Home and Community Care

Department of Health and Aged Care

Canberra ACT
31 March 2000

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a
performance audit in the Department of Health and Aged Care in
accordance with the authority contained in the *Auditor-General
Act 1997.* I present this report of this audit, and the
accompanying brochure, to the Parliament. The report is titled
Home and Community Care.

Following its tabling in Parliament, the report will be placed on
the Australian National Audit Office's Homepage—
http://www.anao.gov.au.

Yours sincerely

P. J. Barrett
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

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Abbreviations/Glossary

ABS	Australian Bureau of Statistics
ACPAC	Aged Care Planning Advisory Committee
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
CCP	Community Care Package
CCP planning population	The population used by Health for planning the allocation of CCPs across and within states and territories. The population used is ABS projections of the population 70 years of age and over.
COP	Community Option Project
CSDA	Commonwealth State Disability Agreement
DFaCS	Department of Family and Community Services
DHAC	Department of Health and Aged Care (Health)
DVA	Department of Veterans' Affairs
HACC	Home and Community Care
HACC Officials	A committee of senior officers of Commonwealth and state and territory departments responsible for administration of the HACC program. It is a subcommittee of the Commonwealth/state Standing Committee of Community Services and Income Security Administrators.
Health	Department of Health and Aged Care (DHAC)
JOG	Joint Officer Group
IT	Information Technology
MDS	(HACC) Minimum Data Set
NRCP	National Respite for Carers Program
PIMS	Project Management Information System
SCCSISA	Standing Committee of Community Services and Income Security Administrators
States	References to 'states' are used for brevity throughout the report and are intended to include all Australian states and territories.
SPTF	Service Provision Targets Framework

Summary and Recommendations

Summary

Background

1.   The Commonwealth provides funding under the *Home and Community Care Act 1985* (HACC Act) for a range of personal, health and domestic services to help frail aged and other people with disabilities and their carers[1]. These services are intended to help people with moderate, severe or profound disabilities to maintain independence in their homes and in the community.

2.   The program developed from a consolidation of a number of Commonwealth and state- and territory-funded programs in 1985. As a result, there were numerous differences between the states and territories in its early operations, many of which persist. The variations have significant implications for Health in developing mechanisms to achieve national consistency in the administration of HACC, coordination with other support programs, and the equitable provision of HACC services between, and within, the individual states and territories.

3.   The Commonwealth provides about 60 per cent of the available funds and the states and territories the remainder. Commonwealth funding for 1999–2000 is $525 million, with state and territory funding of about $340 million. Additional funding comes from fees collected by service providers. The work of volunteers and informal carers adds not inconsiderable further value. HACC services include the provision of meals on wheels, community nursing, personal care, home help, respite care, community transport and home maintenance. The Commonwealth also provides funding to assist younger people with disabilities through the Commonwealth State Disability Agreement (CSDA), which is administered by the Department of Family and Community Services (DfaCS). Other Commonwealth programs, such as Community Care Packages (CCPs), also provide services to the same target group as HACC.

4.   The Commonwealth Department of Health and Aged Care (Health), in conjunction with state and territory government agencies administering HACC, is responsible for developing and implementing national policy and identifying national trends in the HACC program. State and territory annual plans are prepared by the states and territories and approved by the state and Commonwealth ministers responsible for

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[1]   More detail about HACC can be found at www.health.gov.au/acc/hacc/index.htm

aged care. State and territory governments are responsible for the day-to-day administration of the HACC program, management of reviews, coordinating state and regional planning processes and primary contact with service providers.

5. The HACC program operates in a difficult environment. Its joint Commonwealth/state and territory nature results in numerous complexities for the Commonwealth in administering the program. In addition, the program exists within a broader framework of aged-care, community, disability and health services funded by either the Commonwealth or states and territories or both. HACC thus has to respond to different recipient needs and recognise different priorities among the states and territories. Developments in government policy have resulted also in a changing focus for the program, with a growing emphasis on maintaining independence in the community for the frail aged and other people with disabilities. Service providers, in an environment of unsatisfied need, are also required to make difficult resource allocation decisions to balance the needs of both low-care and high-care clients.

6. The HACC program is in a period of transition, with NSW, Victoria, South Australia, the ACT, Queensland and the Northern Territory operating under a new HACC agreement (at January 2000), and the remaining two states at various stages of development of new agreements.

Audit objective

7. The audit's objective was to form an opinion on Health's administration of the HACC program, in particular, to assess:

- the adequacy of the measures the department has taken to ensure equitable and consistent provision of HACC services between, and within, all states and territories;

- the effectiveness of its coordination of HACC services with other support services for the frail aged and other people with disabilities;

- the adequacy of the measures it has taken to ensure that the impact of HACC expenditure is maximised, consistent with HACC objectives;

- whether the department has well-devised administrative systems that minimise the administrative burden on states and territories and facilitate delivery of HACC services; and

- the adequacy of the measures the department has taken to ensure that HACC performance information provides management with reliable assurance that program and management objectives are being achieved.

8.   This audit was designed as a companion to Audit Report No.19, 1998–99, *The Planning of Aged Care* and concentrates on HACC services to older persons with disabilities. It has not examined, in detail, services to younger people with disabilities. However, many of the findings apply as much to the latter as to the former. The audit began and was substantially completed in 1999, the International Year of Older Persons.

Over-all conclusion

9.   The ANAO found that Health's administration of HACC was generally sound, particularly in establishing a national framework for the states and territories to administer the program on a day-to-day basis. Nevertheless, the ANAO has identified a number of areas for improvement. Effective coordination of the planning of HACC services with that of other community services for the frail aged and other people with disabilities was identified as the major area requiring further attention.

Conclusions against the audit objectives

Adequacy of measures to ensure equitable and consistent provision of HACC services

10.   Total Commonwealth and state and territory funding per-capita of the HACC target population ranged from $531 in the ACT to $849 in Victoria in 1998–99. This difference is being addressed by an equalisation strategy, which has the aim of equal funding per-capita by 2011. The strategy has already significantly increased the per capita funding of the three lowest funding states. Health's equity measure is output oriented, which is not consistent with the input oriented equalisation strategy. Health will need to adopt an output-oriented strategy, to assist in achieving its equity performance goal.

11.   Current guidelines for HACC service providers reflect the old agreements. These guidelines are ambiguous in places and can be difficult to interpret. Revised guidelines are being developed for the new agreements, but are not yet in place. National and state and territory HACC triennial plans and state and territory annual HACC plans have not been timely, but the new agreements with the states and territories are expected to expedite state and territory annual plans.

12.   In summary, Health, in conjunction with the states and territories, has reasonable measures in place designed to achieve the equitable funding and consistent provision of HACC services and is working to effect needed improvements.

Effectiveness of coordination

13. Health has developed satisfactory mechanisms to coordinate Commonwealth HACC activities with state and territory HACC activities. However, more effective coordination is needed between the planning of HACC services and the planning of other related community care services. Priority should be given to closer coordination with the planning of Community Care Packages.

Adequacy of measures to ensure that the impact of HACC expenditure is maximised

14. Health is not well placed to monitor adequately the impact of HACC expenditure for those states and territories still under the previous agreements. The new agreements require the states and territories to specify by region the HACC funds required and the service outputs to be produced from those funds. The states and territories are also required to report their results, which will enable Health to monitor achievements and compare the performances of regions and states and territories, thereby providing suitable information to assist in improving program performance.

A well devised administrative system

15. The previous agreements require Commonwealth and state or territory approval for each project, which results in a high level of administrative overlap and duplication. On the other hand, the new HACC agreements will reduce administrative duplication between the Commonwealth and the states and territories, with Commonwealth approval required now only in relation to planning and funding at a regional level. Health's administrative resources for HACC have been reduced in anticipation of streamlined administration flowing from the new HACC agreements. Health's HACC administration costs are estimated to be less than 0.5 per cent of the total program cost to the Commonwealth.

Adequacy of performance information

16. Processing of acquittals under the previous agreements has not been timely. The acquittal process under the new agreements will be much simpler, which should facilitate the acquittals process and its timeliness. Health has included, in its Program Budget Statements, quantity, efficiency and equity performance measures for HACC, but no quality measures. The ANAO has offered several suggestions for improvement to Health's performance indicators. Health and the states and territories are introducing a HACC Minimum Data Set, which will provide more useful performance information for management at all levels.

Key Findings

The latest triennial plan for the HACC program was not issued.

17. The HACC agreements require the Commonwealth and state and territory ministers to formulate and agree jointly a triennial plan for the HACC program. This plan provides an agreed statement of the objectives for achieving the broad goals of the HACC program in the triennium. The plan for the latest triennium, 1996–97 to 1998–99, was not issued. Planning had to be developed in a period of considerable change in the HACC program, which created difficulties in reaching consensus on long-term goals. The absence of a current triennial plan has resulted in limitations on national directions for stakeholders in the program, and little medium-term direction for service providers. The new National Triennial Plan for 1999–2000 is under development.

Approval of state and territory annual HACC plans is not timely.

18. Each state and territory prepares an annual HACC plan specifying priorities, outputs and expenditure by region. Once approved by the state or territory ministers, these plans are submitted to Health for approval. Plans have generally been approved in the last quarter of the financial year, many in the last month. Approval of plans late in the planning period limits their effectiveness as a planning instrument and increases the possibility of inefficient or inappropriate expenditure. The new agreements with the states and territories should assist in expediting state and territory plans. Health advised that, in future, it will regularly monitor the timing of the receipt of state and territory annual plans.

There are major differences between the states and territories in average funding per capita of the HACC target population.

19. Estimated average combined state and territory and Commonwealth funding per capita for 1998–99 ranged from $531 in the ACT to $710 in NSW to $849 in Victoria. The national average funding per capita was $717. Health has adopted an equalisation strategy that has the goal of equal funding per capita by 2011.

Health should adopt an output oriented equity strategy to address its output equity goals.

20. Health's current equity performance measure is units of service output per 1000 HACC target population. Health has also started to move towards an output based funding framework. The imbalances between average funding per capita in each state and territory are still sufficiently

large that a simple, input oriented, equity strategy can be effective in reducing inequities between states and territories. However, as the differences in funding are reduced over time, Health will need to adopt an output-oriented strategy, to assist in achieving its equity performance goal.

It is difficult for Health to obtain a comprehensive indication of the demand for HACC services in isolation from demand for other community services.

21. The primary measures of demand for community services for people with disabilities, including the aged, are the ABS Surveys of Disability, Ageing and Carers. However, HACC is not the only source of community services for the surveyed population. Demand for HACC service cannot be isolated from general demand for community and health services in any data collected on demand and unmet need.

Ambiguity and a lack of definition of key terms in guidelines created difficulties for service–providers in determining eligibility for HACC services.

22. HACC operates in an environment of unsatisfied user need, which requires service-providers to make decisions on how scarce resources should be allocated. The ANAO found that service-providers had difficulty using HACC guidelines because of ambiguity and lack of definition of key terms, resulting in extensive individual interpretation. This can lead to inconsistencies in the provision of HACC services.

Health did not maintain information on the level of fees collected in each state and territory with the consequence that Health is unable to monitor the consistency and equity of fees between states and territories.

23. At present, the fees charged for HACC services vary between service providers and between states and territories. Such lack of consistency leads to inequity—clients in exactly the same circumstances could be charged differing fees, depending on their places of residence. Health was not able to provide information on the level of fees collected in the states and territories for 1997–98 or 1998–99. For the Commonwealth to continue to provide national leadership in this area, Health should maintain at least a minimum level of information on the amount of fee revenue in each state and territory.

The boundaries between accommodation support services provided by the Commonwealth–State Disability Agreement (CSDA) and community services provided by HACC are not clear to clients and their advocates.

24. Under the CSDA, the Commonwealth assists the states and territories with funds to provide community support services for people

of employment age with disabilities. The Department of Family and Community Services (DFaCS) administers the program. State and territory governments are responsible for planning and providing community services funded by the program. People with disabilities also receive community services from HACC. The boundaries between accommodation support services provided by the CSDA and community services provided by HACC are not clear to clients and their advocates.

There are satisfactory procedures in place to coordinate Commonwealth HACC activities with state and territory HACC activities.

25. The primary coordinating body is the HACC Officials Committee and its working groups. Comprising senior Commonwealth, state and territory officers, it is working constructively and effectively. There are adequate procedures in place to manage liaison and coordination with state and territory government departments responsible for the HACC program and Health's state and territory offices and to ensure effective coordination of Health's national office and state and territory offices.

Health is presently working with the states and territories to introduce improved client-assessment processes.

26. Where a HACC client, particularly one with complex needs, receives HACC services from more than one service-provider, the provision of a quality service requires cooperation between service providers. A key element in providing coordinated, quality services is the process of assessing a client's needs. Health, in cooperation with the states and territories, has introduced guidelines for improved assessment practices. Improved assessment practices have been adopted or are being adopted by the states and territories.

Accountability and data requirements can be onerous for small service-providers.

27. Some service providers, particularly in rural areas, can be very small, sometimes with only two or three part time staff. They can provide services funded by HACC and by other programs. The 20 largest service providers receive an estimated 70 per cent of HACC funds. There are over 950 service providers who receive funding of less than $50 000 per year. Large service-providers with sophisticated accounting systems have more capacity than smaller ones to accommodate differing, extensive accountability and data requirements. Health should consider the benefits of tailored accountability requirements for small providers.

Health should adopt a risk-management approach to finalising outstanding acquittals under the previous agreements cost-effectively.

28. The ANAO found that many acquittals had not been finalised because of a few remaining unresolved differences between Commonwealth and state and territory records. In one state, the unresolved differences ranged from 0.6 per cent to 1.08 per cent ($190 000 to $1.9 million) of HACC expenditure for that state. Given that state HACC expenditure had been through the state acquittal process already, the risk that the funds had not been spent for HACC purposes is low. A risk management approach would assist satisfactory finalisation of outstanding acquittals.

Health's response

29. The Department welcomes the comments made by the ANAO on the administration of the HACC program and notes the overall finding that the administration of the HACC program is generally sound. The Department, however, acknowledges that there are a number of administrative improvements that could benefit the effective operation of the program, and is generally in agreement with the key findings and recommendations of the report, particularly the requirement to enhance service coordination within the broader framework of support services to frail older people and younger people with disabilities.

30. The Department is currently in the process of implementing a number of measures to enable a more cost-effective, efficient and flexible approach to service delivery in the HACC program. These strategies will offset several of the recommendations of the ANAO report and include the move to the new Amending Agreements which will reduce administrative duplication between the Commonwealth and the states and territories, the development of the HACC Minimum Data Set to provide detailed information for performance management and the finalisation of the HACC Program Management Manual and National HACC Guidelines to ensure consistency in the application of program objectives.

31. New strategies will also be developed in response to the findings of the ANAO report that will lead to more efficient and effective administration of the HACC program.

Recommendations

The ANAO considers that the most important recommendations are 1 to 5.

Recommendation No.1 Para. 2.39

The ANAO recommends that, to ensure that the target of equal funding per head of target population is met as planned, Health negotiate with the states and territories to use the results of the 1998 ABS Survey of Disability, Ageing and Carers as a basis for the distribution of Commonwealth HACC funding between the states and territories.

Health: Agreed

Recommendation No.2 Para. 2.62

The ANAO recommends that, to promote consistency and equity in service-provision in the HACC program, Health improve guidance to service-providers by:

- clarifying as far as possible key terms in the definition of the HACC target population while ensuring that open eligibility and necessary flexibility for determining individual cases for HACC service provision are maintained;

- reducing ambiguity in the National Guidelines as far as possible, while retaining the level of flexibility appropriate to the nature of Commonwealth guidelines in the HACC program; and

- publishing National Guidelines for the new HACC agreements to ensure that guidance is appropriate and useful.

Health: Agreed

Recommendation No.3 Para. 2.74

The ANAO recommends that Health, in order to assess the success of the National Fees Policy:

- negotiate the inclusion of information on the level of fees collected in the states and territories in the reporting arrangements under the new HACC agreements; and

- request the states and territories to volunteer such information in the meantime.

Health: Agreed

Recommendation No.4 Para. 3.32

The ANAO recommends that Health coordinates, at national level, the planning of HACC and CCPs in order to ensure that HACC services and CCPs are cost-effective, adequately integrated and avoid unnecessary duplication.

