
  Municipal Association of Victoria

Australian Medical Association

- Mr John Francis O'Dea, Director, Hospital Policy

Australian National University

- Dr John McCallum, Fellow,
  National Centre for Epidemiology and Population Health

Carers Association of Australia Inc.

- Ms Anne Marie Mioche, Executive Officer
- Mrs Carole Ann Radnedge, Member, Management Committee

Carers Association of the ACT

- Ms Judy Whyte, Counsellor

Consumers Health Forum of Australia

. Ms Kate Moore, Executive Director

Department of Veterans' Affairs

. Ms Margaret Kidd, Director, Policy Development and Evaluation
. Mrs Sue Frances McHutchison, Project Officer, Health Program, Community Based Health Care Section
. Ms Sarah Joy Simpson, Assistant Director, Strategic Planning, Health Planning Branch
. Mr Lionel Barrie Woodward, Secretary

New South Wales Local Government and Shires Association

. Councillor Elaine Armgard Cassidy, Executive Member
. Ms Louise Anne McDermott, Development Officer, Home and Community Care Services

BLUE MOUNTAINS - 1 DECEMBER 1993

Acquired Brain Injury Group

. Ms Christine Ann Parker, Member, Management Committee
. Mrs Vicki Margaret Wauchope, Coordinator

Bathurst City Council Community Services Committee

. Ms Rhonda Margaret Hodges, Community Representative
. Mrs Narelle Joy Stephens, Member

Bathurst Community Day Centre Committee

. Reverend Paul Bartlett, President
. Mrs Narelle Joy Stephens, Coordinator

Blue Mountains Community Options

. Ms Ruth Baker, Coordinator

Blue Mountains Home Modification and Maintenance Service

. Mr Harold Sydney Cleary, Chairperson
. Mrs Sonja Mary Eyles, Member of Management Committee and User of Services

. Mr George Macfarlane, Handyperson
. Ms Merryanne Sumner, Coordinator

Blue Mountains Volunteer Carers Service
. Ms Denise Veronica Emerson, Coordinator, Lawson Volunteer Carers Service
. Ms Katherine Jane Johnson, Member, Management Committee

Bridges Disability Services Hawkesbury Inc.
. Mrs Helen Margaret Faine, Vice President
. Mrs June Christine Webster, Coordinator

Gilgai Aged Aboriginal Day Care Centre
. Mrs Kathleen Joyce Schilling, Development Officer

Hawkesbury Home and Community Care Forum
. Mrs Janice Cecily Booth, Honorary Secretary

Mountains Community Transport Inc.
. Mrs Helen Walker, Coordinator

Nepean Community Transport
. Mr Erich Weller, Consultant

Penrith City Council
. Ms Christine Anne Mifsud, Aged and Disabilities Services Officer

Southern Cross Home Nursing
. Mrs Barbara Merran Tilden, Director, Professional Services

Wentworth Area Health Service
. Ms Christine Anne Lambert, Assistant Director of Nursing, Community Health
. Ms Pauline Wilson, Occupational Therapist, Aged Care Assessment Team

SYDNEY - 2 DECEMBER 1993

Australian Community Health Association
- Mr Ian Gregory Lennie, Executive Officer

Australian Bus and Coach Association
- Mr Roger Lance Graham, Consultant, Roger Graham and Associates Pty Ltd
- Mr Robert William Hertogs, President
- Mr Barrie Macdonald, Executive Director

Australian Society for Geriatric Medicine
- Dr John Stanley Cullen, Honorary Secretary
- Dr Peter John Kennedy, Federal Councillor

Australian Taxi Industry Association
- Mr John Bowe, President

Marrickville, Canterbury and St George Forums
- Ms Sharryn Maree Llewellyn, HACC Development Officer, Marrickville

Centacare Catholic Community Services
- Ms Elizabeth Morris Gibbons, Director, Disability and Aged Services
- Mrs Carol Logan, Program Manager, Community Options Fairfield-Liverpool

