The Home and Community Care 2009 project Independence: Support for the Elderly in their communities

Home and Community Care operates within the Tasmanian Department of Health and Human Resources to deliver its range of services to the elderly and those with a disability. It funds a position within the Tasmanian Council of Social Service specifically to research client needs and organisational service provision of the Home and Community Care program in Tasmania. In 2009, as the HACC Community Consultation Officer, I conducted research into the factors that support independence for the elderly and those with a disability, specifically:

- Mobility and access to services (HACC and other)
- Health management
- Financial security
- Self care
- Family contact and support
- Community engagement and networks

In this project, I examined delivery of the generic HACC services rather than packages of care:

- Centre-Based Day Care
- Home Help/Home Care/Domestic Services
- Personal Care
- Home Maintenance and home modification
- Transport
- Food services
- Community Nursing
- Allied Health Services
- Advocacy Services
- Social Support

In exploring the nature of independence evidence was gained from the 35 respondents. For the elderly, available finances, mobility in getting about the house and access to transport affected their independence. Care and need, dependence and independence were seen to shift in finely-balanced relationships between social networks, family, care givers and recipients, and, of course, was influenced by personal health and the health of others.

Most elderly people do their best to give, and were valued as volunteers, child minders, family supporters, community support workers, and friends; and in participating in a range of physical, social and cultural activities, clubs and organisations expressed *interdependence* (rather than the dependence/independence polarities). *The participants themselves judged good health as their capacity to continue with these activities, rather than in their personal health profiles*. Each described

'lifecourse', - the health habits and key events of a lifetime- as being of significance in creating current health and well-being. In a sense 'lifecourse' operated as a form of health capital – much like financial capital – in that it was accumulated over a lifetime to be expended in old age. HACC services were valued by the participants, in helping them to remain living independently at home in terms of their current health and well-being. Specific services were shown to successfully intersect with need, particularly when provided by those service providers embracing an independence model of support to their clients.

Case studies of seven communities throughout Tasmania found that each community was unique in character, culture, history and economy, and in the provision of support services for the elderly and disabled. These factors, in turn, contributed to elderly people's engagement with the community, in terms of social inclusion, at best achieving positive outcomes for their health and independence. However, ABS CData and HACC minimum data set data revealed gaps in service provision and emerging trends to be addressed in each community. I found that access to HACC services varied widely and was the result not only of distance and isolation, local economy and demographic change but also of the processes by which need for HACC services was identified. Discrepancies were clear between communities, with some being well serviced and others hardly at all, with no apparent reason. Specific services were well utilised, others were not. I found inequity in access to services between elderly single men and women, and younger people and couples; of particular concern were elderly single people living in isolated farmhouses, lacking personal or community transport to access services, HACC and other.

In some communities, informal care provided by neighbours, family and friends was essential for the elderly to maintain themselves in their homes. While commendable, informal support is not a substitute for policy and programs, and given the changing nature of communities over time, is a fragile situation. My conclusions were that the processes by which need was identified by the HACC program for communities and therefore the type and extent of services provided to elderly individuals and those with a disability in these communities needed review in order to operate more efficiently and effectively with equity of access a goal to be achieved.