Health: Agreed

Recommendation No.5 Para. 3.37

The ANAO recommends that Health work with other Commonwealth and state/territory agencies concerned to develop and promulgate jointly national guidelines in areas in which HACC and CSDA intersect, in order to clarify the boundaries for service providers.

Health: Agreed in principle

Recommendation No.6 Para. 4.9

The ANAO recommends that, to eliminate the backlog of acquittals under the old HACC agreements with states and territories, Health expedite the finalisation of outstanding acquittals by adopting a risk-management approach to their resolution in a cost effective manner.

Health: Agreed

Recommendation No.7 Para. 4.30
The ANAO recommends that Health reduce the administrative burden on service-providers by reviewing the costs and benefits of tailoring accountability and data requirements for service-providers receiving different levels of funding and ensuring that the accountability and data requirements of the various aged- and community-care programs are, as far as possible, integrated or made compatible.

Health: Agreed

Recommendation No.8 Para. 4.34
The ANAO recommends that Health ensure that there is an effective record-management system for the administration of the HACC program in both national and state Health offices.

Health: Agreed

Recommendation No.9 Para. 5.14
The ANAO recommends that, in order to ensure consistency with program goals and objectives, Health should consider varying the output indicator for HACC in relation to equity along the following lines: 'equitable distribution of units of HACC service output across states and territories *and between regions within states and territories* (units of service per 1000 HACC target population)'.

Health: Agreed

Audit Findings
and Conclusions

1. Introduction

This Chapter describes briefly the Home and Community Care program. It also sets out the audit's approach, objective and methodology.

Background

1.1   The Commonwealth Government provides funding under the *Home and Community Care Act 1985* (HACC Act) for a range of personal, health and domestic services to the frail aged, other people with disabilities, and their carers[2]. It does so to help people with moderate, severe or profound disabilities to maintain their independence in the community. The target population for HACC was estimated to be 1 618 200[3] in 1998. Services include meals on wheels, community nursing, personal care, home help, respite care, community transport and home maintenance. There are also HACC funded consumer-information services that provide consumers with assistance on service providers and services available. HACC service-providers include government, charitable and private organisations.

1.2   The Commonwealth provides about 60 per cent of HACC funds and the states[4] the balance. Commonwealth funding for 1999–2000 is $525 million and the states are expected to provide about $340 million for an estimated total of some $865 million. Additional funding comes from fees collected by service-providers, while the work of volunteers and informal carers adds considerable further value to HACC. The Commonwealth also provides funding to assist younger people with disabilities through the Commonwealth State Disability Agreement (CSDA), which is administered by the Department of Family and Community Services (DfaCS). Other Commonwealth programs, such as Community Care Packages (CCPs), also provide services to the same target group as HACC.

1.3   The Commonwealth Department of Health and Aged Care (Health), with state government agencies administering HACC, is responsible for developing and implementing national policy and identifying national trends in the HACC program. State annual plans are

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[2]   More detail about HACC can be found at www.health.gov.au/acc/hacc/index.htm

[3]   Australian Bureau of Statistics, 1998, *Disability, Ageing and Carers*, Commonwealth of Australia, p. 2.

[4]   References to 'states' are used for brevity throughout the remainder of the report and are intended to include all Australian states and territories.

prepared by state government agencies and approved by the state ministers concerned and the Commonwealth Minister for Aged Care. State and territory governments are responsible for day-to-day administration of the program, managing reviews, coordinating state and regional planning processes and primary contact with service-providers.

1.4   The program operates in a complex environment. Its joint Commonwealth/state nature creates a number of difficulties for the Commonwealth in its administration. In addition, the program exists within a broader framework of aged care, community, disability and health services funded by the Commonwealth or states or both. Developments in government policy have also resulted in a changing environment for the program, with a growing emphasis on maintaining the independence in the community of older persons and people with disabilities.

1.5   The program developed from a consolidation of a number of Commonwealth and state programs in 1985, resulting in many differences in the way it operates in individual states. These differences have significant implications for Health in developing mechanisms to achieve national consistency in the program's administration, coordinating it with other support programs and providing its services equitably between and within the states.

1.6   Other support services for the program's target population overlap with HACC services. Their influence needs to be taken into account in the development of policy, and in pursuing equity. For example, although HACC per-capita funding in Victoria is larger than in Queensland, Victoria has a comparatively smaller number of residential-care places than Queensland.

1.7   The program is in a period of transition. NSW, Victoria, the ACT, South Australia, Queensland, and the Northern Territory are operating under a new HACC agreement with the Commonwealth Government (at January 2000)[5]. Western Australia and Tasmania, while operating under the old agreements, are at various stages of development of new agreements.

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[5]   States/Territories listed in order of signing

Program aims and objectives

The aims of the HACC program

1.8   The aims of the HACC program are to:

- *provide a comprehensive and integrated range of basic maintenance and support services for frail aged people and other people with a disability and their carers;*

- *help these people to be more independent at home and in the community, thereby preventing their inappropriate admission to long term residential care and enhancing their quality of life; and*

- *provide a greater range of services and more flexible service provision to ensure that services respond to the needs of consumers.*[6]

Program objectives

1.9   The two main objectives are:

- *to promote the provision of a comprehensive, coordinated and integrated range of home and community care services designed to provide basic maintenance and support to persons in the target population to assist them to enhance their independence in the community and avoid their premature or inappropriate admission to long term residential care; and*

- *to develop home and community care services through the joint cooperation of the Commonwealth, the State(s and Territories), local governments and community organisations representing both consumers and service providers.*

1.10   Other objectives of the program are set out in Clause 3 of the agreements with the states and include the following:

- *to ensure that within available resources, priority is directed to persons within the target population who are most in need of, or who would benefit most from home and community care;*

- *to ensure that all groups within the target population, including persons of non-English speaking backgrounds, persons living in rural and remote areas, Aboriginals and Torres Strait Islanders, persons with dementia and financially disadvantaged persons, have access to home and community care services;*

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[6]   Commonwealth of Australia, 1992, *Home and Community Program National Guidelines*, second edition, p. 2.

- *to provide for persons within the target population an effective and integrated means of assessment of the need for and referral to home and community care services;*

- *to ensure an equitable distribution of services, both within and between regions, taking into account regional differences;*

- *to ensure that services are cost-effective, achieve integration, promote independence and avoid unnecessary duplication;*

- *to enable testing and evaluation of new and differing approaches to planning, coordination and service delivery, and to monitor the effectiveness and efficiency of the program;*

- *to coordinate and integrate with related health and welfare programs and to facilitate the involvement of community organisations and users in the advisory process; and*

- *to ensure information arrangements are in place for planning and evaluation purposes and the operation of effective planning and coordination mechanisms.*

Previous audits and reviews

1.11   Previous audit reports relevant to the HACC program include:

- *Home and Community Care Program,* Department of Community Services and Health, Efficiency Audit Report, 1987–88;

- *The Planning of Aged Care*, Department of Health and Aged Care, Audit Report No.19, 1998–99; and

- *The Management of Performance Information for Specific Purpose Payments— The State of Play*, Audit Report No.31, 1998–99.

1.12   Other relevant reviews include:

- House of Representatives Standing Committee on Community Affairs, *Home But Not Alone*[7]; 1994, and

- Department of Human Services and Health, *The Efficiency and Effectiveness Review of the Home and Community Care Program*[8], Aged and Community Care Service Development and Evaluation Report No.18, 1995. (This was a Joint Commonwealth/state evaluation).

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[7]   House of Representatives Standing Committee on Community Affairs, *Home But Not Alone*, AGPS, Canberra, 1994.

[8]   Department of Human Services and Health, 1995, *The Efficiency and Effectiveness Review of the Home and Community Care Program*,' Aged and Community Care Service Development and Evaluation Report No.18, AGPS, Canberra.

Audit objective

1.13   The audit's objective was to form an opinion on Health's administration of the HACC program. In particular, to assess:

- the adequacy of the measures it has taken to ensure equitable and consistent provision of HACC services between and within all states and territories;

- the effectiveness of its coordination of HACC services with other support services for the frail aged and other people with disabilities;

- the adequacy of the measures it has taken to ensure that the impact of HACC expenditure is maximised, consistent with HACC objectives;

- whether it has well-devised, low-cost administrative systems that minimise the administrative burden on states and territories and facilitate delivery of HACC services; and

- the adequacy of the measures it has taken to ensure that HACC performance information provides management with reliable assurance that program and management objectives are being achieved.

1.14   These objectives were developed from the HACC objectives and previous reviews of the HACC program. They reflect the priority outcomes and key outputs specified for the HACC program in the 1999–2000 Portfolio Budgets Statements for the Commonwealth Department of Health and Aged Care.

Audit scope and methodology

1.15   HACC is a component of Outcome 8, *Enhanced Quality of Life for Older Australian*s, of the Health and Aged Care portfolio. The audit was designed as a companion to Audit Report No.19, 1998–99, *The Planning of Aged Care* and concentrates on HACC services to older persons with disabilities. It has not examined, in detail, services to younger people with disabilities. However, many of the findings apply as much to the latter as to the former.

1.16   To ensure that the audit would be of maximum significance, it was focused on administration under the new HACC agreements. The old agreements are discussed where appropriate.

1.17   Audit criteria, which encapsulate the auditor's expectations, based on observed better practice of sound management and administration, were developed to reflect the audit's objective. The criteria included reasonable and attainable performance and control standards against which the adequacy of systems, practices, programs and administrative activities were assessed.

1.18   The main methods of enquiry were:

• review of Health documents;

• interviews with officers of Health and state departments concerned, HACC service-providers, and representatives of the aged community; and

• engagement of two consultants with expertise in HACC policy development and research–Dr Anna Howe and Ms Dianne Beatty–to advise on the audit's criteria, initial findings and draft report.

1.19   Fieldwork was conducted between May and July 1999 in Health's national office in Canberra and in state offices in Sydney, Melbourne, Brisbane and Adelaide. These states account for more than 85 per cent of HACC expenditure.

1.20   The audit complied with ANAO Auditing Standards. It cost $380 000.

2. Planning, Data and Equity

This Chapter discusses planning for the HACC program, data available for planning and other measures to achieve equity. The audit found that key joint-planning documents were often untimely and in some cases did not exist. There are data available on the number of people requiring HACC and other community services, but not on the level of need. Health's equity strategy is input based, yet its performance measure is output based. Clearer HACC guidelines would help service-providers to supply consistent and equitable services.

Introduction

2.1   The Commonwealth and states share responsibility for planning and funding the program, including developing and approving Triennial Strategic plans and State annual plans. The program is in a period of transition, four states and two territories are operating under a new HACC agreement. Tasmania is very close to signing an amending agreement and negotiations are continuing with Western Australia at officer level. As a result, joint planning differs in the states, as outlined below.

Triennial Strategic Plans

2.2   The Commonwealth, state and territory ministers concerned are required, under both the old and new HACC agreements, to formulate and agree on a National Triennial Strategic plan for the program. This plan specifies program priorities and strategic directions and includes estimates of the moneys to be provided by the Commonwealth and states. Neither the old nor new agreements specify deadlines for the plan's production. However, the Program Management Manual specifies that *'the Triennial Plan must be jointly agreed by the Commonwealth, State and Territory Ministers by 1 July of the first year of the triennium'.*

2.3   The audit found that the most recently approved HACC National Triennial Strategic plan was for 1993–94 to 1995–96. The draft triennial plan for 1996–97 to 1998–99 was not approved by all states before the period expired. The ANAO acknowledges the difficulties in developing and agreeing on a national plan in the transitional period with its variety of different agreements. However, the ANAO found that the lack of a National Triennial Strategic plan impeded creation of a clear national strategic direction for stakeholders in the program. It also impedes the development of State/Territory Triennial Strategic plans and limits stakeholders' understanding of the program's direction at state level.

2.4 Each of the states' triennial strategic plans describes the operation of the program in individual states and identifies strategies to implement the national plan and program objectives. Two states/territories had current state plans in place at the time of audit fieldwork. Four other state/territory plans had lapsed recently, and the remaining two did not have such plans in place. Most were at various stages of development of new plans, with some stating they preferred to wait to ensure that they were consistent with an approved national plan.

2.5 Health is working with officials from the states to develop a National Triennial Strategic plan for 1999–2000 to 2002–2003, for consideration at the May 2000 HACC Officials Committee meeting. This plan will be simpler than the draft 1996–97 to 1998–99 plan. As May 2000 is close to the end of the first year of the triennium, Health should expedite development of the plan.

Audit finding

National and State Triennial Strategic plans for the HACC program are not timely, and in some instances do not exist. However, Health is working with officials from the states to develop a National Triennial Strategic plan for 1999–2000 to 2002–2003.

Annual planning of funding process

2.6 Annual Commonwealth/state planning comprises the determination of program funds, development of State annual plans, allocation of funds to regions within states, funding and managing projects in regions, and annual reporting and acquittal of expenditure. Under the new agreements the Commonwealth approves State annual plans and the allocation of funds to regions. Under the old agreements the Commonwealth also approves the allocation of funds to projects within regions.

State annual plans

2.7 State annual plans are intended to specify program priorities and, under the new HACC agreements, service output levels, and form the basis of joint ministerial approval of funding for the year ahead. Jointly agreed planning tools, including the Service Provision Targets Framework[9] (SPTF) and information and advice provided by regional advisory and/

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[9] The Service Provision Targets Framework provides quantitative and qualitative data on the characteristics of local populations, service provision in HACC, other aged and community care services, and other information to assist with planning. The SPTF is discussed further later in this Chapter.

or consultative mechanisms, are used in identifying priorities and developing planned service outputs for each region. State government officers are primarily responsible for the development and administration of the State annual plan. Commonwealth officers are involved to varying extents in analysing data and attending community consultations, from which they make recommendations to the Commonwealth Minister on the suitability of the plan.

2.8   The ANAO found that State annual plans had been jointly approved generally in the last quarter of the year to which they applied, many of them in the last month of that year. For instance, 1998–99 State annual plans for Queensland, South Australia, Northern Territory, Western Australia and the ACT were approved in June 1999. As a result, State annual plans are often not available to stakeholders, such as service-providers, for planning until late in the year. Approval of plans so late in the financial year also has significant implications for funding, planning and service development at state-government and service-provider levels. Growth funding for each state is determined by approval of the plans by both the Commonwealth and state/territory ministers. All HACC moneys, including growth funds must be spent by the end of the financial year. When approval of state plans is delayed there is a surge of expenditure at the end of the financial year, increasing the risk of inefficient or inappropriate expenditure.

2.9   The delays are associated primarily with joint Commonwealth/ state administration of the program. The new HACC agreements provide for a reduction of administrative duplication between the Commonwealth and the states. Commonwealth agreement under the new agreements is required only in relation to planning and funding at a regional level, as opposed to individual-project level. The fact that the Commonwealth is focusing now on regional-level rather than project-level expenditure should facilitate earlier Commonwealth–state agreement on State annual plans because less detail will need to be agreed at joint ministerial level before their finalisation. It should be noted that one of the keys to early finalisation of state plans is timely delivery of the plans to the Commonwealth.

2.10   Delays in State annual plan development and approval have also occurred because of disagreements and misunderstandings over the content and presentation of plans. New HACC agreements have existed in some states since 1 July 1998. Health has developed a *HACC Program Management Manual* that provides for arrangements under the new agreements. This was approved by HACC Officials Committee in November 1999 and has been issued. It will assist states with the

operational requirements of the amending agreements. In addition, Health has advised that it will regularly monitor the timing and receipt of State annual plans to ensure that any misunderstandings over content and layout are remedied early to prevent lengthy delays in submission.

Audit finding

The majority of State annual plans are approved in the last quarter of the financial year to which they apply. Approval of plans late in the financial year decreases their utility as a planning document for service providers and other stakeholders.

Data

2.11 This section describes the data available on the HACC client population and on the demand for and supply of services to that population.

Demand data

2.12 The primary measure of demand is the five-yearly ABS Survey of Disability, Ageing and Carers, which gives estimates of the number of persons with disabilities who need help, the number for whom that need is fully or partly satisfied and the number for whom it is not. However, HACC is not the only source of community services for the population covered by the survey, so estimates of need and unsatisfied need in the ABS survey take account of needs met by the community-services sector, as a whole, not just by HACC.

