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Performance Audit

Home and Community Care Follow-up Audit

Department of Health and Ageing

Australian National Audit Office

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Canberra ACT
14 February 2002

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Ageing 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 Follow-up Audit.*

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

AUDITING FOR AUSTRALIA

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Abbreviations

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ANAO	Australian National Audit Office
CACP	Community Aged Care Package (formerly referred to as Community Care Package or CCP)
CCP	Community Care Package (now Community Aged Care Package or CACP)
CSDA	Commonwealth State Disability Agreement
DSSC	Disability Services Standing Committee
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
HACC	Home and Community Care
Health	At the time this follow-up audit was conducted the Department was called the Department of Health and Aged Care. It is now referred to as the Department of Health and Ageing.
MDS	Minimum Data Set
TWG	Targeting Working Group

Summary

Summary

Background

1. The Home and Community Care (HACC) program is jointly funded by the Commonwealth Government and State and Territory Governments under the *Home and Community Care Act 1985*. The Department of Health and Ageing (Health) is responsible for national administration of the HACC program.[1]

2. The aims of the HACC program are to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers;
- support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care; and
- provide flexible, timely services that respond to the needs of consumers.[2]

3. The program provides a range of personal, health and domestic services to the frail aged, people with disabilities, and their carers. Services provided under HACC include meals and other food services, nursing, personal care, home help, respite care, transport and home maintenance. HACC service providers include government, charitable and other private organisations.

4. The HACC program is a joint Commonwealth/State and Territory initiative, forming part of a broader framework of community and health services funded either through the States/Territories or Commonwealth or jointly.

5. In 2000–01, total government funding for the HACC program amounted to $932 million nationally. The Commonwealth provided $567 million, approximately 60 per cent of the total amount, and the States and Territories the balance. Additional funding comes from fees collected by service-providers. Nationwide, 494 000 people received services

[1] At the time this follow-up audit was conducted the Department of Ageing was called the Department of Health and Aged Care. The responsible minister was referred to as the Minister for Aged Care, but is now the Minister for Ageing.

[2] Department of Health and Ageing, *Home and Community Care Program Management Manual*, January 2000, p. 9.

through the HACC Program in 2000–01. Total government funding for HACC in 2001–02 is $1012 million, with the Commonwealth providing $616 million.

Audit approach

6. This follow-up audit focused on Health's implementation of the recommendations of Audit Report No.36, 1999–2000, *Home and Community Care*, which was tabled in March 2000. The report made nine recommendations.

7. The objective of this follow-up audit was to assess the extent to which Health has implemented the nine recommendations of Audit Report No.36, 1999–2000, *Home and Community Care*. In making the assessment the ANAO considered the currency of the original recommendations, any changed circumstances, and any new administrative issues.

8. At the commencement of this audit the ANAO wrote to Health requesting that it provide information on the implementation of the recommendations of the previous 2000 audit report. Following receipt of the response from Health, the ANAO:

- interviewed key personnel in the national Health office, one State Health office, and two State/Territory Government offices;
- met with service providers; and
- reviewed Health/HACC documents.

Over-all conclusion

9. Health has made satisfactory progress against the nine recommendations of Audit Report No.36, 1999–2000, with five recommendations having been implemented, and four in the process of implementation.

Key Findings

10. The table below summarises the progress that has been made against the recommendations of the previous audit report. Further detail can be found in Appendix 1.

Table 1

Progress against the recommendations

Rec.	Subject of recommendation	Progress
1.	Use of 1998 ABS Survey of Disability, Ageing and Carers as basis for funding	Implemented
2.	Definition of HACC target population; and Reducing ambiguity in, and publishing, National Guidelines	In progress
3.	National Fees Policy	Implemented
4.	Coordination (with Community Aged Care Packages)	In progress
5.	Coordination (with Commonwealth State Disability Agreement)	In progress
6.	Eliminating acquittals under former HACC agreements	In progress
7.	Tailoring accountability and data requirements for service-providers	Implemented
8.	Effective record management system	Implemented
9.	Variation of equity output indicator	Implemented

11. In addition, the previous audit found that the development and approval of the national triennial plan and State annual plans was not timely. Health has since made good progress in improving the timeliness of these planning tools.

Audit Findings and Conclusions

1. Introduction

This chapter introduces the Home and Community Care program. It also sets out the audit's approach, objective and methodology.

Overview of the Home and Community Care Program

1.1 The Home and Community Care (HACC) program is jointly funded by the Commonwealth Government and State and Territory Governments under the Home and Community Care Act 1985. The Department of Health and Ageing (Health) is responsible for national administration of the program.[3]

