Municipal Association of Victoria

Submission to Productivity Commission Inquiry

Caring for Older Australians

Date: 4th August, 2010

Table of Contents

1 Executive Summary

The MAV believes an expanded and more unified community care system is needed to support the majority of older people who wish to age at home and in their local community.   Ageing in a community also requires suitable and affordable housing options and age friendly environments. Councils' Positive Ageing strategies aim to reduce barriers to maintaining physical and social activity and community participation, and promote opportunities for improving health. It is these responsibilities for local planning, as well as providing a strong local HACC service platform, that informs the following MAV responses to the key areas identified in the Productivity Commission's Issues Paper, May 2010:

- The service delivery framework
- Funding and regulatory arrangements
- Government roles and responsibilities
- Workforce requirements
- Reform options and transitional arrangements

Service Delivery Framework
An enhanced comprehensive community care system should build on the strengths of the large and broad based local HACC platform and its' capacity to maintain and improve independent living by:

- disaggregating the packaged care tier of community care from eligibility for residential aged care (i.e. Aged Care Act 1997) and locate with HACC (or new Community Aged Care legislation over time).

- rationalising the number of organisations providing the core community care services, assessment and case management functions across municipalities and sub – regions. Enough organisations are needed to provide the service range and meet special needs, with client choice of provider, but retain local focus, knowledge, linkages, uniformity and viability.

- ensuring that the supply of core, most commonly used services is adequate to meet needs effectively and implement care plans in a timely, co-ordinated way across the services to achieve the individual outcomes.

- providing well advertised regional entry points for initial information about aged care services, needs identification and referral, to improve access, however they shouldn't become the only entry pathway to community care services.

- co-ordinated production of well written, simply described and illustrated information in a range of languages, about the relevant services, access and pathways.

- responding early as older people find activities of daily living becoming more difficult, and use skilled, home based assessment to identify how functional capacity, social connectedness and wellbeing can be best improved or maintained – for that particular individual, with their own history and aspirations, in that family and community.

- Aged Care Assessment Services (ACAS) continuing to assess eligibility for entry and care levels for residential aged care services, including respite.

- assessment for living at home and community care services to be done by local designated HACC assessment services, with capacity to assist clients

with care plans to support living at home and access to the broad range of services necessary to achieve this.

- articulate the assessment processes and data sets across and between assessment for community care and residential care. There would continue to be some areas for joint work and cross referrals, but less so if all community care has the one assessment point.

- care co-ordination and case management need to be funded as distinct service types, to be available for anyone using community care services, based on established need criteria and assessed as necessary supports to establish and /or achieve an individual's care plan, or assist through transition periods.

- case management should be available as the main point of contact support service to individuals and families needing this through the transition process from community to residential aged care, especially to co-ordinate the linkages with other care systems as required e.g. acute and transition care, palliative care, ACAS, counselling, financial advice, plus follow up support during the settling period.

- resourcing for living at home assessment and care planning needs to include sufficient time for regular review of individual care plans. If care plans are focussed on achieving specific goals with time frames then community care services can be better used in an episodic way and avoid inappropriate long term use.

- commonly utilised core community care service types (housekeeping, nursing, personal care, respite, food services, home maintenance and modifications, allied health, assisted transport, social support and personal alarms) should be allocated in the amounts, episodes or frequencies necessary to meet the individual's outcomes in the care plan – within an overall framework of improving or maintaining capacity to live safely at home, and reducing risks.

  These should be kept flexible to best meet individual needs, but with criteria around maximums of both intensity and episodes, which would act as triggers for review of the sustainability of the care plan, and/or ACAS assessment re planning or accessing residential care. Initially, these maximums could be linked to the current average service provision levels, or dollar equivalents, in HACC, CACP e.g. 5 - 6 hours per week, but with extended resources, to provide up to 14 hours per week, and EACH 15 – 20 hours. Not all clients requiring 5 - 14 hours service per week would require an ACAS assessment, unless needing to also consider residential aged care, but requiring residential respite and/or the highest amounts of care (EACH level) would be a trigger for an ACAS assessment, as a transition plan for residential care would be most likely.

- one common, or linked, data set for all aged care service utilisation, client characteristics and outcomes data collected over time would provide the bases for more analyses re comparative costs and service utilisation patterns, for meeting the different levels of need or dependency, and better understanding the common and exceptional episodes of care needed.

- more exceptional and expensive services e.g. periods of in home overnight care, equipment or services not otherwise obtainable, may require a regional funding pool allocation and approval process.

- provide more flexible funding options for social support options e.g. funding for local social groups to host health promotion programs (especially where there is evidence for improving functional capacity), and funding that can also be directed per individual to allow more choice of suitable activities.

- allocate some core services in bundles to agencies e.g. home care, to allow maximum flexibility in meeting priority needs without getting perverse outcomes e.g. waiting lists for housekeeping and unused hours in personal care or respite.

  That is, use planning frameworks, based on target populations and actual service use data, to allocate community care resources equitably to areas, but allow flexibility at the agency level to provide the mix of services and activities actually needed to meet the individual plans and outcomes.

- establish joint Commonwealth /State aged care planning processes, building on national objectives and outcome measures, with consistent data sets on service provision, utilisation patterns and client characteristics, built up to regional profiles from local areas, with the processes operated through regional structures – in Victoria, co-ordinated by State and local government. At the regional level, aged care planning will need to link to related population planning processes e.g. local government Positive Ageing and Municipal Health and Wellbeing plans, and sub regionally, to primary and hospital care service planning with the Medicare Locals and Hospital Boards.

- continue to improve ease and speed of allocation processes and range of equipment subsidised through the Aids and Equipment program, picking up on new and emerging technologies.

- make the Independent Living Centres more accessible in regions (currently only in Melbourne).

Funding and regulatory arrangements

Local government cannot continue to fund the compounding gap in the core service costs caused by the inadequacy of the annual indexation formula used by the Commonwealth in the HACC program. The real cost of wages and providing the services have to be taken into account if aged care is to attract and retain suitable staff.

Government Roles and responsibilities

The MAV supports having nationally led aged care policy, funding, planning and quality framework with consistent objectives, data and outcome measures, but does not support the community aged care program being administered by the Commonwealth government. Community care is essentially local and the Commonwealth is structurally too remote from local service delivery knowledge, solutions and relationships. MAV supports the Victorian government's position to retain responsibility for administering the HACC program and this should be expanded to include all community aged care programs currently administered by the Commonwealth.

Workforce requirements

Commonwealth/State co-ordinated health and aged care workforce strategies are needed to ensure sufficient access to allied health professionals, including nurses and social workers, and allied health assistants, both within the community aged care system, and linked to primary care and increased community rehabilitation facilities. Workforce strategies to attract and retain a suitably diverse aged care workforce, and in rural areas in particular, need continued attention.