Central Sydney Area Health Service
- Dr Michael William Mira, Director, Division of General Practice

Eastern Sydney Area Health Service
- Ms Ilona Doreen Lee, Director, Health Promotion and Migrant Health

Inner West Community Shopping and Transport Service
- Ms Frederica Joanna Daniella Mantel, Coordinator, Shopping Services

Interchange Respite Care (NSW) Inc
- Mrs Maureen Carroll, Honorary Treasurer
- Miss Patricia Dunn, Executive Officer

New South Wales Consumer Forum for the Aged

. Mrs Joyce Thurgood, Chairperson

North-East Metropolitan Regional Home and Community Care Forum Inc.

. Ms Denise Nicholle Ward, Community Development Worker

NSW Meals on Wheels Association

. Mrs Jeanette Ann Florence Antrum, Director

Western Sydney Community Forum Inc.

. Ms Christine Anne Regan, HACC Planning and Coordination Consultant

MELBOURNE - 3 DECEMBER 1993

Aged Care Australia

. Mr Wayne Laurence Belcher,
Community Care Resource Committee Member

. Mr Richard Nelson Worsley Gray, Executive Director

Australian Federation of AIDS Organisations

. Mr Louis William McCallum, Convener, Care and Support Working Party

Geelong Community Health Services

. Mrs Janice Gae Hewitt, Chief Executive Officer

. Miss Heather Irene McKibbin, Regional Education Officer (Nursing)

Mordialloc Aged Services Committee Inc., Committee of Management

. Miss Mary Josephine Keane, Member

. Mrs Kathleen Patricia Mutimer, Member

Silver Circle Home Support Services

. Mrs Dianne Maree Main, Services Coordinator

. Mr Gerard Michael Naughtin, Managing Director

Uniting Church, Synod of Victoria, Aged Care Advisory Committee

. Mrs Janet Laverick, Member of the Aged Care Advisory Committee

. Mrs Catherine Rogers, Member and Coordinator

Victorian Association of Occupational Therapists

. Ms Susan Lesley Hunt, Convener, Community Health Committee
. Ms Robyn Ann Smith, Member, Aged Care Committee
. Ms Dianne Louise Tribe, Executive Officer

CANBERRA - 17 DECEMBER 1993

ACT Association of Occupational Therapists

. Mrs Mary Ann Edwards, Member

ACT Consumer Forum for the Aged

. Mrs Kathleen Audrey Bourke, Chairperson
. Mr Paul Bruce Free, Member

ACT Council of Social Service

. Mr Allan Anforth, Director

ACT Housing and Community Services Bureau

. Ms Helen Josephine Briggs, Executive Director, Community Programs
. Mr Ken Horsham, General Manager

Department of Health, Housing, Local Government and Community Services
(now the Department of Human Services and Health)

. Ms Gail Jennifer Batman, Acting Assistant Secretary,
General Practice Branch
. Mr Warwick John Bruen, Assistant Secretary, Community Care Branch
. Mr Michael Joseph Doyle, Acting Director,
Hospital Administration Section, Hospitals Branch
. Ms Janet Anne Murphy, Assistant Secretary,
Disability Planning and Review Branch, Disability Programs Division
. Mr Warren Ross Talbot, Acting Assistant Secretary, Casemix Branch

Family Based Respite Care Inc. (FABRIC)

. Mr Christopher James Milton, Director

Handyhelp ACT Incorporated

. Mr John Chapman, Member, Board of Management

. Mrs Helen Holgate, Executive Officer

Home Help Service ACT Incorporated
. Ms Sheena Margaret Dadge, Director
. Ms Ellen Clare Paxton, Assistant Director

South East Regional HACC Forum
. Mrs Janet Ann Chalmers Hayes, Chairman
. Ms Jo Kerry Manion, Manager

Tuggeranong Community Service
. Mrs Margot Jane Strachan, Program Manager, Community Work