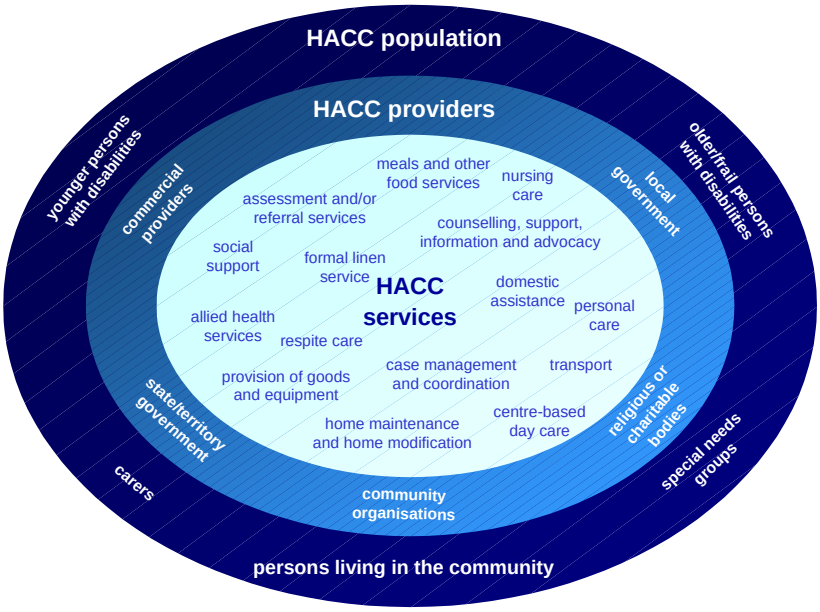
1.2 The aims of the HACC program, as stated in the HACC Program Management Manual, are to:

- *provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers;*
- *support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care; and*
- *provide flexible, timely services that respond to the needs of consumers.*[4]

1.3 The program provides a range of personal, health and domestic services to the frail aged, people with disabilities, and their carers. Services provided under HACC include meals and other food services, nursing, personal care, home help, respite care, transport and home maintenance. HACC service providers include government, charitable and other private organisations.

[3] At the time this follow-up audit was conducted the Department of Ageing was called the Department of Health and Aged Care. The responsible minister was referred to as the Minister for Aged Care, but is now the Minister for Ageing.
[4] The goals of the HACC program are listed in Appendix 2.

Figure 1.1
HACC service types, providers and population



1.4 The HACC program is a joint Commonwealth/State/Territory initiative, forming part of a broader framework of community and health services funded either through the States/Territories or Commonwealth or jointly. Other support services which overlap with HACC include:

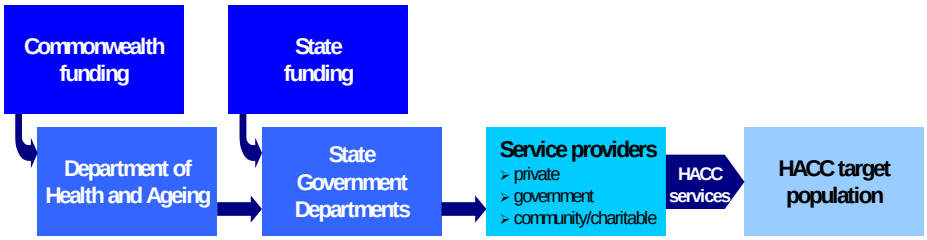
- Community Aged Care Packages (CACPs) and the Extended Aged Care at Home Program (EACH), also administered by Health;
- the Commonwealth State Disability Agreement (CSDA), administered by the Department of Family and Community Services; and
- the Veterans' Home Care Program, administered by the Department of Veterans' Affairs (DVA).

1.5 In 2000–01, total government funding for the HACC program amounted to $932 million nationally. The Commonwealth provided $567 million, approximately 60 per cent of the total amount, and the States and Territories the balance. Additional funding comes from fees collected by service-providers. Nationwide, 494 000 people received services through the HACC Program in 2000–01. Total government funding for HACC in 2001–02 is $1012 million, with the Commonwealth providing $616 million.

1.6 The formal basis for the Commonwealth—State arrangements for the HACC program lies in bilateral agreements between the Commonwealth and the States and Territories. These are known as the HACC Amending Agreements and replace the previous 1985 Agreement. The Amending

Agreements are the legal basis on which HACC program funds are provided to State and Territory Governments.

Figure 1.2
The HACC funding trail



1.7 Under the Amending Agreements, the Commonwealth Government, in consultation with the States and Territories, is responsible for developing and implementing national policy initiatives and identifying national trends in the HACC program. Their joint focus is on funding, accountability and achievement of service goals within a regional framework. State/Territory Governments are responsible for program administration, coordinating State and regional planning processes, managing reviews and the approval and funding of individual HACC services in State regions[5]. State/Territory Governments are also the primary point of contact for service providers and consumers.

1.8 The instrument for presenting the priorities and strategic direction for the program is the National Triennial Plan. The Plan is formulated and agreed jointly by the responsible Commonwealth, State and Territory Ministers and covers a three year period. The previous audit found that the development and approval of the plan was not timely. Health has since made good progress in improving the timeliness of the plan and, during this audit, the National Triennial Strategic Plan for the Home and Community Care Program 2000–2003 (Financial Years) was with the then Minister for Aged Care for approval.[6] Once the Commonwealth Minister has agreed to the plan, it will be forwarded to State and Territory Ministers for their consent.

1.9 Two of the main instruments in the annual Commonwealth/State and Territory planning cycle and reporting cycle are the State and Territory annual plan and business report. The State and Territory annual plan specifies the State/Territory Government's program direction, key priorities and service outputs for the financial year of the plan. It forms the basis of joint ministerial

[5] The term 'region' is used, as per the National Program Guidelines for the HACC program, to refer to a geographical entity as agreed between the Commonwealth and State Ministers.
[6] The Minister for Aged Care is now referred to as the Minister for Ageing.

approval of funding for the financial year. The previous audit found that approval of annual plans was not timely, with the majority of plans approved in the last quarter of the financial year to which they apply. Health has since made good progress in improving the timeliness of annual plans. All 2001–02 Annual State/Territory Plans were approved in early October 2001.