2.13 The ABS survey generates data on:

- people with disabilities living in households[10] (numbers receiving help and needing help);
- people needing help[11] (by provider type); and
- older people needing help[12] (by the extent to which need is satisfied for specific types of service).

2.14 The survey is conducted by interviewing people with disabilities and their carers. To some extent it reflects people's perceptions of their needs—people in the same situations might report differing needs. The survey measures the number of people with unmet needs by service type, but gives no indication of the level of services required. For example,

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[10] Australian Bureau of Statistics, 1998, *Disability, Ageing and Carers*, Commonwealth of Australia, p. 25.

[11] Ibid, pp. 26–28.

[12] Ibid, p. 39.

the survey estimates that in 1998 there were 50 800 people with a partly met need for assistance[13] with housework and 17 200 whose needs were not met at all. The survey gives no indication of the level of services needed to fully meet the needs of these people.

2.15 Despite its limitations, the survey can be used as a proxy indicator of the demand for HACC services.

2.16 Another source of information on the supply of and demand for HACC services is the HACC Service Provision Targets Framework. The SPTF was developed from the *Service Provision Targets*[14] report, commissioned jointly by the NSW Department of Community Services and the then Commonwealth Department of Human Services and Health (a predecessor of Health). The report was commissioned in recognition that equitable service provision needs to take account of service outputs as well as funding inputs.

2.17 The SPTF collates data on indicators of supply and demand, including unsatisfied demand, from information provided by service-providers and other stakeholders. For example, information on:

- services provided in a planning area;

- unsatisfied needs identified by service-providers and consumers, to be assigned priority in a planning area;

- any research or reports indicating unsatisfied need in a planning area; and

- any other information on unsatisfied need.

2.18 The first year the SPTF was used for planning at regional and local level was 1998–99. It is not used yet by all states and is not aggregated to state or national level.

2.19 The SPTF operates as an Internet web site[15] that service-providers and planners can access for information for HACC planning. Service-providers can also lodge on the web site information on the services that they deliver. It has a facility by which service-providers can present estimates of unsatisfied demand in the populations they serve. Although useful, these estimates are of limited reliability. Service-providers indicated that the estimates did not take account of poor knowledge and

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[13] Assistance includes all forms of help provided, including both government and private, paid and voluntary. It includes help from other family members in the same household.

[14] Commonwealth of Australia, 1996, *Service Provision Targets, A report for the Home and Community Care Program, Prepared for the Commonwealth Department of Human Services and Health and the NSW Department of Community Services*, AGPS, Canberra.

[15] www.health.gov.au/acc/hacc/sptindex.htm

use of HACC services by some eligible sections of the community, or the suppression of demand that occurs in the absence of a service or because of historical rationing of services[16].

2.20 Health has informed the ANAO that the SPTF will be redeveloped to form HACC PLANNET, which will be a regional focussed information system, in line with the requirement of the amending agreements. This new system will be output/outcome based and will be useful in highlighting discrepancies between annual plans and business reports, alleviating the current level of administration and duplication.

2.21 More information on the level and nature of demand for HACC services, and unsatisfied demand, is collected at local and regional level in the annual HACC planning process. States have local and/or regional planning groups, comprising primarily service-providers, which constitute a valuable source of knowledge of such data. Additional consultative mechanisms are used to collate information from consumers and other stakeholders.

2.22 The report *Efficiency and Effectiveness Review of the Home and Community Care Program* states[17] *'It has proved difficult to measure objectively the demand for HACC type services'*. The *Service Provision Targets Report* states *'No information is available internationally or in Australia which points to a normative or optimum standard for community care provision.'*[18] While the ABS survey provides a good knowledge of the number of people with disabilities needing community services, it does not provide information on the level of services required.

Summary

2.23 Health has incomplete data on the level, location and nature of the demand for HACC services. The ABS surveys of Disability, Ageing and Carers provide a useful proxy for needs and unsatisfied needs, which can be augmented from other sources. Demand for HACC services cannot be isolated from general demand for community and health services in data collected on demand and unsatisfied need. It is difficult to obtain an objective measure of the demand for community services, including HACC services.

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[16] Section 11 of the *Service Provision Targets* report provides further information on the demand for community services and measurement problems.

[17] Commonwealth of Australia, 1995, *The Efficiency and Effectiveness Review of the Home and Community Care Program*, AGPS, Canberra, p. 6.

[18] Commonwealth of Australia, 1996, *Service Provision Targets, A report for the Home and Community Care Program, Prepared for the Commonwealth Department of Human Services and Health and the NSW Department of Community Services*, AGPS, Canberra, p. 117.

Supply data

2.24 Health has an extensive range of information on the supply of HACC services. The primary source of data is the HACC Service Provision Data Collection[19], containing information from HACC-funded service outlets on the number of people receiving HACC services and amount of services received, by type of service. Data is collected each May and November.

2.25 Three current developments will improve its knowledge. Firstly, new HACC agreements require states to specify, by region, the range and volume of outputs to be produced and their cost, and to report to Health achievements against budgets. Secondly, the HACC Minimum Data Set (MDS) will provide information on the services consumed by individual clients. This information has not been readily available previously. Thirdly, the SPTF will provide a structure that will allow the supply of services to be analysed at regional and local level in a form comparable with other data, such as that on population and demand.

2.26 Health has a good knowledge of the location and number of existing CCPs but has not yet collected information on services they provide. Health, as part of the Respite for Carers program, is developing a Respite for Carers Minimum Data Set. This is being developed from the HACC MDS.

2.27 Under the Commonwealth State Disability Agreement (CSDA) the states are responsible for the purchase or provision of community services for younger people with disabilities. For data on CSDA community services to be useful to Health there will need to be a central data repository that Health can access. To provide a complete picture of community services for the frail aged and other people with disabilities provided via Commonwealth-funded programs, the Department of Veterans' Affairs (DVA) would need to supply information on its health care program's community services to veterans.

2.28 Without knowledge of the services being delivered to the frail aged and other people with disabilities by all programs, Health will have difficulty in identifying and addressing gaps or duplications in service provision. Health administers three of the five major Commonwealth programs that provide community services for the frail aged and other people with disabilities. They account for a majority of Commonwealth community-service funding. Health is therefore the ideal department for the leading role in coordinating collection of comprehensive data on the supply of such services.

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[19] Data on HACC, including that from the Service Provision Data Collection, can be found at www.health.gov.au/acc/stat/ccs/ccsindex.htm

2.29   The ANAO suggests that, to assist in the coordinated planning of Commonwealth-funded community services, Health take a leading role in developing coordinated collection of data on the supply of community services to the frail aged and other people with disabilities.

National Community Services Information Development Plan

2.30   The need to improve community-services data is assigned high priority by the Standing Committee of Community Services and Income Security Administrators (SCCSISA). At its October 1997 meeting SCCSISA asked the National Community Services Information Group to prepare a draft of the National Community Services Information Development Plan[20]. The draft was subject to further consultation with community services, government agencies and non-government peak organisations. The final plan, which establishes a framework for developing community-services data, was published early in 1999. Several data sets are being developed within this framework or redeveloped to comply with it, including the HACC MDS

Audit finding

A framework exists to ensure that the community-service data sets created or being developed are compatible with each other.

The HACC equalisation strategy

2.31   Each year, immediately after both Houses of Parliament approve the Commonwealth Budget, the Commonwealth Minister offers HACC program funding to the state and territory ministers. State and territory ministers respond—accepting all or part of the funds offered, depending on their ability to provide funds at the appropriate ratio[21]. Any Commonwealth funds supplied to a state and not matched by state funds are redistributed to other states able to provide matching funds, with priority given to those whose estimated per capita funding of the HACC target population is below the national average.

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[20]   Australian Institute of Health and Welfare, 1999, *National Community Services Information Plan*, National Capital Printing, Canberra.

[21]   For further discussion of Commonwealth/State funding ratios, see Appendix 1.

2.32   Commonwealth funding is calculated using a formula based on the previous financial year's amount, indexed for inflation plus a growth allowance (currently six per cent per annum). Funding allocations to the states are calculated by a funding formula, which takes into account other factors, including assumed levels of fees collected by service-providers, and an equalisation strategy. As a result of a 1996 Budget initiative, the HACC funding formula assumes that each state and territory has collected fee revenue, from 1999–2000, equal to 20 per cent of total HACC expenditure.

2.33   The HACC equalisation strategy is agreed to by states and the Commonwealth and is intended to equalise the average combined Commonwealth and state government per capita funding of the HACC target population of each state and territory over the period 1994–95 to 2010–2011. The target date was chosen to coincide with that for equalisation between states of residential care places.[22]

2.34   The agreed strategy uses HACC target population projections for each year to 2010–2011, calculated by applying the 1993 ABS Survey of Disability, Ageing and Carers data to a population-projection model developed by Health officers. The ABS survey is conducted every five years. Health has recalculated the HACC target population projections to 2010–2011 using the 1998 ABS survey data and compared projections based on the 1993 and 1998 sets of data. Projections based on the older data show a significantly smaller proportion of the total population with a disability than those based on the 1998 data. A summary of the proportion of the total population with a disability over time is shown in Table 2.1.

Table 2.1

Proportion of total Australian population with a disability

Year	1981	1988	1993	1998
Disability rate[1] (per cent) (age standardised[2])	14.6	16.5	17.2	18.8

Notes: 1   Ratio of people with disabilities to the total population.
         2   Standardised to remove the effect of different age distributions over time.

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[22]   For discussion of the equalisation of residential-care places, see Productivity Commission 1999, *Nursing Home Subsidies: Inquiry Report*, The Commission, Canberra.

2.35 There has also been a variation in the proportions of the target population between the states. A summary is shown in Table 2.2.

Summary of the proportion of the HACC target population in each State and Territory for 1993 and 1998

State/Territory	1993		1998	
	Number	Proportion (%)	Number	Proportion (%)
NSW	335 600	32.2	536 100	33.1
VIC	256 500	24.6	373 800	23.1
QLD	191 500	18.4	324 800	20.0
SA	107 700	10.3	141 600	8.8
WA	95 900	9.2	159 100	9.8
TAS	31 300	3.0	49 200	3.0
NT	5 600	0.5	9 800	0.6
ACT	17 300	1.7	23 700	1.5
AUSTRALIA	1 041 400	100.0	1 618 200	100.0

2.36 When the proportion of a state's or territory's HACC target population increases or decreases relative to those of others, the growth rate required to achieve equal funding per capita by 2010–2011 varies accordingly. If the projections based on the 1998 data are adopted, the funding growth rates for each state or territory required to meet the 2010–2011 target will change from the current ones, requiring increases in projected funding for some and decreases for others. The adoption of projections based on the 1998 ABS survey will need to be negotiated with the states.

2.37 The significant difference between the projections based on the 1993 and 1998 data indicates that Health's current projection method for the equalisation strategy should be reviewed to improve the projections' stability. Because of the difficulties associated with negotiating a more effective projection model with all states, the independent advice of a body acceptable to all parties, such as the Australian Institute of Health and Welfare, may facilitate the process.

2.38 Differences between ABS surveys will continue to affect funding even if the equalisation target is achieved in 2010–2011. If the HACC target-population projections in each state change between surveys, the proportion of funds allocated to each state will have to be adjusted to achieve equal per-capita funding.

Audit finding

When the proportion of a state's or territory's HACC target population, as shown in ABS surveys, increases or decreases relative to those of others, the growth rate required to achieve equal funding per capita by 2010–2011 varies accordingly.

Recommendation No.1

2.39   The ANAO recommends that, to ensure that the target of equal funding per head of target population is met as planned, Health negotiate with the states and territories to use the results of the 1998 ABS Survey of Disability, Ageing and Carers as a basis for the distribution of Commonwealth HACC funding between the States.

Health's response

2.40   Health agrees, and will seek to renegotiate the strategies that underpin the HACC equalisation formula with HACC Officials. The Department has commenced discussions with the states and territories on the use of the 1998 ABS Survey of Disabilities, Ageing and Carers.

2.41   Table 2.3 shows the current per-capita distribution of HACC funds to the states for the HACC target population. Estimated average per-capita funds for 1998–99 ranged from $531 in the ACT to $849 in Victoria. The national average was $717. The state with the most funds in 1998–99 was NSW, which was also closest to the estimated national per-capita average of $710. A consequence of the differing per-capita funding levels between states is differing per-capita levels of HACC service. It should be noted, however, that HACC is not the only source of assistance to frail aged and other people with disabilities. For example, Victoria has higher per-capita HACC funding than Queensland but a relatively smaller number of residential care places.

Table 2.3
Joint funding for the HACC program for 1998–1999

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
Commonwealth funds ($m)	155.9	141.2	87.7	44.8	49.0	13.3	3.1	5.3	500.2
State funds ($m)	104.6	94.3	48.0	27.9	31.7	9.8	1.4	5.5	323.2
Total funding[1] ($m)	260.4	235.5	135.7	72.6	80.7	23.2	4.5	10.9	823.4
Estimated average funds per capita ($)	710	849	618	629	747	682	666	531	717

Notes: 1   Excludes fees revenue collected by service providers in states and territories.

2.42   A key requirement for the equalisation strategy is a positive growth rate in HACC funds for each state and territory. The requirement of real funding growth rates for all states implies that the Commonwealth maintains a minimum level of funding. The Commonwealth has committed to a six per cent real per annum (7.7 per cent including indexation) growth in HACC funding. This is more than sufficient to meet the equalisation target. However, the states must also maintain the projected funding growth rates shown in Table 2.4 by providing matching funding, for the equalisation strategy to succeed. This requires the two territories to increase their funding at over 10 per cent per year.

Table 2.4

Average projected growth rates in total HACC expenditure to achieve equalisation of government funding 1999–2000 to 2010–2011

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
Growth rate (per cent)	7.5	5.8	9.7	8.2	7.8	7.6	11.2	11.7	7.7

Note: The growth rate is the sum of the real growth rate and indexation rate.

2.43   When funds are not fully matched pro-rata by a state or territory, surplus Commonwealth funds are redistributed to other states. Priority for redistribution of surplus funds is given to states with estimated per-capita funding below the national average. States accepting redistributed funds must still match them pro-rata. Redistribution of the surplus funds has implications for the projected growth rates of HACC expenditure and therefore the equalisation target, particularly when the states that do not 'match' Commonwealth funds have average per-capita funding below the national average.

2.44   The equalisation strategy has already significantly increased the per capita funding of the three lowest states. As a percentage of national per capita funding, Queensland has increased from 72 per cent in 1994–95 to 86 per cent in 1998–99. Over the same period the Northern Territory has moved from 82 to 93 per cent, while the ACT has moved from 61 per cent to 74 per cent.

Audit finding

There are major differences between the states in average funding per-capita of the target population for HACC services. Health has a strategy to equalise combined Commonwealth and state funding per-capita for HACC services between states but its success depends heavily on the states' ability to 'match' Commonwealth contributions.

Towards a service-output-based strategy for equity

2.45   Health has an objective:

> *to ensure that, within available resources, and in the context of broader service delivery framework, home and community services are provided equitably between Regions and are responsive to Regional differences.*[23]

2.46   It also has a performance measure to assess performance against this objective as follows (discussed further in Chapter 5):

> *Equitable distribution of units of HACC service output across States/ Territories (units of service*[24] *per 1000 HACC population).*

2.47   The SPTF is intended to help achieve more equity in service outputs. The SPTF uses units of service per 1000 of the HACC target population, consistent with the output indicator for equity. It uses a range of data sources, including those on HACC service outputs and other relevant aged- and community-care services, to assist with planning. Some states used the STPF for the first time in planning 1998–1999 funding at a regional and local level.

2.48   The equalisation strategy is input based. When the strategy was developed the *Service Provision Targets* report had not been completed and Health did not have sufficient information for an output based equity measure. That information is now becoming available. The imbalances between average funding per capita in each state are still sufficiently large that a simple, input oriented, measure can still be effective in reducing inequities between states. However, as the differences in per capita funding are reduced, Health will need to adopt an output oriented strategy which takes into account a wider range of factors, to ensure its target of equity in units of HACC service per 1000 HACC target population between states is met.