Co-ordinated Commonwealth and State funded strategies to support career progression pathways to attract and retain community care workers from a wider range of the labour market would also be helpful e.g. immigrants and young people, with the potential for them to perform a range of roles over time, with additional training supported through workplace support and incentives, such as scholarships, taxation or loan assistance to purchase vehicles necessary to perform their jobs, combining working and studying etc. The older workforce also needs consideration and options to stay in the workforce longer by agencies being able to offer task variety and progressions from the heavier manual handling tasks.

Recommendations:
1. That there be one national community aged care program, administered by the State government in Victoria.

2. That the national aged care planning framework, be based at minimum on local government areas for population, service and client data, and incorporate the local government planning role.

3. That the Commonwealth government indexation formula used for community aged care be in line with health and community care sector annual wages growth.

2   Introduction

As the peak body for local government in Victoria, the Municipal Association of Victoria welcomes the opportunity to contribute to the Productivity Commission's current inquiry into options for restructuring Australia's aged care system to ensure it can meet the challenges facing it in coming decades.

Local government in Victoria has substantial experience in local planning and community care service provision and contributes from its own revenue sources to sustain and improve the available services so that older people can be supported to live in their own homes and community (see Attachment 8. 1). Across Victoria, councils are contributing an additional $115m to local community care services, thirty percent of their total costs of providing both Commonwealth and State programs and additional community care services for aged and disabled residents.(Grants Commission: 2008/9 data).

Local government's interest in aged care funding and system reform thus arises from its roles as both a substantial funder and provider of services in Victoria, in particular community care,   as well as having legislated planning and advocacy responsibilities for its citizens and municipal areas.

3   Previous Inquiries and Reports

3.1   Local government submissions

Over the past decade, the MAV has participated in a number of community care campaigns, and aged care reviews and reports, and provided submissions to various government inquiries. There has been a consistent perspective on the need for reform based on the local government experiences, summarised as follows:

- **Community living focus**:
  Most people do age in their home and community, and want to do so, which the Productivity Commission Issues Paper acknowledges. It is time that the full range of community care programs was organised and funded to more effectively deliver on these community expectations.

- **Demand pressures from future population ageing**:
  Although the future growth in the numbers and proportions of the aged population has been the impetus of recent inquiries, some Victorian municipalities already have an ageing profile equivalent to the national predictions of the next 20 years. Ageing populations are not universally experienced in the same ways at the same time and the impacts affect local communities differently- some coastal retirement and rural areas already have very high proportions of older people; the numbers of older people are declining in some rural areas; inner and middle ring metropolitan municipalities have rapidly increasing numbers of those aged over 85 years; city fringe municipalities have significant growth in actual numbers of older people, at the same time as they face demands from rapid population growth overall and competing need for infrastructure and services for younger people.

  These local variations need to be linked in and understood in the context of national policy and programs. Local government's knowledge of their communities and planning capacity should be recognised and utilised in age care planning frameworks and processes.

- **Supply pressures for community care reducing early intervention**:
  With supply constraints against the growing demand for community care services, there has been concern that the protective factors of early intervention and small amounts of timely assistance to support independence, are being jeopardised by having to prioritise services to those with higher and more urgent needs. The assessment and active service frameworks in the Victorian HACC program have re - focussed the importance of responding early to any functional decline or perception of needing assistance at home. This is to ensure that people get good advice through a Living at Home Assessment and as needed, better use of allied health to improve function, and the timely short term support of capacity building community care.

  There needs to be sufficient resources to allow a balance of access to community care, between those with early and low level needs and those with higher levels of complexity and dependency.

- **Cost pressures**:
  The annual wage indexation factor used by the Commonwealth in HACC (1.7% in 2010) and aged care programs bears no relationship to the real average wages growth in the sector, and this gap compounds each year. This has created significant budget pressure for councils and contributed to rate increases for local communities. Although councils have been willing to contribute to costs they are not willing to continue to bear an unfair share.

  The amount for packaged community care provided under the Aged Care Act 1997, is linked to the residential bed subsidy. However the costs of delivering some services in the community can be greater than in a residential facility -

for example, it is cheaper to provide a meal for 50 people living in one place than deliver a meal to 50 individual homes, particularly in geographically spread and rural communities, or to provide social activities in a residential care facility than transport people from home to a community centre. Substitution or choice of care for the same government subsidy only works if the real costs of accessing the core housekeeping and care services in the different settings are known and factored in. Councils are regularly pressured by CACP providers to cross subsidise an inadequately funded care package, by providing more of the HACC services at less than cost recovery rates (especially meals) to help achieve the overall outcome needed by the client.

There are some particularly unfair cost burdens because of historic patterns and assumptions. For example, the very low per meal subsidy for delivered meals ($1.49 per meal in Victoria) is apparently because of its origin as a volunteer service. This means that fees for clients are higher than the food content costs, and local government is the major funder of this service type, especially of the production, delivery and monitoring costs.

Importantly, all councils do not have the same financial capacity to pay for services. Small rural councils providing community care services need additional consideration in resource allocation over and above unit prices, such as multipurpose or administration funding, to ensure viability. Some have had their sustainability further affected by losing Department of Veteran Affairs Home Care funding through the tender process, which had enhanced scale and efficient rostering and contributed to administration costs.

The additional services that councils provide such as community transport and facilities and staff for recreation and social activities, are essential to an effective local community care system, but are not generally acknowledged as such. Community aged care policy needs to identify these important linkages to the necessary local support infrastructure.

Councils without sufficient rate based revenues to meet all their responsibilities cannot contribute significant extra amounts to additional community support services. The Productivity Commission's 2008 study into local government's own source revenue raising highlights many of the issues confronting councils nationally – including the decline in the proportion of the Financial Assistance Grants. They have reduced from 1.01 percent of Commonwealth taxation revenue in 1995/6 to 0.68 percent in 2008/9. The Australian Local Government Association (ALGA), in their *10-Point Plan, June 2010,* states that *" the continuing and deepening decline of FAGs as a proportion of total Commonwealth taxation revenue means that local and regional communities are paying the price. This price is evident in underperforming council infrastructure …. as well as cuts to important community services such as assisted local transport for those at risk of social isolation or who are unable to travel independently to medical appointments".* (ALGA, June 2010: page 6).