1.10 The business report details progress against the objectives set out in the annual plan. It contains financial and output activities by region in each State and Territory for the previous year. Business reports are tabled in the Commonwealth Parliament.

1.11 The HACC Officials Committee, a sub-committee of the Community Service Ministers' Advisory Council, oversees the general direction of the HACC program. It is the main forum through which States and Territories and the Commonwealth discuss HACC issues. The HACC Officials Committee meets twice per year and it comprises officers of Health, DVA and each State and Territory Department responsible for HACC.

1.12 Since conducting the audit and tabling Report No.36, 1999–2000, *Home and Community Care*, in Parliament in March 2000, there have been no significant changes in the structure or administration of the HACC program.

Previous Audit Coverage

1.13 Previous ANAO 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;
- *The Management of Performance Information for Specific Purpose Payments—The State of Play*, Audit Report No.31, 1998–99; and
- *Home and Community Care*, Department of Health and Aged Care, Audit Report No.36, 1999–2000.

Home and Community Care, Audit Report No.36, 1999–2000

1.14 The primary objective of the March 2000 *Home and Community Care* audit was to form an opinion on Health's administration of the HACC program. The audit was designed as a companion to Audit Report No.19, 1998–99, *The Planning of Aged Care*, and concentrated on HACC services to older persons with disabilities. The ANAO made nine recommendations for

improvement. All of the recommendations were accepted (Recommendation 5 was agreed in principle).

1.15 Overall, 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.*[7]

Audit Objective and Focus

1.16 This follow-up audit focused on Health's implementation of the recommendations of Audit Report No.36, 1999–2000, *Home and Community Care*.

1.17 The objective of this follow-up audit was to assess the extent to which Health has implemented the nine recommendations of Audit Report No.36, 1999–2000, *Home and Community Care*. In making the assessment the ANAO considered the currency of the original recommendations, any changed circumstances, and any new administrative issues.

Audit Methodology

1.18 Audit criteria were set to determine whether Health had implemented all the recommendations and had in place management arrangements to monitor the implementation of the recommendations.

1.19 At the commencement of this audit the ANAO wrote to Health requesting that they provide information on the implementation of the recommendations of *Home and Community Care*, Audit Report No.36, 1999–2000. Following receipt of the response from Health, the ANAO confirmed the information provided by Health by:

- interviewing key personnel in the national Health office, one State Health office, and two State/Territory Government offices;
- meeting with service providers; and
- reviewing Health/HACC documents.

1.20 The fieldwork was conducted during September and October 2001.

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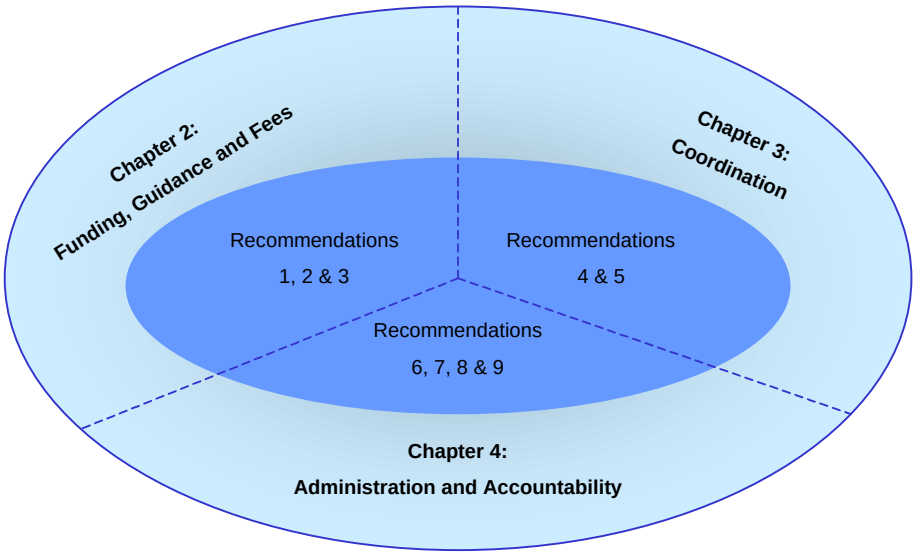
[7] Australian National Audit Office, 2000, *Home and Community Care*: *Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999—2000, Canberra, p. 13.

1.21 The follow-up audit was conducted in accordance with ANAO Auditing Standards at a cost of $81 000.

Report Structure

1.22 The report is organised into five chapters, based on the structure of Audit Report No.36, 1999–2000, *Home and Community Care*. The report structure is illustrated in Figure 1.3.

Figure 1.3
Report structure



2. Funding, Guidance and Fees

This chapter presents a conclusion against Recommendations 1, 2 and 3 of the previous audit relating to funding, guidance and fees.

Recommendation 1 of Audit Report No.36, 1999–2000

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.

Background

2.1 Each year, after both Houses of Parliament pass the Commonwealth Budget, the Commonwealth Minister for Ageing offers HACC program funding to the relevant State and Territory Ministers. State and Territory Ministers respond, accepting all or part of the funds offered, depending on their ability to provide the required matching funds. Any Commonwealth funds not matched by a State or Territory are redistributed to States or Territories able to provide matching funds. Commonwealth funding is calculated using a formula based on the previous financial year's amount indexed for inflation plus a growth allowance (currently totalling 8.54 per cent per annum). The formula takes into account relevant factors, including the assumed levels of fees collected by service providers, and an equalisation strategy.