2.49   As outlined above, the new HACC agreements require the states to project levels of service output by region and by state as a whole in State annual plans. Plans under the new agreements specify proposed outputs by type of service. For example, proposed hours of nursing service, home care, or personal care, or the number of meals on wheels etc. Subsequent State annual Business Reports are required to include data on levels of service output achieved by type of service. Once all states are funding regions on, and reporting against, outputs, the HACC

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[23]   Clause 5. (1)(f), HACC Agreement with the States.

[24]   One hour of service equals one unit of service, one episode of service (one meals on wheels) equals one unit of service.

program nationally can move toward output-based funding. Then Health might be in a position to implement a strategy to achieve equity on a service-outputs basis.

2.50   As outlined in Appendix 1, a significant problem resulting from joint administration of the HACC program is the amount of time needed to negotiate reforms of it. It is therefore important for Health to decide whether a new output-based equity strategy is required soon enough to allow for its development, negotiation with the states, and planning for its implementation.

2.51   In our discussion of demand data above we made the point that demand for HACC services cannot be isolated from demand for general community services. In Chapter 3 we will make the point that HACC services overlap with other community services. An equity measure for the provision of HACC services that does not take account of other community services used by HACC clients will be incomplete.

2.52   A composite equity indicator that included all community services to HACC clients would be a valuable tool for planning and policy development. On the other hand it could be expensive to develop and might not be much more informative than Health's current indicator (units of output per 1000 HACC target population). Health will need to assess the value and cost of a more complete composite indicator against the benefits. The Commonwealth Grants Commission (CGC) prepares recommendations on the shares of general revenue and health grants to be allocated to each state and territory. When doing so it takes into account specific-purpose grants such as HACC. Building on earlier discussion with the CGC, it would be useful for Health to liaise with the CGC to ensure that Health is not duplicating work undertaken by the CGC.

2.53   An advantage of an output-based indicator is its ability to take account of cost differences between states. However, some stakeholders have raised concerns that, in accommodating different costs of achieving outputs in the states, output-based funding might also accommodate inherent inefficiencies in specific states or territories' administration of the HACC program. The ANAO found that Health had monitored implicit prices of services already, from the level of outputs projected in State annual plans and the proposed levels of required funds to achieve them. Health has demonstrated that it considers whether average costs of different types of services in states are reasonable, and resolves significant differences with the states where they occur. Comparison of prices between states will reinforce the importance of benchmarking.

Audit finding

Health's equity measure is output based. However, the equalisation strategy is input based. As differences in HACC funding per capita between states are minimised, Health will need to move from an input oriented equalisation strategy to an output oriented strategy to address its output equity goals. Health will need to initiate an output-oriented equity strategy early, to allow time for joint negotiation, development and implementation with the states.

Clear national guidelines to facilitate the consistent and equitable provision of HACC services

HACC target population definition

2.54   The definition of the HACC target population determines eligibility for HACC services. The HACC target population is broadly defined in the *Home and Community Care Act 1985* to enable the HACC program to provide flexibility in service-provision and act as a safety-net program (discussed further in Chapter 3). The ANAO found that the inherent flexibility of the program was valuable in adapting to local and individual circumstances and accommodating changing needs of the program and its client population.

2.55   However, the ANAO found that significant issues arose because of a lack of definition of many key terms used to describe the HACC target population and, where necessary, there was no clarification in supporting documents. In the absence of clear definition of the HACC target population, extensive individual interpretation by service-providers is required to determine eligibility, resulting in inconsistent application of the guidelines, and thus HACC service-provision between and within the states and territories. This is particularly significant in an environment of considerable unsatisfied need, in which service-providers are required to make difficult decisions about how scarce resources should be allocated. Although Health should clarify as far as possible the meaning of key terms used in the definition of the HACC target population, there is a tension between additional definition to reduce inconsistent application of the guidelines and preserving necessary flexibility for the program, as outlined above.

HACC National Guidelines

2.56   The HACC National Guidelines provide direction on a range of subjects for stakeholders, particularly for government HACC officers and service-providers. National Guidelines have been developed for the new HACC agreements but are not yet in effect. The existing National Guidelines are generally well known and applied by HACC officers and

service-providers. They are ambiguous in parts, particularly in relation to the practical application of broad concepts, and there is a lack of definition of key terms, resulting in difficulties of interpretation for service-providers.

2.57 Stakeholders have also had difficulty in interpretation because of apparent internal conflicts in the program's aims as outlined in the National Guidelines. Further interpretation problems result from conflict between the aims of the program and goals for the allocation of scarce resources specified in the HACC agreements. The agreements state that priority should be assigned to those *'most in need of, and/or who would benefit most from, home and community care'*. A recent consultancy report on targeting[25] has confirmed that giving a high priority to resources for high-needs clients is not necessarily the most effective strategy for achieving the program's goals, which include enhancing quality of life and preventing inappropriate or premature admission to long-term residential care.

2.58 To improve consistency of service–provision, Health should improve guidance to service-providers. It is acknowledged that a certain level of generality is appropriate to the nature of National Guidelines to retain the flexibility to enable the HACC program to be administered in a manner appropriate to the individual environments of the states.

2.59 Possible ways of improving guidance to service-providers include reducing ambiguity in the Guidelines and improving communication by other media, such as an e-mail inquiry line which service-providers can use to resolve interpretive issues. An inquiry line could be operated centrally from one Health state office to provide for consistency and efficiency, while continuing to maximise the benefits of utilising officers in the state-office environment. National Guidelines for the new HACC agreements should be published to ensure that guidance is appropriate and accurate.

2.60 Health has informed the ANAO that interpretive issues are state matters as part of their day to day administration of the program. State agencies contribute to the overall development of the Guidelines. It is the states' role to interpret the Guidelines to service providers and the Commonwealth clarifies the content of the Guidelines to the states as required. This is usually on a one on one basis. In addition, not all HACC service providers are comfortable using an electronic means of answering inquiries.

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[25] National Ageing Research Institute and Bundoora Extended Care Centre 1999, *Targeting in the Home and Community Care Program*, Aged and Community Care Services Development and Evaluation Report No.37, July 1999, Commonwealth Department of Health and Aged Care, Commonwealth of Australia, Canberra.

2.61 The ANAO also identified insufficient guidance for service-providers on targeting of HACC services. Health has since published the consultancy report, *Targeting in the Home and Community Care Program*[26], which includes guidelines designed specifically to help service-providers in resource-allocation decision-making. The targeting guidelines will give service-providers necessary guidance to improve consistency in service-provision in the HACC program[27]. Health has informed the ANAO that this report is now available on the Internet.[28]

Audit finding

The ANAO found that service providers had experienced difficulties in the use of HACC guidelines because of perceived ambiguity and a lack of definition of key terms. This has resulted in extensive individual interpretation by service-providers and consequent inconsistent service-provision.

Recommendation No.2

2.62 The ANAO recommends that, to promote consistency and equity in service-provision in the HACC program, Health improve guidance to service-providers by:

• clarifying as far as possible key terms in the definition of the HACC target population while ensuring that open eligibility and necessary flexibility for determining individual cases for HACC service provision are maintained;

• reducing ambiguity in the National Guidelines as far as possible, while retaining the level of flexibility appropriate to the nature of Commonwealth guidelines in the HACC program; and

• publishing National Guidelines for the new HACC agreements to ensure that guidance is appropriate and useful.

Health's response

2.63 Health agrees. The Department is currently redrafting the HACC National Guidelines to reflect comments raised through consultation with peak organisations representing the HACC target group. The Program Management Manual was endorsed at the November 1999 HACC Officials meeting and has been distributed, nationally, to all HACC Program Managers.

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[26] Ibid.

[27] The report was published with a disclaimer that the content of the report was not necessarily endorsed by the Commonwealth Department of Health and Aged Care.

[28] www.health.gov.au/acc/hacc/sptindex.htm

Equitable fees

2.64 HACC service-providers may charge fees for HACC services. At present the fees vary between service-providers and states. When the level of fees collected by service-providers is high in relation to other states, it will increase service outputs for that state. For example, because of the additional funds available from fee-collection, a state will be able to produce a higher level of service output with the same Commonwealth and state government funding than it would with none, or a lower level of fees.

2.65 However, differing fee levels between states can result in clients in the same financial situation, receiving the same services, paying fees ranging from no fees to full cost recovery, depending on the state in which they live.

2.66 HACC Officials recognised the need for consistency and equity in charging for HACC services when developing a draft National HACC Fees Policy, which is a set of principles for the collection of fees. The aim of the policy is to *'ensure a fair and equitable approach to user charging in the HACC program'.* The policy is set out in draft National Guidelines, which are awaiting approval.

2.67 The policy is consistent with the roles of the Commonwealth and the states, where the Commonwealth, in association with the HACC Officials, provides national leadership in policy for the HACC program, and the states are responsible for its day-to-day administration. As a result, decisions to adopt and implement the policy rest with the state and territory governments.

2.68 The policy recognises that states may develop individual fees policies consistent with the national principles. The states may develop scales of fees to be charged for HACC services, including upper limits. The ANAO considers that states should be encouraged to provide copies of their fees guidelines to enable Health to monitor progress towards consistency with the National Fees Policy.

2.69 All fee revenue must be used to expand and/or enhance HACC service-provision. Service-providers are required to report fee revenue. States monitor the use of fee revenue through their acquittal process.

2.70 The implementation of the policy varies considerably between states. By October 1999, Victoria, Western Australia and Tasmania had adopted the national policy and had implemented user charging by various mechanisms. Although the Commonwealth encourages the states to adopt and implement the policy, the decision rests with each state government. As a result, a lack of consistency and equity in user charging continues.

2.71 In 1996, the Commonwealth announced a Budget initiative to *'increase the contribution user charging makes to HACC funding'*. The initiative provided for savings derived from a *'reduction in the Commonwealth contribution to HACC over four years in line with the assessed capacity for increased fees revenue, thereby maintaining real growth in the program at six per cent'*. The initiative took effect over four years from 1996–97 to 1999–2000.

2.72 Health was not able to provide information on the level of fees collected in the states for 1997–98 or 1998–99. Because of the nature of the respective roles of the Commonwealth and the states in the HACC program, administration of the fees policy, including collection of information on fees charged, is the responsibility of the states. As a result, the Commonwealth's ability to assess the success of the fees policy is limited. For the Commonwealth to continue to provide national leadership in this area, Health should seek to maintain information on the amount of fee revenue in each state and territory.

2.73 Information on the level of fees collected in the states could be incorporated in the reporting arrangements under the HACC agreements. Health should therefore seek to negotiate this requirement in establishing new HACC agreements with the remaining states and in future amendments to agreements. In the interim, Health should ask the states to submit this information voluntarily.

Audit finding

Differing fees policies between states can result in HACC clients paying differing fees for the same service. Lack of information on the level of fees collected in each state limits Health's ability to assess the success of the fees policy.

Recommendation No.3

2.74 The ANAO recommends that Health, in order to assess the success of the National Fees Policy:

- negotiate the inclusion of information on the level of fees collected in the states and territories in the reporting arrangements under the new HACC agreements; and

- request the states and territories to volunteer such information in the meantime.

Health's response

2.75   Health agrees to negotiate the recommendation with the states and territories for the inclusion of information on the level of fees collected in the states and territories under clause 6(3)(b) of the Amending Agreement.

2.76   Agreement by the Joint Ministers would need to be sought under this clause to provide fees revenue information to the Commonwealth.

3. Coordination

The first part of this Chapter discusses Health's coordination of HACC services with other support services for the frail aged and other people with disabilities, and their carers. The second part discusses measures in place to coordinate Health's activities with the activities of State and Territory departments responsible for the administration of HACC. The final part of the Chapter discusses activities to coordinate the provision of HACC services by service providers.

Coordination with other support services

HACC target population

3.1   The HACC target population is defined in the *Home and Community Care Act 1985* thus:

> 6.   The program shall be directed towards assisting—
>
> (a) persons living in the community who in the absence of basic maintenance and support services provided within the scope of the program, are at risk of premature or inappropriate long term residential care, including—
>
> > (i)   frail or at risk persons, being elderly persons with moderate or severe disabilities;
> >
> > (ii) younger disabled persons, being persons with moderate or severe disabilities; and
> >
> > (iii) such other classes of persons as are agreed upon by the Commonwealth and State Minister; and
>
> (b) the carers of those persons

3.2   The HACC National Guidelines state:

> *A person considered to have a moderate to severe disability will have been assessed as having a functional disability which makes it difficult for them to perform the tasks of daily living, such as dressing, preparing meals, house cleaning, home maintenance or using public transport. Some people may need a combination of services.*
>
> *Within this target population there are a number of groups who find it more difficult than most to get access to services in general, and particularly to services which are tailored to meet their cultural or other special needs.*
>
> *The special needs groups are:*
>
> • *people from a non English speaking background;*

- *Aboriginals and Torres Strait Islanders;*

- *persons suffering from Alzheimer's disease or other related disorders;*

- *financially disadvantaged persons; and*

- *frail aged and other people with disabilities living in remote or isolated areas.*

As a general principle, HACC only provides services dedicated to any of these particular groups when an existing service cannot provide, or cannot be modified to provide, such services. However, when special circumstances have been demonstrated, HACC may fund services aimed specifically at one of the above groups.

Programs which overlap with HACC

3.3   To permit the HACC program to provide a comprehensive, integrated and flexible range of services, it has been designed with broad eligibility criteria. These criteria allow it to function also as a safety-net program, which can provide services when the recipient is not eligible for other programs' services or when such services are not available. A consequence of the broad criteria is considerable overlap between HACC and other services.

3.4   An example is the overlap between HACC and Community Care Packages[29] (CCPs). CCPs are designed to allow older people who would otherwise qualify for low-level residential care to be cared for in their own homes (in the community). CCP service-providers provide services to individuals as a case-managed package of care. Services supplied or purchased include:

- personal care, including dressing and grooming;
- preparing meals;
- house-cleaning;
- home maintenance; and
- special transport.

3.5   All these services are also provided under HACC, but individually, not as a package.

3.6   Community Options Projects (COPs), known in Victoria as Linkages, are funded under HACC. They fund brokers, who arrange packages of community-care services for HACC recipients with complex

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[29]   CCPs are provided under the *Aged Care Act 1997* and are administered by Health.

needs. The range of services provided by COPs is similar to a CCP, although COPs also include nursing services. COPs also cover younger people with disabilities who, as a group, represent a larger proportion of COPs clients than of the total HACC client population. High-need HACC recipients can receive a range of services similar to or more expensive than those available to a CCP or COP recipient without the benefit of a formal package.

3.7 Another program that provides services to a segment of the population served by HACC is the Commonwealth State Disability Agreement (CSDA). Under this program the Commonwealth funds employment support services for people of employment age with disabilities and helps the states with funds to provide other services for these people. The states provide and administer accommodation support, respite care, day services and other support. Responsibility for the CSDA lies with the Department of Family and Community Services (DFaCS).

3.8 The Respite for Carers program administered by Health, which provides carers with respite from their caring duties, also overlaps with HACC. Carers play an important role in community care. A key factor identified by Health in developing a policy for carers was their need for respite. Although HACC provides respite such as day-care centres and in-home respite, Health found that HACC respite activities were not well coordinated with other respite services funded by the Commonwealth or states. Carers had trouble in establishing what services were available and accessing them.

3.9 The Department of Veterans' Affairs (DVA) provides veterans with community services that overlap with HACC, in particular, a community-nursing program and some health-related transport services. These services are available to all qualifying veterans. They are free of charge to the veteran and have no waiting period.

3.10 Service-providers can be providing the same service to some recipients under the HACC program, to others under the CCP program and, for some services, under the CSDA or programs administered by DVA.

Audit finding

There is overlap between HACC and other community service programs. In particular, certain combinations of HACC services, such as COPs, are very similar to CCPs.

Closer coordination with CCPs

The population served by CCPs is a subset of the HACC population

3.11   To be eligible for a CCP a person's function must be assessed by an Aged Care Assessment Team (ACAT), which rates that person's care needs equivalent to the level of personal care that would be provided in a low level residential facility. More than 85 per cent of CCP clients are more than 70 years old. CCPs are provided under the *Aged Care Act 1997* as part of the Commonwealth's residential aged-care program. The planning population for residential care is people aged 70 and over.