- **Community Care Workforce**:
  As public sector services, local government has relatively good wages and conditions and also invests in training, occupational health and safety initiatives and staff supervision to ameliorate the risks for both workers and clients in home based care. To date, councils can generally attract and retain a community care workforce.   However, there are particular challenges and cost pressures in keeping the workforce as diverse as needed to match

clients' language needs and also community care has an ageing workforce with a relatively high injury rate from manual handling. Councils' home care services are subject to the same workforce shortfalls as the health and residential aged care sectors, and rural areas in particular report recruitment difficulties for tertiary qualified allied health staff in the assessment roles. It is hard to compete with the health and not for profit sectors for the same allied health professionals where salary packaging can include an 18 - 30% fringe benefit tax advantage, to which council employees are not entitled.

- **Service Planning and Allocation**:
  In Victoria, State and local government work together on HACC planning, at local, regional and state wide levels. There have been no formal structures for integrating processes between the Commonwealth and State for planning HACC and Aged Services as related care systems, nor publicly available Commonwealth services and utilisation data at the local level. Allocation practices between HACC (State) and the Commonwealth (Aged Care) are also very different.

  Community care (HACC, packaged and respite care) needs to be planned as one system of care, and allocations made which support a viable and effective local service system which can deliver co-ordinated care to clients. There needs to be an understanding of and support for service system strength, viability and sustainability, as well as other principles such as fairness and choice.

- **Perverse incentive and barriers**:
  Elements such as different fee assumptions and processes, eligibility boundaries between services funded differently, bundling case management with a fixed amount of subsidy to also pay for needed services, have all created some perverse incentives and barriers.

  The community care system needs to be planned and provided in a more unified and simplified way.

3.2 Recommendations from previous enquiries consistent with Local Government concerns

- Improved information for older people and their families about services, costs, access
- Increased funding for growth in community care services to meet demand
- Greater range of subsidies to meet needs across aged care packages
- Ensure system is client centred in approach through greater funding flexibility
- Integrate systems of assessment across HACC and ACAS
- Greater emphasis on independence models of care and funding to support client outcomes rather than just inputs
- That the Commonwealth introduce a funding supplement to reflect the additional costs of providing community care services in regional, rural and remote areas.
- That the Commonwealth review the indexation arrangements for the HACC program to reflect the real costs of providing care
- That governments assess the appropriateness of competitive tendering process for future programs
- That the Commonwealth expand the National Aged Care Workforce Strategy to encompass the full aged care workforce, including medical and

allied health professionals, and all areas of the age care sector, in particular the community care sector

- That the HACC guidelines be amended to recognise homeless people or people at risk of homelessness as a special needs group
- Recognising the central role of carers in the community care system
- That governments improve co-ordination in the development and implementation of transitional care programs, and that the development of programs include input from the community sector and health professionals
- Analysis to establish benchmark of care costs based on a national survey of residential and community aged care
- Review deficiencies in information in the aged care sector

4   Community Care Service Delivery Framework

4.1 Strengths of the current system – Victoria

The HACC platform
The size, broad reach and provider stability of the HACC service system in Victoria provides a very solid platform for expanding community care.

There has been uniformity and continuity of the service delivery pattern of the core HACC services over time and across the state i.e. councils, health services and the Royal District Nursing Service (RDNS) in metropolitan areas. Because there are only two to three major HACC providers in any local area it has been possible to both provide a reasonably integrated range of services and build and sustain effective relationships and partnerships to improve referrals between each other, and make it easier for clients to get multiple services, with delivery co-ordinated within and across different providers.

The HACC platform of local services has established links with the acute, sub acute and primary health systems at a local and sub-regional level. The Primary Care Partnerships, developed in Victoria over the past fifteen years, have also promoted a culture of shared responsibility amongst HACC, primary care and other providers, working together in sub regions, to improve access and referral pathways and processes – not withstanding that not all system problems are amenable to change by local cooperation and goodwill alone.

HACC has provided a lot of people with access to known and recognisable local support services as they age or lose function, and thus have a point of contact for information and advice about other needs. This means a lot of people have some understanding of these services and where to go to get them. There is also a higher level of perceived accountability in going to your local council for information, than phoning an 1800 number with no prior relationship or knowledge of the provider nor much transparency about who is responsible for the quality of the information.

State government's role
The State government has extensive experience and capacity in administering HACC, demonstrated by an established central and regional administrative structure, linkages with health services, commitment to service co-ordination (e.g. Primary Care Partnerships); consultation processes with stake holders, commitment to local and regional planning, service system development and co-ordination, and taking leadership on quality improvement directions in HACC.

Local government's role
The additional funding and community care services provided by local government contribute significantly to the overall strength of the local community care service system. Local government's local knowledge, planning role and capacity provides links between HACC and other service planning and land use, health and well being planning, plus positive ageing, recreation, housing, community safety, emergency management etc. Another added value of councils' role in HACC is the dialogue with citizens through the HACC service relationship which informs about other needs and solutions in the municipality eg: pedestrian and footpath issues, location of seats and lighting, transport routes etc. Councils who already provide the full range of community care options, either themselves or in partnerships (eg: DVA, HACC, CACP, National Respite) have demonstrated that they can provide greater continuity of community care services for clients, even with different program funding and regulations.

4.2   Weaknesses in current system

Two tiered community care
The two tiered community care system has created some artificial and unwarranted boundary issues and perverse effects for clients and providers. At the very point where needs for community support services are increasing, it is very disruptive to have to use a different provider to get more of the same type of services and pay a different amount, lose some of the services which were valued, or have to change service providers and lose connection with a valued care worker, in order to get some case management assistance. The blurred boundaries have sometimes been used by HACC providers to try and exclude those on CAPC or EACH packages, as a way of simplifying administrative arrangements and costs, and rationing access to scarce resources.

Allocation practices for Commonwealth only funded community care have resulted in a very fragmented local service system in Victoria, with multiple providers, but not always a lot of overlap between the HACC and Commonwealth community care systems. Many of the Commonwealth funded organisations operate across more than one municipality and region and it isn't easy to relate to all the HACC providers who are more local, particularly if there are only a few clients in common. In metropolitan municipalities, there are often just too many organisations and people involved, at different rates of intensity, to develop and maintain good communication, local knowledge and relationships.

There needs to be a major rationalisation of geographic coverage of the CACP/EACH part of community care and the number of organisations needed to deliver the range of core community care services, to ensure service system sustainability, articulation and client choice.

As the Commonwealth funded Medicare Locals develop sub – regionally over the next few years, with a population health planning and service co-ordination focus, it will be important to continue to negotiate clear referral pathways between community aged care and the primary health sector. This is another argument for rationalising and simplifying access to and provision of community care with a local and sub – regional catchment focus.

The high cost infrastructure needs of residential aged care tend to dominate the framing of the debate and understanding of aged care in Australia. The issues for providing sufficient levels and quality in both residential and community aged care service systems need to be separately focussed on.