2.2 The HACC equalisation strategy has been agreed to by the States and Territories and the Commonwealth. The basic principle of this strategy is to achieve equal per capita funding of the HACC target population across States and Territories by 2010–2011.

2.3 The agreed equalisation strategy uses HACC target population projections for each year to 2010–2011, calculated by applying a population projection model to the ABS Survey of Disability, Ageing and Carers data. At the time of the previous audit in 2000, data from the 1993 ABS Survey of Disability, Ageing and Carers was used as the basis for calculating distribution of funding. The ANAO recommended that Health base the population projections on the results of the 1998 ABS Survey of Disability, Ageing and Carers.

Findings of the follow-up audit

2.4 In July 2001, the then Minister for Aged Care approved the movement to a funding allocation based on the 1998 ABS Survey of Disability, Ageing and Carers. The 2001–2002 funding offer to the States and Territories and new target funding projections have been calculated by Health based on the 1998 ABS Survey of Disability, Ageing and Carers.

2.5 Table 2.1 shows funds for the HACC program for 2001–2002 and the estimated per-capita funds for each State and Territory.

Table 2.1
Joint funding for the HACC program for 2001–2002

	NSW	VIC	QLD	WA	SA	TAS	NT	ACT	National
Commonwealth funding ($m)	190.3	167.3	117.0	60.0	54.0	15.9	4.1	7.0	615.6
State funding ($m)	127.6	111.7	64.0	38.9	33.6	11.7	1.9	7.4	396.8
Total funding ($m)	317.9	279.1	181.0	98.9	87.7	27.6	5.9	14.4	1 012.4
Estimated average funding per capita ($)	563.0	709.0	507.0	572.0	598.0	553.0	412.0	561.0	588.0

Source: Department of Health and Ageing

2.6 Table 2.2 shows projected funds for 2010–2011 and the estimated per capita average funds for each State and Territory in that year.

Table 2.2
Projected joint funding for the HACC Program for 2010–2011 based on the results of the 1998 ABS Survey of Disability, Ageing and Carers

	NSW	VIC	QLD	WA	SA	TAS	NT	ACT	National
Commonwealth funding ($m)	395.0	274.1	295.5	131.6	100.5	30.7	10.3	15.0	1 252.7
State funding ($m)	265.0	183.0	161.6	85.2	62.6	22.6	4.7	15.7	800.5
Total funding ($m)	660.0	457.1	457.1	216.8	163.1	53.3	15.0	30.7	2 053.2
Estimated equalisation target average funding per capita ($)	1 046.0	1 046.0	1 046.0	1 046.0	1 046.0	1 046.0	1 046.0	1 046.0	1 046.0

Source: Department of Health and Ageing

2.7 The decision to move from using the 1993 Disability and Ageing Survey to the 1998 Survey was discussed by the HACC Officials Committee. During discussions at the December 2000 HACC Officials meeting, States and Territories indicated they would prefer to maintain 1993 data sources pending a review of appropriate options. An options paper was developed to address the effect of shifting to a new data source every five years and to consider alternative data sources. However, a later HACC Officials meeting in May 2001 noted and accepted that it was the prerogative of the Commonwealth Minister for Ageing to determine the allocation of HACC funding to individual States and Territories. As a result of the Commonwealth's decision, the review was deemed unnecessary and suspended.

2.8 The review may, however, be pursued at a later date, in line with HACC Priority and Direction 1, described in the draft Triennial Strategic Plan 2000–2003, to investigate improved data sources on which to base projections of the HACC target population.

Conclusion

2.9 Recommendation 1 has been implemented. Health has moved to using the 1998 ABS Survey of Disability, Ageing and Carers as the basis for distribution of Commonwealth HACC funding between the States and Territories. The 2001–2002 offer of funding to State and Territory Governments was based on this data.

Recommendation 2 of Audit Report No.36, 1999–2000

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.

Background

HACC Target Population Definition

2.10 The HACC target population, as defined in the *Home and Community Care Act 1985,* states:

> *The program shall be directed towards assisting-*
>
> *(a) persons living in the community who, in the absence of basic maintenance and support services provided or to be provided within the scope of the program, are at risk of premature or inappropriate long term residential care, including-*
>
> *(i) frail or at-risk aged 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 Minister and the State Minister; and*
>
> *(b) the carers of those persons.*

2.11 The definition is also included in the National Program Guidelines and the Amending Agreements.

2.12 This definition determines eligibility for HACC services. It is broadly constructed to enable the HACC program to provide flexibility in service provision. The ANAO found, in the previous audit, that the inherent flexibility of the program was invaluable in adapting to local and individual circumstances and accommodating the changing needs of the program and its client population.

2.13 However, the ANAO also found that significant issues arose because of the lack of definition of many key terms used to describe the HACC target population. The lack of clear definitions resulted in extensive individual interpretation by service providers in determining eligibility. This, in turn, led to inconsistent application of the guidelines and, therefore, HACC service provision between and within States and Territories.

National Program Guidelines

2.14 The National Program Guidelines for the Home and Community Care Program provide direction to stakeholders, including service providers, consumers, and HACC administrators. The purpose of the National Program Guidelines is to set out parameters for the national operation of the Home and

Community Care Program. The National Program Guidelines cover all aspects of the program, including:

- its aims and scope;
- who is assisted;
- Commonwealth, State, service provider, and consumer relationships;
- quality assurance;
- assessment; and
- fee charging.