3.12   The HACC planning population is far more diverse than that of CCPs. For instance, there is very little overlap between the CCP planning population and the segment of the HACC planning population aged less than 70[30]. However, there is overlap between planning populations for HACC and CCPs for people aged 70 or more. Table 3.1 illustrates this.

Table 3.1

Characteristics of HACC and CCP planning populations.

Characteristic	HACC	CCPs
Planning population by age	All ages	70+
Needs	Low to high	High
Available to	Frail aged and younger people with disabilities	Frail aged

3.13   Both HACC and CCPs are aimed at keeping frail aged people in their homes. However, HACC covers clients at all levels of service use, and so overlaps and even extends beyond the levels of service to CCP clients. It provides services to other people with disabilities, including younger people with disabilities and older people who need a low level of assistance only to remain in their homes. Thus the population served by CCPs can be regarded as a sub-set of the HACC population.

Provision of CCPs has the potential to increase the supply of HACC services to low-needs clients

3.14   Discussions with service-providers in the course of audit fieldwork indicated that a small amount of HACC services can have a significant impact on the recipient's quality of life. The service-providers commented that, in an environment of unsatisfied demand, there was tension in meeting the needs of both low-care and high-care users. To service a new high-care user, a service-provider with a fixed budget might have to reconsider service provision to 10 or more existing or potential low-care users.

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[30]   More information on CCP and COP clients can be found in *Community Aged Care Packages. How do they compare*, Commonwealth of Australia, 1997, AGPS, Canberra.

3.15   As mentioned earlier, the target population for CCPs can be regarded as a subset of the HACC target population. Provision of CCPs has the potential to release HACC resources used by high-needs clients to service low-needs clients.

Planning is not coordinated at national level

3.16   The planning process for the residential aged-care program, including CCPs, is specified in the Aged Care Act. Government policy is to provide 102 Commonwealth funded aged care places for every 1000 persons over 70 years of age, of which twelve are CCP places. The Commonwealth Minister, on advice from Health, allocates residential aged care places to states. The aim is to achieve 102 places per 1000 population over 70 in all states. No account is taken of the provision of HACC or other community services to the frail aged.

3.17   CCP places are allocated to regions in states on the advice of State Aged Care Planning Advisory Committees (ACPACs). One of the factors that may be taken into account by ACPACs in formulating advice is the provision of HACC services.

3.18   HACC planning is discussed in Chapter 2. The allocation of funds to states is governed mainly by the equalisation formula, which is driven by projections of the population with a disability. No allowance is made for existing or proposed CCP places. However the allocation of funds within states may take into account the provision of CCPs. The residential aged care program and the HACC program are both the responsibility of Health's Aged Care division.

Audit finding

Planning for the provision of HACC services at a national level does not take into account the provision of CCPs.

3.19   Audit Report No.19, 1998–99, *The Planning of Aged Care*, dealt with Health's administration of the planning of residential aged-care places. It recommended that:

> *in order to develop better coordination of aged care planning, Health systematically take into account state government planning processes including for HACC.*

3.20   In this audit the ANAO found that Health had assigned an officer to explore improved coordination between the planning of CCPs and state government planning for HACC. Health presented a paper entitled *Coordinated Planning of HACC and CCP Funding Allocations* at the May 1999 meeting of the HACC Officials. There was general agreement among the states on the broad direction suggested in the paper and agreement on further action on coordinated planning.

Audit finding

In response to Audit Report No.19, 1998–99, Health has begun working with the states to improve the coordination of the planning of HACC services and the allocation of CCPs.

3.21 Health has an objective for HACC *'to ensure that services are cost-effective, achieve integration and avoid unnecessary duplication.'* Close national coordination of planning for HACC and CCPs would assist Health to achieve this objective. The ANAO did not find evidence of close coordination.

3.22 Recommendation No.4 recommends that Health coordinate, at national level the planning of HACC and CCPs. Given the major overlap between HACC and CCPs the ANAO believes that priority should be given to closer coordination between these programs.

Division of the HACC target population into sub-populations would facilitate coordination with CCPs

3.23 A requirement for closer coordination between planning for HACC and planning for CCPs is the ability to compare the CCP target population with that segment of the HACC target population with similar service needs. At present Health does not segment the HACC target population into sub-populations for planning.

3.24 Because of the growth of demand for HACC services and growing pressure to service clients within the community, provider agencies have been facing increasing pressure on resources and increasingly difficult decisions about how to allocate services among the clients seeking assistance. To address this situation, the HACC Officials commissioned a consultancy in late 1995 on targeting HACC services. The targeting study[31] has used evidence from service providers to indicate that HACC clients could be divided into sub-populations by level of service used, as demonstrated in Table 3.2.

Table 3.2

HACC Clients by use of services—Home Care Service of NSW[32]

Client type	Hours per month	% of clients	% of service hours
Low use	<20	76	21
High use	20-40	19	51
Exceptional	>40	5	28

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[31] Commonwealth of Australia, July 1999, *Targeting in the Home and Community Care Program*, Canberra.

[32] Ibid, p. 48.

3.25   Home Care of NSW is Australia's largest service provider. Evidence from other service-providers shows similar patterns[33].

3.26   The consultancy report proposes three tiers[34] of access to services:

- Basic HACC;

- HACC Plus; and

- HACC Exceptional Clients.

3.27   Dividing the planning population into sub-populations as suggested in the consultancy report would facilitate coordinated planning of HACC and CCPs. It would have the effect of defining that portion of the HACC planning population that most closely matches the CCP planning population and permit a comparison of clients receiving similar levels of service.

3.28   Basic HACC would cover clients needing only low levels of services, who account for about 70 per cent of all HACC clients but receive, on average, a far lower level of services than CCP clients. HACC Exceptional Clients might be receiving more resources than are available from a CCP and they too would be separated out from the population to be compared. Younger people with disabilities receive a proportion of their community services from CSDA programs and, although not part of the CCP planning population, might receive an equivalent level of services through a COP. They need to be taken into account also in the population to be compared. The result would be a subpopulation of the HACC planning population similar in service needs to the combined CCP and COP planning populations.

3.29   The ANAO suggests that, to effectively coordinate the planning of HACC and CCPs, Health divide the HACC planning population into subpopulations by level of usage of HACC services.

The information required to segment the HACC target population will be available from the HACC Minimum Data Set

3.30   At present the only information available on HACC users is the HACC User Characteristics Survey. Additional surveys and databases provide more detailed information on COP and CCP clients. The HACC survey, completed by service-providers from their records about every five years, provides information on HACC users and the services they consume, but not on the services consumed by individual clients in a year, because some HACC clients receive services from more than one provider.

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[33]   Ibid, p. 47.

[34]   See Appendix 2 for a full description.

3.31 Health has been working with the states, service-providers and the Australian Institute of Health and Welfare to introduce an HACC Minimum Data Set (MDS).[35] From 1 July 2000 service-providers will be required to furnish information on services supplied to individual clients, by type of service. The data will be aggregated by client so that total services provided to individual clients by multiple providers will be known. The HACC MDS will allow clients to be segregated by the level of services provided, which will give planners at both national and state level much better data on clients' use of services. However, it should be noted that the HACC MDS will collect information only on HACC-funded community services, not on community services delivered to HACC clients via other programs.

Recommendation No.4

3.32 The ANAO recommends that Health coordinates, at national level, the planning of HACC and CCPs in order to ensure that HACC services and CCPs are cost-effective, adequately integrated and avoid unnecessary duplication.

Health's response

3.33 Health agrees. It is intended that a coordinated planning framework between HACC and CCPs be established to enable these two systems to fit together better. What is needed is a cooperative approach to setting resource allocation priorities within regions.

Closer coordination with the CSDA

3.34 Under the CSDA the Commonwealth funds employment-support services for people of employment age with disabilities and helps the states with funds to provide them with other services. The states provide and administer accommodation support, respite care, day services and other support. The accommodation services provided by the states to people with disabilities include some, but not necessarily a full array of, support services. These people may require further support through HACC. The question is the extent to which HACC services can be provided to people with a disability in CSDA accommodation services. While Health has clear boundaries between services provided by the CSDA and services provided by HACC for clients in supported accommodation, the boundary between CSDA accommodation support services and HACC services is not clear to clients and their advocates.

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[35] See Appendix 1 for a further description.

3.35 Another issue is how people with disabilities receiving community services, who are ageing and want to retire from Commonwealth employment support, will be supported pre- and post-retirement. That is, how will community support services be maintained as people transfer from the disability pension to the age pension. Health has stated that they are addressing this issue, but has agreed that ongoing collaboration is required with states and with DFaCS.

3.36 Most coordination of CSDA community services and HACC is required at state level and is a state responsibility. However, there are some points of tension between HACC and disability services that require national policy direction and clarification. Health, DFaCS and state and territory governments need to develop and promulgate national guidelines jointly in areas in which HACC and CSDA intersect.

Audit finding

The boundary between CSDA accommodation support services and HACC services is not clear to clients and their advocates.

Recommendation No.5

3.37 The ANAO recommends that Health work with other Commonwealth and state/territory agencies concerned to develop and promulgate jointly national guidelines in areas in which HACC and CSDA intersect, in order to clarify the boundaries for service providers.

Health's response

3.38 Health agrees in principle and will seek collaboration with the Commonwealth Department of Family and Community Services and respective State/Territory Departments which administer the CSDA.

Closer coordination with DVA

3.39 DVA helps veterans and war widows to maintain their health and independence[36]. Veterans are also eligible for HACC support, particularly for those needs not satisfied by DVA. A specific area of overlap with HACC is DVA's purchase of community nursing services for veterans.

3.40 DVA attends selected Health and Community Care planning meetings as an observer and is also on HACC's main coordinating committee, the HACC Officials Committee (discussed below). The main problem identified in coordinating DVA's community services with

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[36] The ANAO has reported on DVA's administration of health care for veterans in *Administration of Veterans' Health Care*, Report No.29 1999–2000.

HACC's is a lack of good-quality data on HACC services received by veterans. DVA has commissioned a research consultancy recently to collect information on veterans' community-care usage, concentrating on identifying gaps in service. In the longer term the HACC MDS will provide improved information on HACC services to veterans.

Coordination of HACC administration between the Commonwealth and the States and Territories

HACC Officials Committee

3.41　The primary mechanism for coordination both between states and between Health and the states is the HACC Officials' Committee. This group is a subcommittee of the Standing Committee of Community Services and Income Security Administrators (SCCSISA), which reports to the joint Ministers responsible for income support and community-services portfolios. Membership of HACC Officials comprises officers of the Department of Health and Aged Care and each state or territory department responsible for HACC. Although the Department of Veterans' Affairs is not a signatory to an HACC agreement it is an observer at HACC Officials meetings. It does not have voting rights but contributes to discussions and makes presentations on matters relevant to HACC.

3.42　HACC Officials meet twice a year to oversee the general direction of the HACC program. They also have working groups that drive the development of specific areas of the HACC program (for example, the Fees Working Group, the Standards Working Group, and the Data Reform Working Group). Working groups continue work on their areas of responsibility between meetings. Health and state departments correspond and have other contact regularly between meetings. This includes consultation on policy development.

3.43　The Commonwealth and the states contribute to a Planning and Development (P&D) fund, used to finance the HACC Planning and Development program, which is managed by HACC Officials. Examples of current projects include:

• HACC Minimum Data Set implementation;

• HACC Minimum Data Set policy review; and

• the National Consumer Appraisal Survey.

3.44　The ANAO observed two HACC Officials' meetings and examined the minutes of the last four years' meetings. The ANAO concluded that the HACC Officials Committee works constructively and effectively.

Coordination with the states

3.45   The primary mechanism for coordination, both between Health and the states and between the states, is the HACC Officials Committee (discussed above).

3.46   Structures and practices exist in all states to facilitate joint planning of not only HACC service-provision, but also that of other services for the aged, such as residential care. They vary from state to state. A common device is to have Commonwealth and state officers who are members of both ACPACs and HACC advisory committees. In some states these committees have common membership.

3.47   Most states have Joint Officer Groups (JOGs), comprising officers of Health state offices and the state department(s) responsible for HACC. JOGs provide forum at which state and Commonwealth officers can discuss common concerns and exchange information on developments. Where JOGs exist they are normally involved in the development of state HACC plans. Some states have gone further and have established or are moving toward joint Commonwealth/state Aged Care planning structures, which vary from state to state.

3.48   In three states visited, project officers working on the planning and allocation of residential aged places (including CCPs) used their local knowledge to help assess the proposed state HACC plan. The ANAO believes that their involvement is a valuable tool for coordinating CCP and HACC community services. It serves also to inform the project officers of likely outcomes of state-government community service planning processes.

Audit findings

Formal procedures exist to ensure that Commonwealth HACC activities are coordinated with state HACC activities. Formal procedures exist to manage coordination of and liaison between Health's state offices and state-government departments responsible for HACC programs.

Coordination with Commonwealth offices in the states and territories

3.49   Health has a HACC Program Managers' meeting every six months after HACC Officials' meetings, at which officers of the Community Care branch of National Office meet officers of Health state and territory offices responsible for the HACC program. The meetings have two purposes: to permit briefing of state office staff on the outcomes of the latest HACC Officials meeting and policy developments in HACC and related programs; and to enable each state's officers to brief national-office and other state staff on developments in their home states.

3.50   The ANAO found evidence of extensive communication between state and national-office staff about developments in the negotiation of state plans and other matters. The evidence showed that state officers sought guidance from national-office managers when necessary. Another coordinating mechanism consists of visits by national-office managers to state offices. Overall, coordination between National Office and state offices is satisfactory.

3.51   There are major differences between states in HACC service-delivery. For instance, in NSW community nursing services are generally delivered via the State Government's Area Health Boards, whereas in Victoria, those services are provided in Melbourne and surrounding areas by the Royal District Nursing Society of Victoria, a non-government organisation. The Royal District Nursing Society of South Australia, also non-government, provides those services for urban Adelaide. There are major differences too in the progress of individual states in adopting initiatives. An example is output-based funding, which some states have adopted for all state programs including HACC; but for other states its introduction for HACC is breaking new ground[37].

3.52   The diversity of service-delivery and innovation among states provides an opportunity to share experience and better practice. However, except at HACC Program Managers' meetings (which only selected officers attend), Health's state officers have little opportunity for face-to-face discussion of problems and developments. This requires the use of other facilities to share the experience of peers who have faced similar problems.

3.53   Health has stated that officers currently use Health's e-mail system and communicate regularly through both informal and formal meetings. There may also be benefits if Health were to provide other opportunities (such as an internet chatroom) to facilitate peer-group discussion between officers in different states, the results of which should be available to other officers. If this is a success, a similar service could be used to facilitate discussion between state and Commonwealth officers in different states.

Audit finding

Formal procedures exist to ensure that the activities of Health's National and state offices are coordinated.

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[37]   More examples of diversity and differing progress can be found in Appendix 1.

Coordination of service-providers

3.54   A HACC client might receive services from more than one provider, for example, nursing services from a community nursing organisation, and home-care services from another provider. To provide a high-quality service, the providers must cooperate. This is acknowledged in the HACC National Guidelines[38], which state, *'cooperative working arrangements between service providers are essential to achieve the best results for the benefit of the people they serve'.* The ANAO found that the level of cooperation between service-providers varied from state to state.

3.55   A key element in coordinating services is the process of assessing a client's needs. Ideally, a client with complex needs should be assessed only once. However, it has been common (and still is in many areas) for each service-provider to have its own assessment process. Not only can clients be subject to multiple assessments, but also service-providers differ in their interpretations of eligibility requirements (discussed further in Chapter 2). Further, there is a possibility that a client would receive the services the provider could supply rather than those he or she actually needed.

3.56   There are examples of service providers recognising these problems and creating informal methods of tackling them. For example, a group of providers held case-management meetings to ensure that clients received the appropriate suite of services.

3.57   The need for better client-assessment practices was identified in the reports *Home But Not Alone*[39] and *Efficiency and Effectiveness Review of HACC*[40]. In response, a project to improve HACC's assessment process was conducted by the Lincoln Gerontology Centre on behalf of all governments concerned. The outcome was a report *National framework for comprehensive assessment of the HACC program.*[41] The states have accepted that there are gaps and duplications in assessment processes that inhibit provision of high-quality client service and have introduced or are introducing improved assessment practices.

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[38]   Commonwealth of Australia, 1992, *Home and Community Program National Guidelines*, second edition.