Planning systems for Commonwealth funded aged care and HACC are not integrated and operate quite separately. Information on service provision levels and service utilisation, and client characteristics are not integrated, nor are they all available at the LGA level. The Commonwealth government does not currently have the infrastructure at state and regional level to engage and interact with local area knowledge, and current planning processes are very one sided, i.e. annual letter from the Commonwealth requesting local submissions, but no provision of any Commonwealth data sets or discussion.

4.3   Accessibility

Service availability and gaps
Although there is a reasonably good range of the HACC community care service types available to provide assistance with activities of daily living, services can have waiting times, which reduces responsiveness and timeliness and undermines client confidence in the system. For services to be effective   and used episodically, it is essential that clients feel assured that they can actually get services when they are needed. Delays can be both about the level of resources and workforce availability. There are some linkages where staffing gaps in one service can create delays in implementing another e.g. occupational therapist advice for bathroom modifications so that the personal care worker can work safely or client can be assisted to shower independently.

It can be difficult to meet all assisted transport needs - apart from Red Cross who provide transport for health appointments in 22 areas; it is not generally a funded HACC activity in Victoria, although a substantial amount of one on one assisted transport for shopping and medical appointments is provided as part of home care (but not recorded as such in the HACC Minimum Data Set). Although there are a lot of local government funded or supported community transport arrangements (90% of councils provide or contribute to some type of service), they generally don't meet all the need, and there are gaps where councils haven't had the resources to establish or expand such schemes.

 Access to some equipment and technology to improve independence can be expensive and slow if relying on the subsidised options. Improved systems for the Aids and Equipment scheme are underway, but there are still gaps in what can be funded and what proportion of costs can be met. The Independent Living Centre showrooms are only available in Melbourne, and although the on line resources are continuing to improve, for many people there is no substitute to being able to actually see and try the various aids, and receive advice and instruction. On the other hand, there has been rapid growth in the popularity and utilisation of some assistive technology e.g. motorised scooters, many purchased without much advice or training in their safe use. The growth in use has been challenging for councils' capacity to plan and resolve the related access and parking issues along footpaths, and try and ensure there is access to information and instructions in safe use and battery charging. As new and emerging technologies become more readily available for assisted living, information and co-ordination about the impacts needs to be more closely linked to community aged care planning.

More flexible funding is needed to support physical and social activity options, provided both within and outside of the community aged care services, but necessary to be available and affordable if individuals are to improve and maintain function and social interaction. There needs to be more cross government planning and co-

ordination (across aged care, health promotion and prevention) and enduring funding to ensure local availability of the type of programs with an evidence base for improving function. For example; despite the evidence of the efficacy of Tai Chi for those with a risk of falls, it is not possible to access Tai Chi classes in every municipality at an affordable rate and in the right locations and settings to attract and support older people. It is very difficult to implement a care plan if there isn't a reasonable suite of appropriate service options locally available.

Community care assessment staff are well placed to provide printed or web linked information to clients and their family carers in a timely way, on relevant topics related to improving their health. The MAV recently undertook a review of all the readily available health promotion information that assessment staff could be accessing for this purpose and there is a very large range of material available from Commonwealth and State government sites and specific organisations, with quite a lot of duplication and overlap, and yet gaps, particularly in availability in a range of languages. (See, for example: HACC On-Line Resource List). Putting this material together and updating it, and over viewing gaps, is not a task efficiently done by every community care service, and could be a more centralised resourcing function in a community aged care program.

Access to assessment, care co-ordination and case management activity types should be funded and readily available as needed across all community care clients – these are the connecting and facilitating activities that allow individuals to receive timely advice and assistance to make the service system and their own resources work as well as possible to meet their goals and needs. Access to case management should not be coupled with eligibility for residential care or a notional amount of money to broker services, but based on complexity of care needs and transition points and not having the capacity individually or within a family to achieve the desired outcomes without this assistance. Case management is both about co-ordinating and facilitating smooth pathways across multiple service systems or types, and also about supporting individuals and families to mobilise their own resources and strengths to achieve the outcomes that best suit them.

Special needs
Targeting and allocating Commonwealth packaged community care direct for special needs groups can have the outcome of changing the base line access by priority of need in any one area. For example, at a given point in time, it can be easier for a veteran or someone from a CALD background, or living in a particular retirement village, to access an available CACP, than another citizen of the same municipality who has higher or more immediate care needs but can't readily access the available package as it has already been allocated for special needs. There are insufficient mechanisms in a local area for managing priority or reviewing the access outcomes. There is an impression that some providers are choosy about which clients they take up on packages, and the reasons are not always transparent. This is not an argument against corralling resources for special needs groups, but for more accountability about how effective that is in regions. The data on CACP service utilisation that would inform on outcomes of special needs targeting and allocations is not currently available for analysis and discussion at the local or regional level. The approach to special needs in HACC has been handled very differently than in the Commonwealth community care program.

4.4   Maintaining independence
There is not yet sufficient consistency across community care practice on maintaining independence, health promotion and capacity building, although that direction is clear. HACC in Victoria with the Active Service Model/approach is working towards

this and there is good awareness and developing practices across the health and HACC sector. There still needs to be more consistency of message and more community education about the value and reason for these approaches for older people and their families, including for those communities where English is not a first language. All parts of the health and community care sector need to be more consistent and user friendly in messages and language.

Allied health professionals, allied health assistants, Independent Living Centres, community rehabilitation services, ready access to affordable aids and equipment and home modifications are all essential elements for promoting independent living and need to be available in range, quantity and well connected to each other, from the primary health care and related systems.

The links in Victoria through local Positive Ageing plans have put a much greater emphasis on strategies to support ageing well in local communities. Although there was initially Commonwealth financial support (to ALGA for a national web based planning toolkit) and then in Victoria from the Office for Senior Victorians, with a three year funded project to provide both leadership, shared learning and support, and direct funding to some councils, there is no ongoing financial support to implement or review and update the plans. Although over half the Victorian councils have committed staff resources to on –going implementation and review, there are smaller councils who don't have the resources to do this.

4.5   Interface with wider health and social services and social policy
Given the need for reform and direction setting to support larger numbers of older people it makes sense to continue to have overarching, national aged care policies and objectives and they should be clearly connected to, share similar human rights principles and be consistent with other relevant policy areas, including Disability and Health. Policies need to acknowledge ageing as a life stage with particular common needs and features, and confront ageism in all policy areas and services. Respect for and responsiveness to diversity, individuality, autonomy and capacity building needs to be addressed across and within all care systems.

Strategies to reduce age related conditions causing significant functional loss and dependency also need to connect to aged care policies eg the National Framework for Action on Dementia, but also vision loss, arthritis, incontinence etc, and such areas should continue to be prioritised for research on prevention, treatment, management and care options, as well as evidence based coordinated and funded health prevention and health promotion strategies.