2.15 The Summary Guidelines, a summarised version of the National Program Guidelines, provide a brief guide to the HACC Program. Together they are referred to here as 'the Guidelines'.

2.16 The previous audit found that while the version of the Guidelines existing at the time were generally well known and applied by HACC officers and service providers, they were ambiguous in parts and there was a lack of definition of key terms which resulted in difficulties of interpretation. In 2000, Health informed the ANAO that interpretive issues were State and Territory matters forming part of their day to day administration of the program.

2.17 In summary, the previous audit 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.*[8]

Findings of the follow-up audit

HACC Target Population Definition

2.18 As discussed above, the *Home and Community Care Act 1985* defines the HACC target population, and the definition is included in the Guidelines and the Amending Agreement. However, Health recognises that further clarity is required in the definition and stratification of the target group. To this end, the Targeting Working Group (TWG), a lapsed sub-group of HACC Officials, was

[8] Australian National Audit Office, 2000, *Home and Community Care*: *Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999–2000, Canberra, p. 47.

reconvened by the HACC Officials in December 2000. The TWG is examining the targeting issue in a number of forms:

- developing a tiered approach to targeting based on level of dependency;
- the concept of a HACC exit point[9]; and
- methods of funding for HACC targeting.

2.19 The work of the TWG is carried out with reference to the continuing work on the development of community care classification overseen by the Joint HACC/ACAP Assessment Working Group[10]. The Joint HACC/ACAP Assessment Working Group reports to HACC Officials on issues surrounding classification and assessment. A major part of the work of the Joint HACC/ACAP Assessment Working Group was the *Development of Dependency Data Items for HACC* consultancy completed for discussion at the May 2001 Joint HACC/ACAP Officials Meeting. The report is with the TWG to progress.

National Program Guidelines

2.20 The latest version of the National Program Guidelines for the Home and Community Care Program was developed as a result of a number of reviews of the HACC program:

- *Home But Not Alone*[11]
- *Efficiency and Effectiveness Review of the HACC Program*[12]
- Auditor-General Audit Report No.36, 1999–2000, *Home and Community Care Program*[13].

2.21 The revised Guidelines were distributed to all States and Territories, via HACC Officials, for consideration and comment. They were discussed in general terms at HACC Officials meetings and, where appropriate, specific amendments were discussed and approved. In addition, the Amending Agreement requires that, where appropriate, consumers and service providers are consulted regarding changes to the Guidelines. A number of peak bodies

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[9] A HACC exit point is the point at which a HACC client ceases to receive HACC services. Issues related to the HACC exit point include: the re-allocation of resources freed as a result of a client exiting from services; exit point definition; and exit point criteria.

[10] The community care classification system is defined as *a classification system that classifies clients into mutually exclusive groups based on their need for services (Policy Directions Workshop: Classification—Background Papers, July 2001*, p. 2).

[11] House of Representative Standing Committee on Community Affairs, 1984, *Home But Not Alone*, Canberra.

[12] 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.

[13] Australian National Audit Office, 2000, *Home and Community Care*: *Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999–2000, Canberra.

were canvassed in late 1999 and relevant comments were incorporated into the revised Guidelines. In June 2000, HACC Officials endorsed the redrafted Guidelines.

2.22 Following endorsement by HACC Officials, the Guidelines were to be subjected to a Regulation Impact Statement as part of the National Competition Policy Review of the *Home and Community Care Act 1985*. Health advised the ANAO that the *Home and Community Care Act 1985* is in the process of being removed from the Commonwealth Legislative Review Schedule and as such there is no need to finalise the Regulation Impact Statement. The Guidelines were forwarded to the then Minister for Aged Care for approval on 5 September 2001. When approved by the Minister, the Guidelines will be available in printed form and on Health's website on the Internet.

Conclusion

2.23 Considerable progress has been made against Recommendation 2. With respect to the first part of the recommendation, the Targeting Working Group, a sub-committee of the HACC Officials, is responsible for refining HACC eligibility guidelines. The work of this committee is ongoing. With respect to the second part of the recommendation, the National Program Guidelines and Summary Guidelines were developed in consultation with peak bodies. They have been endorsed by HACC Officials and were provided to the former Minister for Aged Care for approval. Health has advised that they will resubmit the Guidelines to the current Minister for Ageing for approval in early March 2002. Implementation of this recommendation will be complete when approved program guidelines are issued.

Recommendation 3 of Audit Report No.36, 1999–2000

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.

Background

2.24 HACC service providers may charge fees for HACC services. At the time of the previous audit, the fees varied between service providers and States and Territories. Differing fee levels between States and Territories 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 or Territory in which they live, and even depending on which part of a State or Territory they live. Because of the respective roles of the Commonwealth and the States and Territories in the HACC program, administration of the fees policy, including collection of information on fees charged, is the responsibility of the States and Territories.

2.25 The previous audit found that 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 recognises the need for national consistency in HACC user charging while maintaining flexibility for the States and Territories to develop and implement their own policies within the principles of the HACC fee policy framework. The policy is set out in the draft National Guidelines, which are awaiting approval, as noted above.

2.26 At the time of the previous audit, Health was unable to provide information on the level of fees collected in the States and Territories for 1997–98 or 1998–99.