[39]   House of Representatives Standing Committee on Community Affairs, 1994, *Home But Not Alone*, Canberra.

[40]   Department of Human Services and Health, 1995, *The Efficiency and Effectiveness Review of the Home and Community Care Program,*' Aged and Community Care Service Development and Evaluation Report No. 18, AGPS, Canberra.

[41]   Commonwealth of Australia, 1998, *National framework for comprehensive assessment of the HACC program*, Canberra.

3.58   The Lincoln Gerontology Centre report noted that there was considerable overlap between an HACC assessment for a client with complex needs and an ACAT[42] assessment and discussed ways of coordinating them. The ANAO found in fieldwork that, in some areas within states and in some cases for whole states or territories, joint ACAT/ HACC assessment teams had been established or were being tested. Although common assessment is a promising development, it is not yet widespread. The ANAO considers that there would be benefit in the wider use of common assessment.

3.59   An existing tool, which will facilitate improved assessment practices, is the Client Information and Referral Record (CIARR). This has existed for some years and provides for a common record of all services used. It is held by the client. Evaluations have indicated that it is highly valued by clients but its use varies among providers and states. Further, it is not computerised and so does not allow for transfer or aggregation of data.

3.60   Although Health can take steps to facilitate desirable innovations to help service-providers cooperate, administration of service-providers is the responsibility of the states. When it desires major changes Health must first win the states' agreement and cooperation. Some states recognise that improved cooperation and coordination are needed between service-providers and are working to encourage them.

3.61   For example, NSW made mandatory the use of the CIARR for HACC service-providers in June 1997. By October 1999 about two thirds of the state had implemented it; the rest were to implement soon. A consulting group is providing training in its use. Its implementation is the first of two phases of reform of assessment in NSW. The second involves separating client assessment from service-provision.

3.62   The NSW general information booklet for the 1999–2000 HACC expression of interest process states that:

> *all service providers will be required to participate in Community Care Assessment (CCA). CCA will involve the establishment of local networks which will coordinate assessment of people with complex needs using the community care system. Services within a network will be involved in identifying which services in that network conduct assessments of consumers with complex needs and in establishing an*

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[42]   Aged Care Assessment Teams assess the level of function of candidates for residential care, including CCPs.

adequate referral system for complex needs assessment. The system will depend on adequate use of the CIARR. The NSW Ageing and Disability Department (ADD) will be conducting training in community care assessment, and all funded service providers will be required to participate.

3.63   CCA networks in NSW have the potential to provide a structure within which further cooperation can occur.

3.64   Victoria, too, has identified the need for improved coordination and cooperation between providers of community services. Its initiative envisages Primary Health and Community Support Services (PHACS) at key delivery sites in the state. Its aim is to provide local service systems that are client–centred, to ensure that clients have improved access to services they need and can move through the service system easily, confidently and quickly. The services that will make up a PHACS will include:

- HACC assessment and Aged Care Assessment Services (ACAS);
- all allied health services funded through HACC, Aged Care and Community Health budgets;
- all community nursing funded through HACC, Aged Care and Community Health budgets;
- all HACC services; and
- state-funded community health services, including family planning, women's health and health promotion.

3.65   Key elements of the PHACS initiative are streamlined assessment practices and development of protocols enabling agencies to communicate with each other about clients who need a number of services. The Victorian Government requested proposals in early 1999 for demonstration projects to prove the PHACS concept.

3.66   These examples illustrate the key role of the states in encouraging cooperation and coordination of HACC service providers. The discussion illustrates also the Commonwealth's role in providing leadership by developing national guidelines the states can follow to develop policies.

3.67   Service-providers in many states are required to bid for HACC service contracts. They are also required to cooperate with other services providers, through initiatives such as coordinated assessment. However, there are instances where those with whom they have to cooperate are their competitors for service contracts. Service-providers contacted in the course of fieldwork commented that they were being sent contradictory

signals. Sometimes they were reluctant to supply information to other providers who might use it to win business away from them. There is a need to ensure that messages to service providers are consistent.

Audit findings

Health is working with the states toward introducing improved client-assessment processes, which should help coordinate services to HACC clients with complex needs.

4. Program Administration

This Chapter addresses Health's administration of the HACC program. It details measures Health has taken to acquit Commonwealth expenditure and concludes that the annual acquittals of HACC expenditure, under the old agreements, are untimely. A risk-management approach would assist timely acquittals. The ANAO found that administrative duplication was being minimised by the implementation of the new HACC agreements. Health should ensure that sufficient resources are provided to enable Health's HACC state officers to make informed recommendations to the Minister on the suitability of State annual plans. Tailored accountability and data requirements could reduce the burden for smaller service-providers.

Administrative arrangements

4.1   The administrative arrangements for the HACC program are outlined in the HACC agreements. Under the previous agreements the states approve projects and acquit against projects. Commonwealth approvals, monitoring and acquittals, are conducted at project level. Two states are operating under the previous agreements.

4.2   Under the new agreements the Commonwealth and states approve planning and funding of service provision for regions jointly. The states are solely responsible for administering individual projects, including their approval and acquittal. Commonwealth acquittals of state and territory expenditure are conducted at regional level. This results in reduced administrative duplication.

4.3   A summary of the significant differences between the previous and latest agreements is in Table 4.1.

Table 4.1

Summary of significant differences between the old and new HACC agreements

Previous Agreements	New Agreements
Commonwealth ministerial approval of funding required for each project	Commonwealth ministerial approval of funding required for each region rather than each project • State ministers solely responsible for approval of funding for individual projects within regions
Commonwealth acquittals of HACC expenditure required for each project	Commonwealth acquittals of HACC expenditure required for each region but not for each project in each region
Input based-funding • State planning and reporting against funding	Output-based funding • linking funding with the services delivered to people, state planning and reporting against service outputs
Only government and not-for-profit-organisations funded to provide HACC services—(private-enterprise organisations excluded from providing HACC services)	As well as government and not-for-profit organisations, private-enterprise organisations allowed to provide HACC services
Program objectives do not include reference to the importance of quality in HACC services	Program objectives include reference to 'high quality home and community care services …'

Acquittals

4.4   Acquitting Commonwealth expenditure is an important accountability control to provide an assurance that program moneys are spent for the purpose intended. For this control to work, acquittals must be timely. Commonwealth acquittals of HACC expenditure cover two aspects: data received from the states, and its processing by Health.

4.5   HACC agreements require state governments to provide statements of acquittal, showing state HACC expenditure data for the financial year, by the following November. As HACC is a joint Commonwealth–state program, all pooled expenditure is acquitted at both the state and at the Commonwealth level. The states, under both the old and new agreements, acquit HACC expenditure at the individual project level. This includes certification by qualified accountants that service–providers' HACC funding has been spent for its intended purpose. In addition, the state or territory auditors-general form opinions on the financial statements of the state government agencies responsible for administering HACC. The financial statements include HACC expenditure but it is not a material item for some state-government health agencies.

Old agreements

4.6   The ANAO found that acquittals of state expenditure under the old agreements were, in most cases, significantly behind schedule. However, in the past 12 months Health has all but completed a number of older acquittals, some of which date back to 1990–91. Acquittals for the last two financial years (1997–98 and 1998–99) have not been finalised. As all states are moving toward signing the new HACC agreements, it is imperative that Health resolves all outstanding acquittals under the old agreements as soon as possible.

4.7   In the course of the audit fieldwork, the ANAO reviewed Health's state-office acquittal working papers. The ANAO found that many acquittals had not been finalised because of a small number of unresolved differences between Commonwealth and state records. It was apparent that more work was not going to resolve them. The sums involved were not substantial. In one state the unresolved differences ranged from 0.1 per cent to 0.95 per cent ($190 000 to $1.9 million) of total HACC expenditure for a financial year.

4.8   After consideration of:

- the relatively small amounts outstanding;

- the fact that HACC expenditure had been through the state acquittal and audit process already; and

- the requirement that accountants' certificates be provided by individual service-providers to the state/territory government;

it was clear that any possibility that the money had not been spent to provide HACC services was low. Health must evaluate the risk and related cost of further resolving these outstanding differences. The cost of undertaking such an exercise, especially for immaterial amounts, may outweigh any benefit. It would be appropriate for Health to adopt a risk-based approach to reconcile the data discrepancies between PIMS and the respective state database systems. As indicated below, a stronger emphasis on the timely acquittal of state and territory expenditure would facilitate the resolution of discrepancies and limit the resources required for follow-up action.

Audit finding

A significant number of acquittals of state expenditure are outstanding, including some dating back to 1990–91. Many outstanding acquittals involved relatively minor unresolved differences between Commonwealth and state information.

Recommendation No.6

4.9 The ANAO recommends that, to eliminate the backlog of acquittals under the old HACC agreements with states and territories, Health expedite the finalisation of outstanding acquittals by adopting a risk-management approach to their resolution in a cost-effective manner.

Health's response

4.10 Health agrees. The Department will develop a risk management strategy to ensure that all outstanding acquittals are finalised.

New agreements

4.11 The Commonwealth, under the old HACC agreements, approves HACC individual projects jointly with the respective states. The Commonwealth acquits HACC expenditure allocated under the old HACC agreements at project level. This task has increased over the years with the number of HACC projects. For example, in 1988–89 there were 2378 HACC projects with over-all funding of $344.9 million. By 1997–98 there were 3556 HACC projects with funding of $784.6 million.

4.12 Under the new HACC agreement, the Commonwealth approves HACC expenditure by region and acquits by region. This has simplified the acquittal process greatly. For example, the NSW Government had to acquit 1238 different HACC projects in 1997–98 (under the old agreement) but only 16 HACC regions in 1998–99 under the new agreement. Acquittals under the new HACC agreements will be required only for the 58 HACC regions nationally.

4.13 The ANAO is unable to comment on the effectiveness of the new acquittal process because, at the time of the audit fieldwork, acquittals for the first year of the new agreements had not begun. However, in the light of past experience, it would be prudent for Health to emphasise the importance of early acquittal action and monitor closely ongoing performance.

Information for Ministerial inquiries

4.14 Under the old agreements, all the approval limits and expenditure for each project are recorded by Health on the Project Information Management System (PIMS). Health, under the new HACC agreements, will not be required to keep detailed data on individual projects for acquittal purposes. However, to respond to ministerial inquiries and to brief Members of Parliament on HACC, in particular HACC projects in electorates, Health will need access to project information details. Health has informed the ANAO that the HACC PLANNET information system, which is currently being developed, will be able to provide client focussed information at agency level.

Administration costs

4.15   The ANAO estimates that about 40 Health officers are assigned to the HACC program nationally and administration costs represent less than 0.5 per cent of the total program cost to the Commonwealth. Health does not have good information on its HACC administrative costs, partly because, many officers with HACC responsibilities have responsibilities for other programs too, particularly in state offices. Health's administrative resources for HACC have been reduced in anticipation of streamlined administration flowing from the new HACC agreements. Any further administration savings will not have a significant impact on over-all expenditure on the program.

Commonwealth/state roles

4.16   The respective roles and responsibilities of the Commonwealth and the states are outlined in several key documents, including:

- HACC agreements with the states;
- *Home and Community Care Program National Guidelines*;
- *Home and Community Care Program Management Manual*; and
- *Home and Community Care Act 1985*.

4.17   The ANAO found that most Commonwealth and state government officers perceived the roles of the respective partners in the HACC program to be clear. Nevertheless, the ANAO found that the two states visited which were under the new HACC agreements were experiencing some difficulties in clarifying roles under the new arrangements. However, there was strong evidence that such difficulties were being addressed by Commonwealth and State officers as they arose.

4.18   A key role of Health HACC state officers is to make a recommendation to the Minister on the suitability of the State annual plan for approval. Health state office managers are assigned a pool of resources, which they must allocate to programs and tasks. However, it is important that resources allocated to HACC by state office managers are sufficient to maintain adequate levels of intelligence to enable HACC officers to provide informed opinions or recommendations to the Minister, particularly in relation to approval of State annual plans and funding packages. In at least one Health state office, the ANAO found that insufficient resources had been allocated to HACC to allow officers to maintain adequate levels of intelligence, for example, by attending HACC consultation and planning groups, for program management purposes.

4.19   In this light, the ANAO suggests that Health state office managers review resources allocated to the HACC program in Health state offices to ensure they are appropriate for the responsibility carried in relation to the program.

4.20   The move away from joint ministerial approval of individual projects has resulted also in a shift in the skills required in Health state offices. HACC project officers need the skills necessary for full participation in planning of regional funding and to adapt to the changed tasks and duties under the new agreements. The ANAO found that some Health state offices had begun taking steps to ensure that those officers had appropriate skills, including drawing on planning expertise in other programs in those offices. Acquisition of appropriate skills will enable Health state officers to give the Minister timely advice on State annual plans' suitability for approval.

4.21   The ANAO suggests that Health expand the skill sets of Health State Office personnel to adapt to changes in tasks and duties under the new HACC agreements and to assist in providing informed advice to the Minister on the suitability of plans for approval.

Commonwealth/state communication and dispute resolution

4.22   The ANAO found that Health had formal and informal communication and consultation mechanisms with each state and territory (see Chapter 3 for further discussion). The range of mechanisms varied between states to provide for necessary flexibility.

4.23   Mechanisms exist to resolve disputes between the Commonwealth and state governments in relation to joint administration of the HACC program. The auditors discussed dispute mechanisms with officers of both Commonwealth and state governments. There was strong consensus that current dispute-resolution mechanisms were satisfactory.

Accountability and data requirements for service providers

4.24   Many service-providers supply the same or similar services funded by different government programs. This is particularly the case in rural areas, where they are often required to supply services to a relatively small population under several Commonwealth and state programs. Rural service providers can be very small; perhaps two or three people each working 20 hours per week. The different programs have different administrative requirements. Large service-providers with sophisticated

accounting systems had greater capacity to accommodate differing accountability and data requirements than smaller ones.

4.25 Overall government requirements of service-providers are exacerbated by inconsistencies in the accountability and data requirements of different aged and community-care programs for which service-providers receive funding. Service-providers can receive funding from both Commonwealth and state agencies. Each agency can have different accountability requirements. An example is a small-to-medium provider visited in the course of field work. It was receiving funds from six different sources—two Commonwealth, three state and one local government. Each source had its own accountability requirements. In addition, accountability and data requirements of the associated programs, including HACC, have changed regularly over time. In the course of audit field work, both large and small service-providers expressed frustration at allocating resources to meeting the requirements of new accountability and data systems, which are then modified or replaced, often requiring more investment of resources.

4.26 Nationally, an estimated 70 per cent of HACC expenditure is distributed to the largest 20 service-providers. In 1997–1998, a total of 2367 organisations were providing HACC services. Of them, 963 had expenditures of less than $50 000 and 1007 had expenditures between $50 000 and $300 000. A large number of providers supply relatively small amounts of HACC services. Health should examine the costs and benefits of streamlining accountability and data requirements for service-providers, especially smaller providers.

4.27 Health has stated that, in piloting the HACC Minimum Data Set (MDS), data collection mechanisms were specifically tailored for smaller agencies to assist them in their data collection requirements. The MDS will also assist smaller service providers in that it will form the basis for more efficient data management processes.

4.28 The joint Commonwealth/State Standing Committee of Community Services and Income Security Administrators (SCCSISA) has identified the need for consistency between data collections for community services as high-priority. As a result, it has developed a National Community Service Information Development Plan[43] to help improve consistency between such data collections. The HACC MDS is being developed as part of this framework.

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[43] Australian Institute of Health and Welfare, 1999, *National Community Services Information Development Plan*, National Capital Printing, Canberra.

4.29 Inevitably, the HACC MDS will increase the information required from service-providers because it will collect data not available now. Software is being supplied to help service-providers collect and process data for the Data Set. There are provisions that allow providers of certain types of services, such as telephone information centres, to collect minimal data.

Audit finding

Accountability and data requirements can be onerous for smaller service-providers. There may be benefits in providing streamlined requirements for smaller providers.

Recommendation No.7

4.30 The ANAO recommends that Health reduce the administrative burden on service-providers by reviewing the costs and benefits of tailoring accountability and data requirements for service-providers receiving different levels of funding and ensuring that the accountability and data requirements of the various aged- and community-care programs are, as far as possible, integrated or made compatible.