The major policy interfaces and need for pathways (eg preventive, primary and acute health, rehabilitation, transition care, palliative care etc) should be made explicit, but there are some different considerations, linkages and pathways for residential aged care and community care, and both should be operated as separate, but related programs within aged care policy. Aged care needs more horizontal than vertical linkages as most older people don't inevitably progress from one system to the other. Both systems share the challenge of needing to grow in quantity, and deficiencies in one part of aged care will impact on the other.

Residential Care
Residential care is a necessary step for some people when the high dependency, health related, end of life care can't be adequately met at home. There are a set of issues to manage about major life transitions – leaving one's home, losing functional capacity, failing or unstable health and nearing end of life. It can be a stressful, new and often one off experience for individuals and families, so entering residential care

should be possible with maximum support, clarity and simplicity about choices and costs. Individuals and their families are dealing with new information, complex choices and decisions, and often time pressures and financial issues. The pathways for entry to residential care whether transitioned from home or via hospital, need to be well managed and co-ordinated, with very good information and easy linkages between acute hospital, palliative care, transition care, financial advice and choice of facility. The Aged Care Assessment Service may be well placed to provide not just the assessment of eligibility and care level, but also the short term case management support and assistance with navigation through the entry pathways and settling period, where people need this and don't already have a case manager allocated to assist with their community care. The issues of providing the funding incentives and systems to ensure affordable high quality, individualised medical (including specialist, dental, palliative etc), physical, social, emotional and spiritual care in a congregate setting are quite complex and must be focussed on in their own right.

Community Care
There is a very different focus where there is capacity and will to continue to live in one's own home, or move to supported housing, particularly when still healthy and active, or managing chronic illness but maintaining functional capacity. Some of the service use needs and thus linkages between service areas change with increased dependency, but the transitions involved in supporting living at home are generally of degree rather than direction. The focus is more on maintaining the matrix of services and supports, and their dynamic inter play over time, with the individual at the centre selecting from them as needs dictate.

Within community care, services and supports to live independently in the community are not uniquely part of an aged care system – the same services can cover a range of circumstances and reasons for reduced functional capacity in activities of daily living. Thus community care shares policy and operational objectives across a range of human services and life stages eg disability, aged care, mental health, palliative care, support in epidemics and other emergencies etc.

4.6   Adaptations to meet future challenges
There are a lot of strengths to build on in the current community care service system and it is adaptable to meet future need, by:

- integrating program management of Commonwealth respite and packaged care with HACC

- focus on maintaining community living through supporting and improving functional capacity in activities of daily living, community connectedness and opportunities for improving health

- entry to community care services via home based assessment and care planning, with criteria based access to care co-ordination and case management services for those who need it

- core services available based on a care plan, with a range from minimum to maximum intensities, or minimum to maximum dollars, for those clients who want to purchase elsewhere or manage self directed care

- addressing the need to develop better access to assisted transport services and episodic overnight care; better access to ADL equipment, modifications and use of monitoring and assistive technology.

- integrating inter – government planning processes for local area needs, within a region or sub – region, for positive ageing, health improvement, community care, supported housing and residential care, linked to a national planning framework

- agreed inter – government arrangements around planning processes and program administration – this might vary from state to state.

- balancing competition/markets/choice/service system viability and workability in allocation polices

  This will ensure that there are capable service providers able to offer a range of community care services, singly or as partners, some choice of providers for users where possible, but not so many providers that it is just confusing and unworkable. The focus should be on methods of ensuring that there is a strong, enduring, viable, quality integrated service system, because there isn't much point having choice if there isn't a quality provider available.

- acknowledging difference in scale and sustainability in rural areas.
  o Some areas need an additional infrastructure grant allocated as well as unit prices
  o Consideration of the extra travel and training costs
  o Support for co-operative models - eg: larger councils support smaller councils in a sub regional approach; partnerships between NGOs, health services and councils to achieve economies of scale and a good service range for clients.

(See Attachment 8.2 for case examples of how some Victorian councils have co-operated to improve their capacity and viability as community care providers and improve the service experience and outcomes for clients).

4.7   Consumer directed care
Consumer directed care options should be progressively developed. People should have choice and be able to manage purchasing services themselves if they wish to, but based on assessment and goal directed care plans. However, many of the needs people experience do require a tried and true service response – wound dressing needs home nursing; if you can't vacuum, a cleaner is needed, so these core services are generally not where a lot of innovation or extra choice is required. Because some of the tasks are very intimate, and the home is also a workplace and there are occupational health and safety risks and responsibilities to the worker which have to be balanced, many people still prefer to be allocated or purchase these services from an experienced reputable organisation, particularly if they are operated with cultural sensitivity and some range of choices such as worker etc. Some other changes in the community care system should be introduced and consolidated first, as it is important to be able to choose reliable well managed services rather than have choice drive the growth of an even more fragmented community care industry of variable quality and standards.

Assessment, care co-ordination and case management should be freely provided as needed and not combined as part of a package of resources for purchasing services.

4.8   Special needs
Flexible models of both community care and residential care should continue to be available and/or developed where it can be demonstrated through the local and regional planning processes that the general services are not adequately meeting the needs of particular groups either in access or acceptability, or that particular models are very successful with some groups. Strategic approaches need to be evaluated

and access monitored by utilisation data compared with relevant population, at local, regional, state and national levels.

4.9   Retirement Villages and Supported Housing Options

Because of local government's strategic and regulatory land use planning role, there is some capacity to influence age friendly developments and options for downsizing housing and re – locating within the municipality. These options may include well located and designed general housing developments, attractive to older residents (e.g. affordable lift serviced apartments using universal design principles, located in shopping strips or activity centres on transport routes, or smaller units amongst family housing development, to be near relatives); partnerships with social housing development; or supported housing targeted at older people (e.g. retirement villages, or supported housing attached to residential care). However because such developments are either market driven or a mix of public and not for profit initiatives, the supply is not always very linked to any planning frameworks estimating current and potential demand.

Popular coastal areas can be overloaded with retirement villages, particularly if there is not the general community infrastructure of health services, transport, shops, residential care, or the wider population base to supply an aged care workforce.

Some rural areas have found that they cannot attract a retirement village developer because they don't have the guaranteed scale of need to be profitable, yet through the local planning processes, rural living older people have expressed interest in being able to relocate into townships, if there was a cluster of supported housing.