2.27 In summary, the previous audit found that:

> *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.*[14]

Findings of the follow-up audit

2.28 Health has requested that the States and Territories report on their fee systems as part of the new reporting obligations specified in the HACC Program Management Manual issued in January 2000 and the National Training Package released in early 2001. The Program Management Manual states that annual plans should include a description of the State's fees policy, and business reports should detail the fees collected. Fees information from the States and Territories will assist Health to assess the success of the National Fees Policy and will allow better informed program management.

2.29 An examination of 2001–02 Annual Plans revealed that the provision of fees information and the detail included varies from State to State. Western Australia, Victoria, South Australia, Northern Territory and Tasmania have chosen to implement their own fees policies in line with the draft National Fees Policy. The Australian Capital Territory is considering the possibility of implementing a Territory fees policy. New South Wales supplied limited

[14] Australian National Audit Office, 2000, *Home and Community Care: Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999–2000, Canberra, p. 49.

information on meeting fees targets but otherwise did not mention a State fees policy. Queensland has made a decision not to adopt the National Fees Policy and will not be providing fees information to Health. Therefore, Health is better informed on the level of fees collected in each State, but is not yet fully informed.

2.30 Health has stated that the recommendation to incorporate fees information into the Amending Agreements will be considered in 2003 when the Agreements are reviewed.

2.31 The aim of the fees policy is to ensure a fair and equitable approach to user charging in the HACC Program. However, although Health encourages the States and Territories to adopt and implement the fees policy, the decision rests with each State/Territory Government. As a result, there is still considerable variation between States and Territories on fees policy and a lack of consistency and equity in user charging continues. In addition, HACC clients are still paying differing fees for the same service both within and between States and Territories.

2.32 Under the Amending Agreements, service providers are required to enter into contracts with the States and Territories. One of the information requirements they must meet is to specify the fees scale for services and report on the fees collected. This information is reported by service providers only to the State/Territory Government. Health does not require or receive information at this level.

Conclusion

2.33 Recommendation 3 has been implemented. Health has negotiated the inclusion of information on the level of fees collected with the States and Territories and this information has been incorporated into reporting arrangements. Health has stated that the recommendation to incorporate fees information into the Amending Agreements will be considered in 2003 when the Agreements are reviewed.

3. Coordination

This chapter presents a conclusion against Recommendations 4 and 5 of the previous audit relating to the coordination of the HACC program with other aged and disability care programs.

Introduction

3.1 Recommendations 4 and 5 of the previous audit covered one central issue: Health's coordination of the HACC program with other aged and disability care programs. The relevant findings of the follow-up audit relate to both recommendations and have, therefore, been combined in this Chapter.

Recommendation 4 of Audit Report No.36, 1999–2000

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.

Recommendation 5 of Audit Report No.36, 1999–2000

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.

Background

3.2 There is considerable overlap between the HACC program and with other aged and disability care programs within Health and with aged and disability care programs administered by other Departments. Overlap occurs with the population to whom HACC services are provided and with the type of services provided. One service provider may be providing services to an individual under several different programs, or the same services to different individuals under different programs.

3.3 Programs which overlap with the HACC program include:

- Community Aged Care Packages (CACPs), administered by Health;
- National Respite for Carers, administered by Health;
- Extended Aged Care at Home (EACH), administered by Health;
- Commonwealth State Disability Agreement (CSDA), administered by the Department of Family and Community Services; and
- Veterans' Home Care, administered by the Department of Veterans' Affairs.[15]

3.4 As a result of this overlap, it is necessary that Health:

- coordinate the planning and delivery of related Health administered programs; and
- work with other departments when planning and delivering overlapping programs.

3.5 Without proper coordination, inequities in funding and allocation of program places may arise. For example, coordination is necessary to avoid a situation whereby a region receives an amount of HACC funding regardless of the level of CACPs allocated in the regions. One region with a high number of CACPs may receive a large amount of HACC funding, while another region with fewer CACP places may be allocated a similar or smaller amount of HACC funding.

3.6 The previous audit examined this issue, concentrating on the relationship between HACC and two other programs: CACP (formerly Community Care Packages, CCPs) and CSDA. The audit reported that there was considerable overlap between the planning for HACC and CACPs for people aged 70 or more and that both programs aimed to keep frail aged people in their homes. The population serviced by CACPs can be regarded as a sub-set of the HACC population. Consequently, it is important that there is close coordination between the two programs and, when planning for HACC, account is taken of existing or proposed CACP places.

3.7 During the previous audit, the question arose as to the extent to which HACC services can be provided to people with a disability in CSDA accommodation support services. The audit found that the boundary between CSDA accommodation support services and HACC services was not clear to clients and their advocates. Another issue revolved around maintenance of community support services as people transfer from the disability pension to the age pension. The audit found that, while most coordination of CSDA

[15] These programs are briefly summarised at Appendix 3.

community services and HACC is required at State and Territory level and is a State/Territory responsibility, there are some points of tension between HACC and disability services that require national policy direction and clarification.

Findings of the follow-up audit

3.8 While progress is being made against Recommendations 4 and 5, as discussed below, Health has considerable work to do before the recommendations will be fully implemented.