Health's response

4.31 Health agrees. The Department has begun to implement measures to ensure that the accountability and data collection requirements of service providers are tailored to the needs of organisations, whether they are large or small service agencies.

Record management

4.32 In the course of the audit, the ANAO examined a large number of HACC files. The ANAO found that the poor quality of filing systems in both Central office and some state offices was impeding effective administration of the HACC program. In some cases, Health officers were unable to find key documents.

4.33 In audit fieldwork the ANAO noted a relatively high turnover of Health HACC officers. A high turnover of staff can lead to problems in maintaining corporate memory. An effective record-management system would help alleviate potential problems associated with high staff turnover.

Audit finding

Health's filing system, in both central and state offices, was not effective in terms of record management for the administration of the HACC program.

Recommendation No.8

4.34   The ANAO recommends that Health ensure that there is an effective record-management system for the administration of the HACC program in both national and state Health offices.

Health's response

4.35   Health agrees

5. Performance Measures

This Chapter describes the output and outcome performance indicators used to monitor the HACC program. Health is moving towards effective output-performance measures, but will need a more comprehensive knowledge of HACC expenditure.

Output/Outcome performance reporting

5.1 The Commonwealth's Accrual-based Outcomes and Outputs Framework[44] requires all agencies, from 1999–2000, to move from reporting inputs to reporting outputs. Input reporting concentrates on whether the money was actually spent for the purposes for which it was appropriated; output and outcome reporting focus on what has been achieved by the expenditure.

5.2 Health's 1999–2000 Portfolio Budget Statement is its first to be produced under the Framework. The Statement contains output and outcome indicators for Outcome 8, Enhanced Quality of Life for Older Australians. Within Outcome 8 there are four administered items.

Table 5.1
Outcome 8—Administered Items and Price of Outputs—1999–2000

Administered Items	Budgeted Expenditure $m
1. Healthy Lifestyles for Older Australians	2.0
2. Community Care and Support for Carers	804.6
3. Residential Care	3216.0
4. Client Assessment by aged care assessment teams(ACAT) and referral to appropriate services	40.0
Total Administered Items	4062.7
Price of Departmental Outputs	89.5
Total Estimated Expenses	4152.2

Note: Figures used have been rounded.

5.3 HACC is a component of Item 2, Community Care and Support for Carers. Commonwealth budgeted expenditure for HACC is $525 million, 12.7 per cent of the $4.2 billion budgeted for the Enhanced Quality of Life for Older Australians.

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[44] Department of Finance and Administration, 1998, *Specifying Outcomes and Outputs—Implementing the Commonwealth's Accrual-based Outcomes and Outputs Framework*, Commonwealth of Australia.

5.4   Under the Outcomes and Outputs Framework all agencies are required to specify the price, quality and quantity of departmental outputs. The Portfolio Budget Statement for the Health portfolio complies with these requirements[45]. The price of Departmental Outputs, $89.5 million, has the components shown in Table 5.2.

Table 5.2

Departmental Outputs for Outcome 8 (Enhanced Quality of Life for Older Australians) 1990–2000

Output	Price $m
Policy advice to the Ministers and Government	11.2
Services to the Minister and Parliament	9.6
National Leadership	8.1
Information	13.3
Contract Administration and Funds Management	44.0
Regulatory Activity	11.1
Total Departmental Outputs	**97.3**
Accrual adjustment	-7.8
Total Departmental Outputs (Accrual basis)	**89.5**

Source: Portfolio Budget Statements, Health and Aged Care Portfolio, page 201

5.5   While Health has knowledge of the cost of departmental outputs incurred in managing Outcome 8, there is only limited information on the cost of administering HACC[46]. DOFA's *Specifying Outcomes and Outputs* states *'Costing (is) primarily a management tool to improve operations within agencies by identifying cost drivers and non-value added activities leading to more efficient operations'*[47]. With limited information on the costs of HACC, Health managers are not well placed to manage administrative costs. Further, Health is unable to inform stakeholders on the costs incurred by Health in administering HACC.

5.6   The performance measures for *'Administered Item 2, Community Care and Support for Carers'* relevant to the HACC program are shown in Table 5.3.

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[45]   Commonwealth of Australia, 1999, *Portfolio Budget Statements 1999-2000, Health and Aged Care Portfolio*, Budget Related Paper No. 1.11, Canberra, Table C8.4, p. 206

[46]   Each state and territory is permitted to allocate a sum for administration from joint HACC funds. This allocation is based on the previous year's total state allocation plus an amount for indexation. The average administration provided to the states for administration in 1999–2000 was 1.1 per cent ($9.5 million) of total HACC funding.

[47]   Department of Finance and Administration, 1998, *Specifying Outcomes and Outputs—Implementing the Commonwealth's Accrual-based Outcomes and Outputs Framework*, Commonwealth of Australia, p. 35.

Table 5.3

HACC Performance Measures for 1999–2000

Quantity	3.8–3.9 million units of HACC service output per month (an increase of 3–5 per cent over November 1997 figures) 50 HACC services appraising their performance against agreed standards
Efficiency	Current average cost to Commonwealth per unit of HACC service output increases no greater than inflation: (in 1997–98 the cost per unit of HACC service output averaged $11.25 within a range of $36 for 1 hour of community nursing to $1 for a meal).
Equity	Equitable distribution of units of HACC service output across States/Territories (units of service per 1000 HACC target population).

5.7   Quantity, quality, efficiency and equity measures are discussed below.

Quantity measures

5.8   The quantity performance measure is 50 HACC service providers appraising their own performance against the National Standards Instrument. The value of 50 larger service providers undertaking assessments is somewhat different from the value of 50 smaller ones doing so. The indicator would be more useful if it included an estimate of the percentage of HACC expenditure accounted for by the service-providers appraising their own performance. Note that the 20 largest HACC service-providers in Australia account for more than 70 per cent of total HACC expenditure.

Quality measures

5.9   There are no quality performance measures specified for Administered Item 2, Community Care and Support for Carers. Health, in consultation with HACC Officials, has identified a need for more work in developing quality standards. The National Standards Instrument, which incorporates quality aspects, was agreed to by HACC Officials committee in May 1995 and came into effect on a state-by-state basis on 1 July 1999. The Australian Institute of Health and Welfare (AIHW) has been commissioned to conduct a standards consumer appraisal project. Health has introduced also a *Quality Assurance Circular—HACC*. The first issue was published in June 1999, and more are to be issued quarterly.

Efficiency measures

5.10   Health has a target of restricting the change in average unit cost of HACC output to the rate of inflation. If this measurement is to be useful in a period of low inflation the accuracy of unit costs is important. Errors as small as two per cent in the estimates of unit cost could give

the impression that Health had not met the set target. For example, with an inflation rate of three per cent, an actual change in cost of two per cent plus a compounding error of two per cent could give an apparent change of four per cent. The apparent change would be outside the target range even though the actual change was within it.

Equity measures

5.11   As stated in Chapter 2, Health has an objective for the HACC program:

> *to ensure that, within available resources, and in the context of broader service delivery framework, home and community services are provided equitably between Regions and are responsive to Regional differences;*

5.12   Health's equity performance measure for the HACC program is:

> *Equity: equitable distribution of units of HACC service output across states/territories (units of service[48] per 1000 HACC target population).*

5.13   This performance measure gives no information of whether services are provided equitably between regions.

Recommendation No.9

5.14   The ANAO recommends that, in order to ensure consistency with program goals and objectives, Health should considering varying the output indicator for HACC in relation to equity along the following lines: 'equitable distribution of units of HACC service output across states and territories *and between regions within states and territories* (units of service per 1000 HACC target population)'.

Health's response

5.15   Health agrees to discuss this issue with the states and territories and highlights that the issue requires further consideration and negotiation. Although differences in cost structures for services across the states and territories may suggest that inequities exist in service outputs across regions, the basis of the resource allocations in the program is relative need for services through a strategic planning process. The issues of regional inequities are complex.

Audit finding

Health is reporting by outputs and outcomes in compliance with the Commonwealth's Accrual-based Outcomes and Outputs Framework.

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[48]   One hour of service equals one unit of service, one episode of service (one meals on wheels) equals one unit of service.

Benchmarking

5.16 Benchmarking involves identifying a point of reference (the benchmark) from which quality or excellence is measured by comparison. The HACC program does not have benchmarks at the moment. Information in State annual plans on outputs and their cost is a useful first step toward establishing national benchmarks for HACC. In the next couple of years, when all states are operating under the new agreements, Health will be better placed to develop benchmarks against which the states' and territories' performances can be assessed. As well as providing a performance yardstick, benchmarking will help Health monitor cost differences between states.

5.17 In the future, Health could take a national leadership role also by developing benchmarks, against which service-providers can compare their performances. The approach could be similar to that used by industry groups in the private sector. There would be a survey of service-providers to collect information on costs and performance against selected performance indicators. Each participating provider would receive a report showing its own costs and performance, in a standard format, and average costs and performance nationally and for their state. Note that state averages would be provided only if there were enough participants in the state to maintain confidentiality.

5.18 Approval of funding for, and administration of agreements with, service providers is a state responsibility. Development of provider benchmarks would require the cooperation of the states and would need to be negotiated with them.

Better practice

5.19 Another possible leadership role for Health could be to assist service providers to improve service quality by identifying and promoting examples of best practice service provision in areas such as:

• service delivery;

• coordinated service delivery;

• performance evaluation; and

• assessment.

5.20   This could be achieved through a service-provision better-practice repository. The repository would need to be easily accessed by service providers and its existence would need to be widely known amongst service providers. It would be even more useful if service providers could add their experiences to the repository. A format such as the Service Provision Targets Framework[49] web site may be appropriate.

5.21   Because day-to-day contact with service providers is a state responsibility, Health would need the cooperation of the states in identifying examples of service provision best practice. Health's primary role would be to maintain the repository and ensure easy access and the quality of the contents.

5.22   Before proceeding Health would need to ensure that the benefits justify the cost.

Canberra   ACT
31 March 2000

P. J. Barrett
Auditor-General

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[49] The Service Provision Targets Framework is discussed in Chapter 2.

Appendices

Appendix 1

The Home and Community Care Program

This appendix provides background information on the HACC program, including the environment in which it operates.

Introduction

1. The Commonwealth provides funding under the *Home and Community Care Act 1985* (HACC Act) for a range of personal, health and domestic services to support older persons and other people with disabilities who live at home, and their carers, where those persons' capacity for independent living is at risk or where they are at risk of premature or inappropriate admission to long-term residential care. The HACC program operates as a safety-net program and has broad eligibility criteria. Targeting guidelines are used to manage resource-allocation in an environment of unsatisfied need.

2. The HACC program is funded and administered jointly by the Commonwealth and states. The Commonwealth provides about 60 per cent of funds and the states the balance. Commonwealth funding for 1999–2000 is $525 million and state funding of about $340 million for a total estimated expenditure of about $865 million. State and territory departments are allocated a proportion of HACC expenditure specifically for administrative costs of the program.

3. In administering the program, Health is working in a complex environment. An appreciation of the complexity is essential to understanding the context in which the program operates and the issues associated with the Commonwealth's role in its administration.

Agreements with states and territories

4. The HACC Act provides for the Commonwealth and the states/ territories to enter into agreements for the provision of HACC services. The agreements allow for Commonwealth payment of financial assistance to the states.

5. The HACC program is in a period of transition with six states operating under a new agreement. Tasmania and Western Australia are continuing negotiations for the move to the new agreements. The first new agreements were signed in 1998.

6. The Act includes a schedule containing a model agreement, with which HACC agreements made with the states must be consistent. The original HACC agreement provides for joint Commonwealth and state or territory agreement in relation to funding allocations to the state or territory, regions and individual projects.

7. The new agreement provides for reduced administrative duplication between the Commonwealth and the states, with Commonwealth agreement required only in relation to planning and funding at a regional, as opposed to individual-project, level. In addition, the new agreements require the states to plan and report against service-provision outputs.

Objectives of the program

8. The objective of the HACC agreements is:

The provision of moneys by the Commonwealth and the State:

a) *to assist service providers to develop, through the rationalisation and expansion of existing services and development of new services, a comprehensive range of integrated home and community care for persons within the target population and their carers where possible and appropriate; and*

b) *to provide basic maintenance and support home and community care services to those persons, in their own homes, to improve their quality of life; and/or*

c) *to avoid premature or inappropriate admission of those persons to long term residential care.*

9. In addition, the 1999–2000 Portfolio Budget Statements for Health outline outcomes in relation to programs. Outcome 8 is *'Enhanced Quality of Life for Older Australians'* and its objective is to ensure *'Support for positive and healthy ageing and high quality and cost-effective service for frail older people, people with disabilities, and their carers'*. The HACC program is included in Outcome 8 in addition to other aged and community care programs and initiatives administered by Health.

10. The category of output indicators in Outcome 8 relevant to the HACC program is Community Care and Support for Carers. Key outputs include:

- 3.8–3.9 million units of HACC service output per month (an increase of 3–5 per cent over November 1997);

- 50 HACC services appraising their performance against agreed standards;

- Current average cost to Commonwealth per unit of HACC service output increases no greater than inflation (in 1997–98 the cost per unit of HACC service output averaged $11.25 within a range of $36 for one hour of community nursing to $1 for a meal).

- Equitable distribution of units of HACC service output across states/ territories (units of service per 1000 HACC target population).

Roles and responsibilities

11. The Commonwealth assumes the role of funder under the program, and the states can hold the role of funder, purchaser or provider of HACC services. In addition, private-sector and not-for-profit organisations and local governments provide HACC services.

12. The Commonwealth, with the states, is responsible for developing and implementing national policy initiatives and identifying national trends in the HACC program. In addition, the Commonwealth and state ministers have a joint responsibility in relation to agreement of funds for each state and subsequently the allocation of funds to regions in each state and territory.

13. The states are responsible for the day-to-day administration of the HACC program, managing reviews and coordinating planning processes and are the primary points of contact for service-providers. State and territory ministers are responsible for program management and, under the new agreements, approving and funding individual services within regions.

14. HACC Officials representing the Commonwealth and the states meet twice yearly to discuss significant program issues. They also manage the Planning and Development Fund, consisting of pooled Commonwealth and state and territory funds, used to finance various research and other projects for the development of the program.

15. An example of an initiative funded by the HACC Officials Planning and Development Fund is the HACC Minimum Data Set, the objectives of which are:

- *To provide HACC program managers with a tool to access data required for policy development, strategic planning and performance monitoring against agreed output/outcome criteria;*

- *To facilitate consistency and comparability between HACC data and other aged, community care and health data collections; and*

- *To assist HACC service providers to provide high quality services to their clients by facilitating improvements in the internal management of HACC funded service delivery.*

16. The data set has been developed to ensure that HACC Officials have access to data necessary to develop and manage HACC policy, undertake strategic planning of the program and monitor its performance against agreed output and outcome criteria. It is due to be operational in July 2000.

Evolution of the HACC Program

17.   Before the HACC Program began, the states, local governments and community organisations had been providing and funding a range of home and community care services. The Commonwealth had also been providing financial for such services under several Commonwealth Statutes:

- *Home Nursing Subsidy Act 1956;*
- *State Grants (Paramedical Services) Act 1969;*
- *State Grants (Home Care) Act 1969;* and
- *Delivered Meals Subsidy Act 1970.*

18.   The HACC Act commenced in 1985, consolidating several Commonwealth and state and territory funded programs. One consequence of this consolidation was diversity of operation of the HACC program between states. For example, in NSW, a large state government organisation, Home Care, is the largest service-provider, receiving about half the HACC funding for the state. In Victoria, the State Government funds local government and other service-providers to provide HACC services. Local governments in Victoria provide HACC services and fund other providers.

19.   Community nursing is also provided quite differently under individual state governments. In NSW, for instance, they are generally delivered via state government bodies called Area Health Boards. In Victoria they are provided by the Royal District Nursing Society of Victoria, a non-government organisation, and likewise in the Adelaide area of South Australia by the Royal District Nursing Society of South Australia.

20.   The variation in the operation of the HACC program in the states has significant implications for the Commonwealth in developing mechanisms to achieve national consistency in its administration and coordination with other support programs, and in the equitable provision of HACC services between and within the states.