Data on location, scale and services of retirement villages and other forms of supported housing provision are included in local land use plans and ageing or housing strategies, but these are not linked to state and national aged care planning considerations. There is no common way of describing the different types of housing so classifying the different types as suggested in the AHURI report no 141 on *"Service integrated housing for Australians in later life"* makes sense. Design guidelines principles may also help. Some councils do develop their own guidelines for aged housing, linked to their other planning requirements, but it would be simpler if there were widely available good practice design guidelines, both for providers and for councils to incorporate with their local conditions. (see for example; Glen Eira Council Aged persons Housing Policy http://www.dse.vic.gov.au/planningschemes/gleneira/home.html)

One council commented "*A recently built village has accessible features in the homes, but no footpaths for easy movement around the village. There is poor public transport and most residents rely on driving a car. It is unclear what they will do if future disability means they can no longer drive. There is no nearby or on site open space or playground, even though many have grandchildren to visit"*.

Supported housing options provide choice between living in an individual home and mixed age neighbourhood, and having more services and support provided as part of housing, with peers as immediate neighbours. In aged care policy terms, supported housing is still about living at home and in the community, and shouldn't be regulated as a type of residential aged care, and people living in supported accommodation should continue to be eligible for funded community aged care services. However, there are distinctions to be made about who is providing and paying for the housing

services, the social activities and the personal and domestic care services to support activities of daily living.

As a general principle, there is a need to balance the advantages and choice of congregate living and support with lack of transparency and capture. Consumer protections need to apply about the services being purchased, as generally provided by State Governments responsible for retirement villages and tenancy legislation. The information needs to clearly specify the services available within standard maintenance fees, and those provided in addition as commercial arrangements and those that may be provided on assessment and are government subsidised. Any limits to care that can be provided and arrangements for transition to other forms of care if required, including property sale, also need to be clearly available to purchasers. Standard guidelines around how these arrangements are operated and communicated (including common terminology) would be beneficial.

One council says *"residents entering a retirement village have indicated that they believed this would be the last move they would need to make, and been dismayed that they have had to find residential care elsewhere when their needs increased."* How the different levels of care services operate and are named are often not very apparent to people until they have first- hand experience.

Assessment and case management functions that govern access to and the organisation of subsidised community care services should generally remain external to living arrangements. There may be a case for organisations providing accommodation to also be funded to provide the care co-ordination function, and for organisations catering only for individuals with special needs e.g. homeless people, to provide a mix of case management and service provision as part of supported accommodation.

Options for less formal shared living arrangements e.g. several older friends living together, or older people providing student accommodation for the advantage of having someone in the house overnight, or doing the gardening etc., need to be facilitated by ensuring Centrelink rules for pension payments are not a barrier.

4.10   Objectives of aged care
There are three groupings of objectives:

1. Those aimed at keeping older people healthy, self reliant, engaged with interests, families, friends and communities and physically active as they age.

This may not be seen as the main target group for age care policy per se, however strategically, these are the next generation of community aged care users, so actions to support these objectives will be beneficial, and overlap with community care at the local level.

2. Those aimed at sustaining community living through: -
   - improving and maintaining functional capacity, managing chronic disease, promoting healthy living, and providing supports for daily living activities and community connections
   - planning and providing age friendly community infrastructure, including accessible transport and meeting places
   - providing options for local, suitable and supportive housing and living arrangements.

The HACC objectives, with some minor word changes, remain relevant to an enhanced community care system and have provided strong guidance for what is required over many years. The resources needed to match expectations haven't always been there but the practices to better achieve these objectives have changed and improved over time.

> *The HACC Program aims to:*
> • *provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers*
> • *support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing inappropriate admission to long term residential care*
> • *provide flexible, timely services that respond to the needs of consumers*

3. Those objectives aimed at providing well integrated, affordable quality health and care services to appropriately address acute episodes or end of life medical and care needs, and support frail older people and their families, who need to move from community living to residential care to receive the intensity and levels of care needed.

The range of other themes as outlined in the Issues Paper, that have been part of the current legislation, are still relevant to be included, as are principles and linkages, but they are more about process than outcomes in their orientation.

5   Funding and Regulatory Arrangements

The core community care services should continue to be funded from taxation, with assessment, care co-ordination and case management provided without charge to service users, but the other services provided with means tested fees. The community care services should be allocated and funded by units of outputs of activity, based on a review and benchmarks of the real costs (including all the administration, supervision, OHS, training, travel, out of hours costs etc.) More flexibility to respond to local need could be achieved by bundling the service types further (e.g. allocate units to one home care category to cover housework, shopping and escorting, personal care and respite care, to allow for the appropriate activities and tasks needed to meet individual need and care plan, but payments be aggregated, adjusted or based on the type of task activity provided).

The annual indexation factor should be related to the wages growth in the wider health and community care sector.   It is important that wages aren't uncompetitive and kept low, or without wage progression and career options, because of the indexation factor, if a community care workforce is to be attracted and retained. A quality service is very dependent on well paid, well supported and well trained staff. Training community care staff is expensive because there are additional wages costs for training times which can't be absorbed against service delivery. Productivity gains are more likely to be made from service delivery models and service system improvements, increasing emphasis on episodic care and promoting independence. The currently low indexation just produces a cost shift from the major funders to the other funders /providers.

The pricing for food services should comprise the food content (to be met by the client), the other inputs and labour to produce the meal and the delivery costs.

Funding for social support should include both payments to providers for a place in an activity program, and an equivalent amount that can be used when there is a more suitable program available locally for that person.

Fees for community care services have to be affordable - thus the number of services needed has to be taken into account, but no one provider should bear the brunt of discounted or waivered fees because of multiple service use. This is not always easy to achieve with administrative ease and simplicity for the service user.

Means testing needs to be simple, transparent and based on reliable systems.

The costs of collecting frequent low fees also needs to be considered, especially in the short term, while there are older people not comfortable using electronic systems or automatic withdrawals for payments.

Reliable and affordable sources of sound advice need to be available to older people on financial matters – especially at the interface with Centrelink/ Superannuation/ Taxation /Reverse Equity loans etc.

6   Roles of different levels of government

MAV supports having a national policy, funding and planning framework for residential aged care and community age care, but not that the Commonwealth government should have sole responsibility in the administration of the community aged care service system. There are strong arguments and consumer preferences for having one gradated, seamless community care program for older people, and national consistency. However the integration difficulties between HACC and the Commonwealth aged care programs care have been largely created by the Commonwealth's entry into community care as an alternative option to residential care, with the constraints of the Aged Care Act 1997, its centralised administration and allocation practices.

 In the longer term, it may be necessary or preferable to create new community aged care legislation and program guidelines. In the short and medium term, the HACC objectives and range of funded service types provides a good structure for delivering integrated community care services under one set of arrangements, if the packaged care resources are added in to the HACC service types, not as packages, but as units and resources for the relevant service types (e.g. case management, housekeeping, food services, etc). It would require a transition period, starting with new allocations and then absorption as packages turnover.