3.9 As a first step, Health has identified as a priority the minimisation of gaps and duplication in policy and service delivery between the HACC Program and other aged care, disability and health programs. The draft National Triennial Plan for the Home and Community Care Program lists ten Priorities and Directions. The second of these is:

> *to ensure that initiatives within the HACC Program are aligned with developments in related programs, including those for people with disabilities and veterans, to the extent possible and consistent with all jurisdictions' policy directions.*

3.10 Health's draft National Triennial Plan discusses a number of approaches for planning, including consultation with relevant national policy forums, greater use of joint working groups, links between the data collections of different programs, and greater use of information from other regional programs to develop regional plans.

3.11 Planning of the HACC Program and coordination of HACC with specific programs, such as CACPs and CSDA, have been considered as part of a wider review of planning practices across Health. The scope of the review was to examine current approaches to the planning and delivery of specified programs, including the HACC Program. The consultancy was overseen by a Reference Group that included representatives from a number of Health divisions and the State and Territory offices of the Department. The report of the review was presented to Health in July 2001 as a Draft for Departmental Discussion.

3.12 The recommendations in the report covered improving planning within programs, facilitating better coordination across programs, and strengthening the planning infrastructure and management framework. The recommendations and the proposed action plan were accepted by Health in December 2001. The development of the proposed action plan indicates that Health has examined the problem and is preparing a course of action to address it. The ANAO considers this to be a substantial action towards implementing Recommendations 4 and 5 of the previous audit report.

3.13 The Program Management Manual outlines the administrative arrangements and procedures for the HACC Program as agreed between the States and Territories and the Commonwealth in the Amending Agreement. The Manual includes a short section titled *Relationship to other programs*. The section discusses, generally, the approach to be taken to individuals receiving other government-subsidised services, including residential care, CACPs, National Respite for Carers Program, and services provided by the Department of Veterans' Affairs. It does not, however, provide sufficient detail or instruction to ensure that HACC services and other programs, such as CACPs, are cost-effective and adequately integrated. The Program Management Manual also states that service contracts with providers must contain a requirement to cooperate with other service providers within the same region, both HACC and non-HACC funded, to meet client needs. The Manual does not include a request that States and Territories consider other programs, such as CACPs or the CSDA, in annual plans. However, a number of States and Territories include references to cross-program coordination in their annual plans.

3.14 Coordination between programs and individual clients most often occurs at the State and Territory and service delivery level. For example, it is common for personnel in State and Territory Government offices to work on a number of different programs, while State and Territory Health personnel regularly consult with counterparts working on other programs. The Program Management Manual and the draft National Program Guidelines call for extensive communication and coordination between service providers.

3.15 In response to Recommendation 5, a Joint DSSC/HACC Officials Working Group has been established as a subgroup of HACC Officials and the Disability Services Standing Committee. The Group was established to explore the boundary issues between the HACC Program and the CSDA. The first meeting of the Joint DSSC/HACC Officials Working Group was held in November 2000. Joint issues discussed at the meeting included targeting, assessment, continuity of care, planning, and data collection. A list of coordinated HACC/Disability Program projects has been developed. The working group has not, to date, developed joint national guidelines for areas in which HACC and CSDA intersect.

3.16 The formation of the joint working group is a first step towards addressing the recommendation, but greater coordination is more likely to occur with regular meetings. Of note is that the next meeting of the group, originally scheduled for August 2001, has been deferred until August 2002.

3.17 The CSDA is due to expire on 30 June 2002. Health has advised the ANAO that they anticipate being involved with the Department of Family and Community Services in the development of the new Agreement.

3.18 Issues of joint concern between the HACC and Disability Programs now form a standing item on the agenda of the HACC Officials Meeting. Joint issues are also considered by the Targeting Working Group and the CSDA has been invited to join the HACC/ACAP Assessment Working Group[16]. An account of the first meeting of the Joint DSSC/HACC Officials Working Group was reported in the newsletter of the HACC Program.

Conclusion

3.19 Progress is being made against Recommendations 4 and 5. A review of planning practices across Health is a substantial first step towards implementing the recommendations.

3.20 However, Recommendation 4 will not be implemented until Health has coordinated, at national level, the planning of HACC and CACPs in order to ensure that HACC services and CACPs are cost-effective, adequately integrated and avoid unnecessary duplication.

3.21 While progress has been made in the coordination of the HACC program with CSDA through the formation of a Joint DSSC/HACC Officials Working Group, Recommendation 5 is yet to be implemented. It will be implemented when Health and other relevant Commonwealth and State/Territory agencies have promulgated joint national guidelines in areas in which HACC and CSDA intersect.

[16] The Joint HACC/ACAP Assessment Working Group reports to HACC Officials on issues surrounding classification and assessment.

4. Administration and Accountability

This chapter presents conclusions against Recommendations 6, 7, 8 and 9 of the previous audit relating to administration and accountability issues.

Recommendation 6 of Audit Report No.36, 1999–2000

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.

Background

4.1 Acquitting Commonwealth expenditure is an important accountability control to provide an assurance that program money is spent for the purposes intended. In the context of the HACC program a certified statement, or an acquittal, is a declaration on the part of a body receiving program funds that those funds have been applied in accordance with the terms of the Amending Agreement. As HACC is a joint Commonwealth-State/Territory program, all pooled expenditure is acquitted at both the State/Territory and Commonwealth level. The States and Territories acquit HACC expenditure at the individual project level. In addition, State and Territory Auditors-General certify the financial statements of the State/Territory Government agency responsible for administering HACC.