21.   Funding for the HACC program has increased considerably since 1985—by the Commonwealth alone from $100.8 million in 1985–86 to $500 million in 1998–99. In 1999–2000 it will contribute $525.56 million. There has been considerable growth since 1985 also in the number of individual projects providing services.

Other aged and community care programs

22.   The HACC program constitutes part of a broader framework of aged care, community and health services funded by the states or the Commonwealth or both. The services within this framework include residential and community based services, such as community health-care services, disability services (like accommodation, support and attendant care), low level and high level residential care, Community Care Packages (CCPs), and the National Respite for Carers Program (NRCP). Other Commonwealth departments such as the Department of Veterans' Affairs and the Department of Family and Community Services also administer related aged and community care programs.

23.   Several of the support services within the framework have begun since the HACC Act was promulgated. Although the HACC Act sought to bring national coherence to community care, the creation of these programs has resulted in more growth of aged and community care programs providing services similar to those of the HACC program.

24.   The overlap of eligibility criteria for aged and community support services is also significant for the HACC program. In addition to providing a safety-net for clients who do not satisfy the criteria for other programs, the HACC program has to pick up clients whose needs exceed the limits set by them. As a result, unsatisfied demand in other programs within the framework has a direct impact on the unsatisfied demand for HACC and the levels and types of needs of those seeking HACC services.

25.   Developments in government policy have also had a profound impact on the HACC program. Current government policy promotes assistance to frail older people who choose to stay in their homes, by providing assistance via community-care options and mechanisms to prevent premature or inappropriate admission to residential care. As a result, the proportion of the target population continuing to stay in their homes has increased.

26.   Significantly, the proportion of people with high and/or complex needs staying in their homes has increased too. In addition, as a result of increased life expectancies, there are increasing numbers also of much older people, with a higher incidence of conditions, such as dementia, most frequently encountered in such people. There are also increased numbers of older people and younger people with disabilities, arising from general demographics and from increasing numbers' surviving longer with chronic or disabling conditions and traumatic events (such as strokes and brain injury), with disabilities.

27.   These developments have had a significant impact on the program, as high-need clients consume relatively high levels of resources, which affects unsatisfied need for the program. It has been estimated that although about 10 per cent of highest-service users absorb up to 50 per cent of resources, 40 per cent of the lowest-service users absorb only 10 per cent of resources. In an environment of unsatisfied need, services have to be withdrawn from or reduced for a significant number of low-use clients to generate additional services for a relatively small number of high-use clients.

Funding of the HACC program

28.   As outlined above, the HACC program is funded jointly by the Commonwealth and the states. Commonwealth funds are supplied on the condition that the states or territories contribute funds according to an appropriate funding ratio. The Commonwealth provides about 60 per cent and the states the rest. Funding ratios vary between the states.

29.   When a state or territory cannot 'match' the available Commonwealth funds fully, surplus funds are supplied to the remaining states. Commonwealth and the respective state or territory funds are pooled and distributed to regions within the state or territory to fund individual projects providing HACC services. The conditions of this redistribution are outlined under the heading Equalisation Strategy, below.

30.   The funding formula is based on the amount paid to the respective state or territory for the previous year, plus indexation and growth funding. The formula was derived to take into account, among other factors, the HACC target population and growth programs in the states, as well as the equalisation strategy and the User Charging 1996 Budget Initiative.

31.   The annual process of planning funding includes the development of State annual plans, which identify funding priorities on a state-wide and regional basis, and the projected outputs for each region for the financial year. State annual plans are prepared primarily by the state and territory governments. The extent to which Commonwealth officers are involved varies in accordance with the individual state or territory. Triennial Strategic plans might be developed also for each of the states and on a national level.

Equalisation strategy

32. The equalisation strategy was developed to equalise the average per-capita funding of the HACC target population for each state and territory. It was formulated to take effect over 16 years to 2010–2011. The total Commonwealth, state and territory pooled funding and the national average per-capita funding from 1995–96 to 2010–11 is shown in Table A1.1.

Table A1.1

Total funding and average funding per capita from 1995–96 to 2010–11

Year	Total Commonwealth and State/Territory funds ($)	National average funding per capita of the HACC target population ($)
1995-96	697 760	645
1996-97	743 483	674
1997-98	784 580	697
1998-99	823 393	717
1999-2000	864 806	738
2000-01	933 229	781
2001-02	1 006 827	826
2002-03	1 086 230	873
2003-04	1 171 896	924
2004-05	1 264 320	977
2005-06	1 364 035	1 033
2006-07	1 471 616	1 092
2007-08	1 587 684	1 155
2008-09	1 712 911	1 221
2009-10	1 848 017	1 291
2010-11	1 993 785	1 365

Note: Figures for 1999–2011 are estimates only based on projections of funding which assume the ability of the Commonwealth and the states to provide planned funding. Average funding per capita estimates are based on HACC target population projections calculated using the 1993 ABS Survey of Disability, Ageing and Carers.

33. A key requirement of the equalisation strategy is a positive growth rate for each state and territory. The requirement of real growth rates for all states implies that the Commonwealth maintains a minimum level of funding. The current projected average growth rate of 7.7 per cent, including indexation, is more than enough to reach the equalisation target.

34. When funds are not 'matched' fully by a state or territory, surplus Commonwealth funds are redistributed to other states. Priority for redistribution is given to the states whose estimated per-capita HACC funding is below the national average. States accepting the funds must 'match' them pro-rata too. This redistribution has implications for the projected growth rates and therefore the equalisation target, particularly when the states that do not 'match' have an average per-capita funding lower than the national average.

35. Table A1.2 shows funds for the HACC program for 1998–99 and the estimated average per-capita funds for each state and territory.

Table A1.2
Joint funding for the HACC program for 1998–99

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
Commonwealth funds ($m)	155.9	141.2	87.7	44.8	49	13.3	3.1	5.3	500.2
State funds ($m)	104.6	94.3	48	27.9	31.7	9.8	1.4	5.5	323.2
Total funding ($m)	260.4	235.5	135.7	72.6	80.7	23.2	4.5	10.9	823.4
Estimated average funds per capita ($)	710	849	618	629	747	682	666	531	717

36. The difference between the lowest estimated per capita average—$531, in the ACT—and the highest, Victoria's $849, is $318. The ACT is $186 below the national estimated average. Victoria is $138 above it The total national funding for the HACC program in 1998–99 was $823.4 million.

37. Table A1.3 shows projected funds for 2010–2011 and the estimated per capita average funds for each state and territory in that year. The projected funding levels assume a sustained average growth rate of 7.7 per cent, including indexation, for Commonwealth funding, and full (pro-rata) match by the states.

Table A1.3

Projected joint funding for the HACC program for 2010–2011

State	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
Commonwealth funds ($m)	371.9	277	267	114.6	120.8	31.8	10.9	20	1214
State funds ($m)	249.5	185.4	146	71.3	78.2	23.5	5	20.8	779.8
Total funding ($m)	621.4	462.4	413	185.9	199	55.3	16	40.7	1993.8
Estimated equalisation target average funding per capita 2010-11 ($)	1365	1365	1365	1365	1365	1365	1365	1365	1365

38. For 2010–2011 the projected target average per capita funding across all states is $1365, and total national funding $1993.8 million.

Flexibility of the program

39. The HACC program is inherently flexible and adaptable to local and individual circumstances, providing benefits and disadvantages. As outlined above, eligibility criteria are broad to ensure that HACC operates as a safety-net program and allows for flexibility to accommodate changing needs. It is sufficiently flexible also to allow service-providers to tailor service to clients' individual needs and circumstances. This aspect of the program is considered one of its valuable characteristics.

40. However, this flexibility does have significant implications for the Commonwealth in developing mechanisms to provide for national consistency and equity between clients in similar circumstances. It is acknowledged that this inherent tension between providing for flexibility and ensuring national consistency creates challenges and difficulties for the Commonwealth's administration of the program.

The HACC Market Place

41. The structure through which HACC services are delivered varies from state to state. However, there are some similarities.

Few private-sector service-providers

42. The old agreements did not allow services to be provided by the private sector, although service-providers could subcontract to the private sector. Private-sector providers may provide the services under the new agreements, but most providers are public-sector or not-for-profit organisations.

Dominant service providers

43.   In some states there are very large service-providers that dominate the provision of specific services. For instance, NSW's Home Care provides nearly all the state's home care and personal care services. The Victorian Royal District Nursing Society is by far the largest provider of community nursing services in Melbourne and surrounding areas. Similar situations exist in other states.

Service-providers need to cooperate

44.   HACC clients, particularly those with complex needs, might need services from more than one provider. To provide a high-quality service these providers might need to cooperate. Even those who offer competing services might cooperate to ensure an equitable supply of services. This issue will taken up in the context of the National Competition Review of the HACC Act.

Consumers are not purchasers

45.   HACC service-providers enter into agreements with state governments or other bodies to supply services to HACC clients. Although they are encouraged to charge fees, services cannot be denied to those unable to pay. This limits consumers' ability to influence service provision by exercising choice.

Consumers are not fully informed

46.   Consumers can have problems finding out what HACC services are available and who the service-providers are. HACC services include consumer-information services. Carelink centres will be a future source of consumer focussed information.

There is significant unmet demand

47.   HACC consumers (or their advisers) are aware that there is unsatisfied demand for services, and tend to take the first service supplied unless the provider has an abysmal reputation. Again, this limits consumers' ability to influence service-provision by exercising choice.

48.   An outcome is that solutions that work well in a better-structured market can have unintended consequences that conflict with other policy goals when applied to HACC. An example is that service agreements between providers and state governments often contain a requirement that the provider cooperate with other providers. A number of providers commented that they were required to cooperate with providers with whom they competed for HACC contracts, and felt that they were being sent contradictory signals. Survival compels them to compete, not cooperate.

Reform of the HACC program

49.	The HACC program is undergoing significant reform. Many of the reforms are in response to the recommendations of an evaluation of the program, the *Efficiency and Effectiveness Review of the Home and Community Care Program,* in 1995. In addition, a Parliamentary report was prepared by the House of Representatives Standing Committee on Community Affairs in 1994, *Home But Not Alone.*

50.	As outlined above, new HACC agreements have been signed with six of the states, and are being developed for the rest. They provide for reduced administrative duplication between the Commonwealth and the states, while Commonwealth agreement on planning and funding is required only at regional level, as opposed to individual-project level under the old agreements.

51.	A significant aspect of the new agreements is the move to planning funding on the basis of outputs of service-delivery. Under the new agreements, the State annual plans must outline proposed levels of outputs for services for each region. State Business Reports are required to report subsequently on levels achieved. Once all states are reporting against, and funding regions on, outputs, the program as a whole can move toward output-based funding nationally.

52.	In accordance with the move toward output planning of funding, HACC has developed the Service Provision Targets Framework (SPTF), which is intended to achieve greater equity in the program's outputs. It uses a range of data sources, including data on both HACC and other aged and community care services, and information to assist with planning. The STPF was utilised in the development of State annual plans for 1998–99.

53.	Other significant reforms of the program include development of the Minimum Data Set, due to be operational in July 2000; a Comprehensive Assessment Framework; and targeting strategies to help service-providers allocate resources to clients.

54.	A significant issue for reform in the program is the differing progress of individual states in adopting initiatives. An example of this aspect is output-based funding. In states whose governments have adopted output-based funding for all their programs, adopting output-based funding for the HACC program will clearly be facilitated. In those that have not, its adoption for HACC can involve an extensive process of negotiation and development of appropriate policies, processes and systems.

55.   Some states might also initiate reforms at the state level. For example, one state is trialling an initiative to provide for increased coordination of community services, including HACC services. The Commonwealth is taking action also to address coordination of aged and community services, but the work is not as advanced. In addition, the approach a specific state takes to address such coordination might not be applicable to other states and might not be the appropriate approach nationally.

56.   In summary, the differing progress of individual states in adopting initiatives further complicates the Commonwealth's leadership role in national policy. The Commonwealth has the challenge of encouraging states that are slower in adopting reforms, and trying to achieve national consistency, without unduly restraining positive developments by more innovative states.

Conclusion

57.   The HACC program operates in a complex environment. Joint Commonwealth/state/territory involvement complicates the Commonwealth's administration of the program. In addition, the program exists within a broader framework of community and health services funded by the Commonwealth or states or both. Developments in government policy, too, have resulted in a changing environment for the program, with an increasing emphasis on maintaining independence in the community for older persons and people with disabilities.

Appendix 2

Targeting in the HACC program

This appendix contains an extract from Targeting in the Home and Community Care Program, *by the National Ageing Research Institute and Bundoora Extended Care Centre, 1999,* Aged and Community Care Services Development and Evaluation Report No.37, July 1999, *Commonwealth Department of Health and Aged Care, Canberra, pp.25–26. It is included to provide further information to readers on the background of tiers of access to services, as discussed in Chapter 3.*

Integrating targeting strategies and guidelines for resource allocation

The effectiveness of different targeting strategies in addressing the differing needs of the diverse HACC target population lead the Consultancy to seek a means of integrating the various targeting strategies in a way that aligned targeting mechanisms with access to different levels of services and resources. In line with the framework proposed for providers to apply in developing resource allocation guidelines, alignment can be addressed at the various points on the pathway of access to services.

The system proposed here has the capacity not only to assist in decision making about resource allocation to clients but can also add to the range of tools available for strategic planning and monitoring outcomes of HACC at the client, provider and program levels. With tools available that parallel those used for planning and monitoring residential care, there is greater scope for integration of the two systems. Further, the proposed system may provide a means of addressing several of the problematic issues that the Consultancy identified at the boundaries between HACC and a number of other Commonwealth and state funded programs. Finally, to address a number of limitations in data availability and analysis encountered in the course of the Consultancy, some proposals for strengthening evaluation of community care are advanced.

Aligning targeting mechanisms and tiers of access to services

A system of three tiers of access is proposed to integrate targeting mechanisms and provider guidelines developed in a common pathway framework. Each tier is defined by aligning targeting mechanisms at different points on the pathway of access to services, as follows:

Tier 1: Basic HACC covers the major part of HACC as it now operates, preserving broad eligibility and open access, with assessment, admission to service and care planning carried out by individual providers, but

using guidelines that have been developed in accord with the common principles across the HACC Program. All funds at this level would be allocated by providers, with output based funding of providers at standard unit costs.

Tier 2: HACC "Plus" covers all clients who reach a defined level of resource use and who are then referred to a Comprehensive Assessment Service, recognising that referral for comprehensive assessment may also be made on other grounds besides level of resource use. Where the outcome of the comprehensive assessment is the provision of package including additional services, all additional services would be funded through brokerage funds. Brokerage funds would cover services above the resource level at which referral was triggered, hence the name "HACC Plus". As a very first and preliminary estimate, some 15 per cent of HACC clients might be expected to gain access to HACC Plus.

Tier 3: HACC "Exceptional" Clients would also be identified through the Comprehensive Assessment Services. Funding for these clients would be individually approved and drawn from a separate pool that did not impinge on the budgets of individual HACC providers. That is, additional funding would be drawn from the designated pool for each additional client rather than being taken from HACC funds. The total number of exceptional clients nationally would be very small, probably no more than two per cent of the current HACC client population.

Some further features of this three tier framework that integrate access and targeting mechanisms at each level can be noted.

Targeting for access to different tiers of service

1. Open eligibility and access to initial services is preserved and fostered. In terms of resource allocation, sustained high demand creates incentives to provide an initial level of services and to increase services sparingly. Access to higher levels of service is managed by requiring assessment once a certain level of resource use is reached.

2 Assessment at a given trigger point provides a means of reviewing appropriateness of services as well as the level of resource use.

3 In line with the proposals for Comprehensive Assessment Services in HACC, the accreditation of other assessment services in addition to ACATs would address the range of care needs experienced by younger people with disabilities and their carers. It would be the outcome of assessment that gave access to a higher level of services through brokerage funds, rather than dividing the client population on the basis of age or nature of disability.

4 The role of assessment, review and service limits as mechanisms for resource allocation would be strengthened by formalising their operation across HACC with providers operating within a common framework of guidelines that addressed these decision points in resource allocation.

5 Making case management a general HACC service rather than funding it only through brokerage programs would remove the perverse incentive that currently exist in brokerage programs to cross subsidise high service use/high cost clients by admitting low cost clients who need case management but not high levels of service.

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