In Victoria, the expanded HACC program should be managed by the State government, but it will require the joint efforts of the Commonwealth and Victorian governments, with local government and the other community care providers, to work through a series of service system improvements to remove barriers that have a negative impact on clients, improve entries and pathways, and rationalise the number and locations of providers, so they can work productively together. Common data collections across community care on user characteristics, service costs and utilisation patterns will also help inform the sort of eligibility categories for care levels and subsidy values, including the possibility of per capita allocations and moves to more consumer choice re mix of services and providers.

Since 2008, when COAG considered a proposal for the Commonwealth to take over responsibility for all aged care, both state and local government in Victoria have raised concerns about how the strengths in the Victorian HACC system could be preserved and built on.

MAV negotiations at this time included the following points:

- Local government is committed to working on solutions to improve integration between HACC and packaged community care

- State government should have a continued role in policy and program planning, resource allocation and service system development

- The operational platform for HACC services in Victoria should not be compromised and continue to be based on State/local partnerships and local planning and delivery

- Local government would continue to contribute additional funding

- Commonwealth needs to increase the annual funding escalator to realistically match cost movement in the HACC program

In April, 2010 COAG made decisions re health and aged care reform and signed the National Partnership Agreement. Whereas other states (except Western Australia) agreed to the Commonwealth having full funding and policy responsibility for aged care, involving the transfer of responsibility for the HACC program, this was not agreed to for Victoria, where the Commonwealth /State HACC Agreement will continue.

The Hon Lisa Neville, State Minister for Senior Victorians, in outlining the Victorian government's reasons for this position, noted the important features of HACC in Victoria as follows:

- HACC services are closely related to and support older people's experience across the health system, including acute, sub acute and primary care

- Local councils in Victoria have a unique role in planning, service development and service delivery of HACC services, including contributing significant levels of their own resources

- Victoria already has activity based funding

- Victoria services a high proportion of the target population

- Victoria provides more hours of service at a relatively lower cost

- Victoria has a positive service development agenda

- Victorian government has a strong relationship with stakeholders

The Commonwealth government could also consider the opportunity for building a national framework, but capturing local knowledge, by strengthening the local government positive ageing/aged care planning capacity nationally, by providing funding support to councils.

7   Workforce

The MAV supports the overall Commonwealth/State co-ordination and planning for the Health and Aged care workforce.

- Need more allied health staff, allied health assistants in community care
- Strategies to train, recruit and retain allied health staff for rural communities
- Supported career pathways for younger people in community care with options to move from direct care to assessment and service co-ordination
- Continued efforts to reduce injuries in home based care work and provide opportunities through task variety for retaining older workers
- Review the Fringe Benefit tax advantage for not for profit organisations which disadvantages public sector recruitment of health professionals

8   Attachments

8.1 Background   information on local government in Victoria

Municipal Association of Victoria
The Municipal Association of Victoria (MAV) is the peak body for local government with a legislative responsibility to represent the 79 councils in Victoria. The purpose of the Association is to promote and support the interests of local government, as defined in the Municipal Association of Victoria Act 1907, through its work with State and Commonwealth governments and a wide range of interest groups.

Local Government in Victoria
 Councils in Victoria have played a major role in the planning, funding and provision of a range of human services for more than half a century, including community and home based care services for older people and people with disabilities. From the 1940's, community care services grew out of local models to meet local need, and then expanded to other local government areas through State encouragement and funding.

Planning:
Under the Local Government Act 1989 and subsequent amendments, councils are charged with
- providing peace order and good government in the municipality
- providing equitable and appropriate services and facilities for the community
- ensuring that those services and facilities are managed efficiently and effectively

There are also specific planning responsibilities under the Planning and Environment Act 1987 and the Public Health and Wellbeing Act, 2008. Councils are well used to managing planning processes which combine community consultation and local priority setting with the policy objectives of all levels of government, and integrate the built and natural environment considerations with the needs of the population across the life stages, including those with additional needs.

Example: Positive Ageing Plans

See for example City of Casey Ageing Positively Plan and Resources.
http://www.casey.vic.gov.au/ageingpositively/?nav=pdm

Councils have Positive Ageing or Later Years Strategies which focus specifically on the needs of their current and projected older population, and opportunities for making urban environments more accessible and supportive and keeping older people healthier, physically active and socially engaged. The specific action plans link to other council plans and strategies such as disability access, recreation, transport, housing, foot and bike path management, street lighting and community safety etc, thus highlighting the needs of older people across a range of council functions and contributing to a more age friendly municipality. Councils continue to be involved in the WHO Age Friendly Cities project.

Many municipalities also use their Positive Ageing plans as well as the Municipal Public Health and Wellbeing Plans to engage with other health and welfare service providers, including the sub –regional Primary Care Partnerships, to create links with other related plans and opportunities for reviewing co-operative efforts for providing necessary health promotion and support services in their areas. Victoria is currently reviewing the integration of national health promotion objectives and priorities with the principles and processes of the municipal and State Health and Wellbeing plans.

Most councils have their Health and Wellbeing Plans on their website e.g.
http://www.hobsonsbay.vic.gov.au/Files/Health_Wellbeing_Plan_2007-2011.pdf

http://www.moreland.vic.gov.au/mccwr/publications/policies-strategies-plans/moreland%20health%20wellbeing%20plan%202010-2014.pdf

With the regional offices of the State Department of Health, councils have taken a lead role in the local planning of priority needs for annual growth funds in the HACC program.

Provision:

HACC
In Victoria, local government is the largest public sector provider in the delivery of Home and Community Care (HACC) services, and the major provider of a range of the most commonly used or core HACC services, including domestic assistance, personal care, respite care, property maintenance, delivered meals, assessment and care co-ordination, and social support services. It thus operates a locally accessible and integrated range of core HACC services and is also able to link clients with a wide range of other local services, facilitated by local knowledge and inter agency relationships.

Councils have extensive experience in local service provision and the management or corporate capacity necessary to support it. In small rural communities often council and the health services are the only organisations with the scale and capacity to manage community care and related programs across the municipality. In a number of rural areas, joint approaches between local organisations, or between councils across a sub –region, have developed to overcome issues of sufficient scale and expertise. A few, mainly rural councils, no longer provide HACC services themselves, but many continue to provide additional funding to the other local organisations who have taken on the delivery role (further described in Attachment 9.2)

Having the council based HACC platform also allows for some value adding where municipalities have a co-ordination role.

Example: Climate Change: emergency management and heat wave planning.