APPENDIX 3

PUBLIC FORUMS

SYDNEY - 28 MARCH 1994

Facilitator

. Mr David Efraemson, David Efraemson and Associates

Panel Participants

. Felicity Purdy
Australian Quadriplegic Association
(Representing ACROD)

. Ms Heather Johnson
Council on the Ageing (Australia)

. Ms Anne Hampshire
Federation of Ethnic Communities
Councils of Australia

. Ms Lyla Rogan
Australian Council of Social Service

MELBOURNE - 31 MARCH 1994

Facilitator

. Mr David Efraemson, David Efraemson and Associates

Panel Participants

. Mr Denys Correll
Council on the Ageing (Australia)

. Ms Voula Messimeri-Kianidis
Ethnic Communities Council (Victoria)

. Mr Rob Nicholls
Australian Council of Social Service

BRISBANE - 20 APRIL 1994

Facilitator

. Mr David Efraemson, David Efraemson and Associates

Panel Participants

. Ms Sue Taylor
ACROD

. Ms Wendy Skitch
Executive Director
Council on the Ageing (QLD)

. Ms Margaret Hess
Federation of Ethnic Communities
Councils of Australia

ADELAIDE - 26 APRIL 1994

Panel Participants

. Sue Taylor
ACROD

. Mr Darryl Bullen
Council on the Ageing (SA)

. Mr Michael Shulz
Federation of Ethnic Communities
Councils of Australia

HOME AND COMMUNITY CARE (HACC) PROGRAM

SERVICE TYPE EXPENDITURE BY PERCENTAGE (%) BY STATE IN RESPECT OF 1992-93

SERVICE TYPE	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	TOTAL
Recurrent									
Community Nursing	16.77	30.87	25.81	28.90	41.08	36.00	1.84	14.83	25.78
Community Options	6.69	4.01	6.20	13.93	4.02	5.92	6.25	7.92	6.18
Community Paramedical	0.63	2.89	1.37	9.12	0.48	1.23	3.51	2.91	2.12
Delivered Meals	1.46	3.09	2.96	2.90	2.83	2.43	2.83	5.57	2.45
Food Services	2.02	0.00	0.16	0.03	0.00	0.00	0.00	0.38	0.76
Home Help	33.81	27.54	22.52	24.50	16.07	33.83	2.74	22.97	27.79
Home Maintenance/Modification	5.71	3.23	0.91	1.64	0.08	3.16	0.26	3.83	3.38
Program Support	12.81	9.61	3.94	6.05	3.41	5.33	0.98	10.62	9.00
Community Respite Care	11.72	7.51	26.60	7.92	8.43	7.41	4.02	19.77	11.66
Home Help Specific	0.00	6.13	0.00	0.00	0.00	0.00	0.00	0.00	1.77
Transport	3.47	0.01	1.04	0.27	0.21	1.95	4.32	8.05	1.59
Rec. Centre Maintenance	0.00	1.36	0.00	0.00	0.00	0.00	0.00	0.00	0.39
Undetermined	0.00	0.00	0.91	4.03	16.32	0.00	67.77	0.39	2.37
sub-total	95.09	96.25	92.42	98.47	92.92	97.26	94.52	97.24	95.24
Capital									
Land/Buildings	2.63	0.71	4.03	0.00	1.75	0.00	0.51	0.00	1.83
Vehicles	0.52	0.76	2.07	0.12	2.32	0.40	0.00	0.00	0.92
Equipment	0.45	0.89	0.13	0.07	1.48	0.02	0.00	0.96	0.60
sub-total	3.61	2.36	6.23	0.19	5.56	0.42	0.51	0.96	3.36
State Administration	1.30	1.39	1.35	1.35	1.52	2.32	4.97	1.80	1.41
Total Estimated Expenditure ($'000)	204 286	163 517	70 596	46 971	56 696	15 258	2 336	6 657	566 317

APPENDIX 4
Table 2

HOME AND COMMUNITY CARE (HACC) PROGRAM

STATE INDEXATION FACTORS

(%)