Council's have prepared heat wave plans to ensure health information and support is readily available in their communities, and that individuals, organisations and health and community service providers are prepared to minimize harmful health impacts.   Councils' home maintenance services have been playing a critical role in supporting HACC clients prepare their homes for heatwave, water and power efficiency and fire risk. Because home maintenance is a core HACC service provided in each area, either by council staff or local contractors, with a track record of working with the HACC client group, it has been appropriate to add in additional roles of advising and assisting with local and other government programs to address the impact of adverse environmental conditions and health risk for older people. The HACC services also provide advice and monitoring for their clients during   adverse weather conditions, and assist vulnerable clients prepare their bushfire plans.

Commonwealth programs

Although the major commitment has been in HACC services, some councils also provide other Commonwealth funded aged and community care programs, although this is less uniform. Less than half the councils still deliver Veterans Home Care as each tender round produces different outcomes, and continuity for clients or providers has been lost in about 40% of municipalities. About a third of the councils provide Commonwealth funded community care packages and/ or national respite program services. Fewer than 20% of councils are still directly involved in residential aged care provision, and there has been a trend over the past decade for councils to devolve their facilities where there have been other experienced providers and opportunities for amalgamation and consolidation as the industry restructured.

Council funded programs

Councils provide significant levels of additional services and infrastructure from their own revenue sources which are necessary to support living at home and in the community. These have generally arisen from local need and funding shortfalls or gaps from other government programs, or as with capital for seniors' facilities, past programs that have not continued their funding.

Example: Community transport and seniors' meeting facilities

Community transport provided by councils is not generally a HACC or State government funded activity in Victoria and has relied on council contributions, occasional past HACC capital grants, donations and particularly in rural areas, volunteers. Based on a 2009 survey, the MAV estimated that councils spent at least $21 million in 2007/8 on providing or supporting local community transport services, used significantly by aged and disabled residents, and essential for supporting their access to health appointments, shopping and community care and recreation programs. Without these additional local transport options, HACC programs would not work as effectively in assisting people to stay living at home. 45% of the rural councils reported that the community transport trips provided to older people was the only transport option available to them.

Many councils have also been re – developing their senior citizens' facilities to modernize and update to meet access and other legislative requirements or co – locating to achieve greater access and integration with a wider range of community groups and activities.

Many councils also provide staff to work with older groups to support and resource their activity programs, link them to health promotion opportunities, and to keep them well informed about services and involved in community events.

Funding

Thirty – seven percent (37%) of the annual recurrent HACC Program grants in Victoria for 2008/9 were paid to local government to provide these core services, however councils contribute additionally from their own resources to supplement the cost price and expand the available community care services.

Local government in Victoria funds thirty percent of the costs of all the local community care services it provides for aged and disabled people. This includes both State and Commonwealth funded programs as well as purchased or unfunded services (Victorian Grants Commission data, 2008/9).

- Commonwealth and State grants $200.2 m (52%)
- Local government own source contribution $115.1 m (30%)
- Fees and other contributions $69.4 m (18%)

8. 2   Some examples of joint structures developed by Victorian councils and other organisations for improving capacity to deliver HACC assessment and community care services, particularly in rural areas, or for complex client groups.

1. **Consolidated multi – disciplinary assessment across the range of community based assessments i.e. comprehensive (ACAS) and Living at Home (HACC).**

> **Bendigo Council/Bendigo Health**
> The sub – regional Aged Care Assessment Service auspiced by Bendigo Health is contracted by Council to also provide the HACC Living at Home and service specific assessment for the Greater Bendigo catchment. The strength of this model is in the continuity of approach and purpose for clients at any one visit and over time, and ready access to a range of multi – disciplinary health based skills as needed (including geriatricians) with well established team processes for achieving this.
>
> Given the higher volume of HACC referrals to ACAS referrals, and the need to link closely with council's home care services, this approach requires additional ACAS staff dedicated to the community care end of the role. In the Bendigo model, the arrangement is historically contractual and based on competitive tendering, but this approach could be achieved either by contract or by a partnership agreement.

2. **Regional or sub – regional consortium of councils**

> **Loddon Campaspe; Greater Shepparton:**
> Individual councils provide HACC assessment and core HACC services in each municipality in the region, or sub – region, as well as DVA home care and CACP/EACH. Through partnership agreements, one of the larger councils provides the lead agency co-ordination, DVA assessment, and resources to support the local assessment and care management staff with practice supervision, staff support and uniformity re practice standards, reporting etc.
>
> The consortia models build on local capacity by consolidating roles across a number of community care programs (eg DVA, CACP and HACC) to ensure easy and local access to the relevant service range for local clients and the retention of assessment and direct care staff in townships, but provides support for the smaller services with the backup of shared program co-ordinators and a larger peer network, not otherwise available in small areas.
>
> Success is reliant on being able to recruit and retain suitably and diversely qualified staff across the region and use communication technology for backup support and secondary consultations. Protocols with nursing and allied health services locally /sub regionally for specific and clinical assessments are still needed.

3. **Local or sub – regional multi agency alliances /mergers**

> **Moira Health Alliance.**
> Create one strong local community care provider through devolving, or amalgamating. Two or more services merge, become one larger organisation or create a new organisation with a larger service range and staff capacity. This has occurred in a number of municipalities, ranging from a total devolution of council HACC services to another local health service or NGO provider, with or without council financial contribution, eg East Gippsland, Wellington, Mitchell, Towong and Cardinia - to arrangements whereby council has continued to make a governance, financial and in kind contribution as part of forming a new provider organisation as in the Moira Health Alliance. Council retains the aged planning role for the Shire, and with the local hospitals, contributes to the governance structure and administrative costs for the MHA, which is the providing organisation of all the community aged and related health care services in the Shire.

4. **Co-ordinated multi – agency teams**

> **HARP Projects- Yarra, Darebin, Boroondara:**
> The capacity to run a virtual, multi – disciplinary, multi - agency, multi - location, sub regional assessment and care planning and co-ordination team for a specific target group with complex needs has been successfully illustrated through the HARP project in Yarra, Darebin, and Boroondara. This model does require the additional resources of a co-ordinator, time for team meetings, case discussion and working through practice arrangements. It has included ACAS and hospital based staff as well as HACC funded community care positions in RDNS, councils and community health services, and although this is in a metropolitan area, could equally apply in a rural area.
>
> As it has focused on a small part of the HACC target group (those with complex needs at risk of hospital admission) the cost benefit of this model has been viewed in relation to savings on inappropriate hospital admission, but it did in fact cover a lot of older people also at risk of residential aged care. It still stands as a model for formalising and operationalising multi – disciplinary working relationships across a group of sub- regional services**,** based on clear objectives of multi service care planning to improve client outcomes.