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	NAT AV.
1987-88	20.00	20.00	8.84	18.79	12.39	20.00	8.50	14.00	15.32
1988-89	19.70	20.00	20.00	4.30	19.65	20.00	20.00	20.00	17.96
1989-90	15.53	12.30	20.00	20.00	10.09	23.38	20.00	20.00	17.66
1990-91	15.00	12.30	20.00	13.10	13.87	8.97	8.00	20.36	13.95
1991-92	10.28	9.24	15.59	18.52	6.83	14.50	5.06	3.16	10.40
1992-93	7.73	8.02	13.32	6.21	13.60	2.72	3.49	4.30	7.42

APPENDIX 4
Table 3

HOME AND COMMUNITY CARE (HACC) PROGRAM

EXPENDITURE BY STATES AND TERRITORIES SINCE 1984-85

($M)

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	NAT
Commonwealth Expenditure (a)									
1984-85	25.834	23.455	9.079	7.102	9.564	2.368	0.254	0.427	78.083
1985-86	32.451	31.560	12.584	8.791	11.417	3.343	0.337	0.361	100.844
1986-87	46.945	41.854	15.567	12.584	13.594	3.222	0.587	0.793	135.146
1987-88(a)	59.518	53.385	19.425	13.546	17.818	3.521	0.672	1.291	169.176
1988-89(a)	72.382	64.724	22.630	15.812	21.685	4.729	1.001	1.785	204.748
1989-90(a)	86.999	72.786	29.024	19.338	23.719	6.123	1.331	2.357	241.677
1990-91(a)	98.407	80.935	35.196	22.978	27.879	7.709	1.799	3.038	277.941
1991-92	113.016	91.935	39.380	27.681	30.098	8.580	1.612	3.120	315.422
1992-93	121.637	97.560	45.634	28.949	34.409	8.793	1.605	3.254	341.841
State Expenditure (b)									
1984-85	25.536	22.257	8.003	6.173	8.353	2.437	0.221	1.158	74.138
1985-86	31.328	28.727	10.540	6.938	9.451	3.014	0.225	1.115	91.338
1986-87	37.824	31.885	10.108	9.199	10.377	2.986	0.372	1.384	104.135
1987-88	45.972	39.915	12.842	9.653	13.164	3.236	0.397	1.715	126.894
1988-89	52.615	44.991	14.278	10.681	15.250	3.909	0.520	2.267	144.511
1989-90	61.113	50.436	16.646	12.825	16.371	5.090	0.673	2.633	165.787
1990-91	69.600	56.250	19.915	14.458	18.632	5.392	0.699	3.229	188.175
1991-92	75.764	61.457	21.461	17.263	19.475	6.266	0.733	3.262	205.681
1992-93	81.538	65.245	24.964	18.022	22.287	6.465	0.731	3.403	222.655
Estimated HACC Expenditure									
1984-85	51.370	45.712	17.082	13.275	17.917	4.805	0.475	1.585	152.221
1985-86	63.779	60.287	23.124	15.729	20.868	6.357	0.562	1.476	192.182
1986-87	84.769	73.739	25.675	21.783	23.971	6.208	0.959	2.177	239.281
1987-88(a)	105.490	93.300	32.267	23.199	30.982	6.757	1.069	3.006	296.070
1988-89(a)	124.997	109.715	36.908	26.493	36.935	8.638	1.521	4.052	349.259
1989-90(a)	148.112	123.222	45.670	32.163	40.090	11.213	2.004	4.990	407.464
1990-91(a)	168.007	137.185	55.111	37.436	46.511	13.101	2.498	6.267	466.116
1991-92	188.780	153.392	60.841	44.944	49.573	14.846	2.345	6.382	521.103
1992-93	203.175	162.805	70.598	46.971	56.696	15.258	2.336	6.657	564.496

(a) Figures include Commonwealth unmatched money provided to the States in the 1986-87 Budget context and incorporated under the Agreements in 1991-92 ie. Excludes national initiatives expenditure.

(b) Estimated expenditure required for matching Commonwealth cash outlays.