4.2 Under the former HACC agreements, States and Territories were required to provide Health with acquittals outlining HACC expenditure against individual projects for the financial year.

4.3 The previous audit found that:

> *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.*[17]

Findings of the follow-up audit

4.4 Health has stated that they have been provided with documentation on the majority of acquittals by the States/Territories, but are unable to finalise them due to discrepancies between Health and State/Territory systems and the duration of time that had elapsed, in some cases up to 10 years.

[17] Australian National Audit Office, 2000, *Home and Community Care*: *Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999–2000, Canberra, p. 69.

4.5 Health's Audit Committee, in September 2001, endorsed a proposal to ensure that all outstanding acquittals under the former HACC agreements are finalised. Health has informed the ANAO that the proposed risk-based approach will be implemented by February 2002. The proposed approach takes an overall State/Territory HACC expenditure view. It will compare the total funding that the State/Territory acquitted with the total HACC funding available to the State/Territory in that year.

4.6 As at August 2001, when the proposed risk-based approach was developed, New South Wales, Victoria, Queensland, Western Australia, Tasmania and Northern Territory had outstanding acquittals. South Australia and Australian Capital Territory expenditure had been fully acquitted against the previous HACC agreement.

4.7 The acquittal process has been revised under the new Amending Agreements. It requires States and Territories to submit annual business reports, specifying expenditure of HACC Program funds in the financial year, by region and service type. The business reports comprise simple statements by region and service type that all program funds were expended in accordance with the Agreement. This expenditure report is based on the receipt and acceptance by the State/Territory of certified financial statements from service providers by 30 November each year.

4.8 As audited statements for all service providers may not be available before this deadline, Clause 31(2) of the Amending Agreements allows for the Commonwealth and State/Territory Ministers to agree on the minimum proportion of service providers' certified statements required for this purpose. The HACC Program Management Manual states that, unless otherwise agreed, the report of acquittals by service providers should be based on a minimum of 70 per cent of certified statements covering at least 80 per cent of approved program funds for all regions and in aggregate at the State/Territory level.

Conclusion

4.9 Recommendation 6 is being implemented. Health has adopted a strategy to eliminate the backlog of acquittals under the prior HACC agreements, with a target for finalisation of February 2002. The recommendation will be implemented when all outstanding acquittals under the prior HACC agreements are eliminated.

Recommendation 7 of Audit Report No.36, 1999–2000

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.

Background

4.10 Service providers may be providing the same or similar services under different programs, most of which have differing accountability and data requirements. The size of the service provider, and the experience and training of its staff, impact upon the ability of the provider to accommodate these differing accountability and data requirements. In addition, regular changes are made to the administrative requirements of the various programs.

4.11 The previous audit found that:

> *accountability and data requirements can be onerous for smaller service-providers. There may be benefits in providing streamlined requirements for smaller providers.*[18]

Findings of the follow-up audit

4.12 Instructions on accountability and data requirements for the HACC Program can be found in the Amending Agreement, draft National Program Guidelines and Program Management Manual. All contain details on core items to be included in service contracts with providers including: financial management obligations and accountability requirements; the nature of the data to be collected; and reporting items. For example, in terms of financial accountability, the States and Territories prescribe the information the service provider is required to produce. Health requires only that States and Territories receive certified acquittals of expenditure from service providers.

4.13 Health has included in the draft National Triennial Plan the following Priority and Direction:

> *to continue improvements in the collection and use of data relating to HACC clients and service delivery.*

[18] Australian National Audit Office, 2000, *Home and Community Care: Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999–2000, Canberra, p. 74.

4.14 The primary means of addressing this Priority and Direction is the implementation of the HACC Minimum Data Set (MDS). The objectives of the HACC MDS are:

- to provide HACC program managers with a tool to access data;
- to facilitate consistency and comparability between HACC data and other related data collections; and
- to assist service providers to provide high quality services to their clients.

4.15 Health has advised the ANAO that the HACC MDS addresses the requirements of Recommendation 7. In a letter to the ANAO dated 31 August 2001, they stated that:

> *the implementation of the HACC MDS in January 2001 has ensured that the data requirements for the Program are efficient and effective. In addition the data items collected are as far as practicable, compatible with other aged and community care programs, thus minimising the burden on service providers in the collection process.*

4.16 The development of the MDS was initiated in 1995. Following extensive consultation with stakeholders, service providers and State/Territory Governments, and piloting with all States and Territories and a number of selected agencies, the collection of data using the MDS began in January 2001.

4.17 To assist in the implementation of the MDS, training and a small amount of funding was made available to service providers. In addition, guidance was provided in the form of orientation workbooks, manuals, and regular bulletins; information is available on the Health website; and there is a national helpdesk accessible via an 1800 telephone number.

4.18 The MDS is to be reviewed over the next two years with MDS Version 2.0 scheduled to be implemented in September 2003. The purpose of reviewing the MDS will be to determine whether existing items should be removed or new items included, and whether any changes should be made to existing items to enhance their effectiveness. When reviewing the MDS, Health will consider the administrative impact of data requirements on service providers.

4.19 MDS issues are discussed at HACC Officials meetings. Additionally, a MDS Implementation Committee and a Data Reform Working Group both report directly to HACC Officials. The MDS Implementation Committee is concerned with detailed issues associated with the implementation of the current MDS. The Data Reform Working Group is concerned with broader data issues including reform and improvement of data collections and the

promotion of consistency and coherence between the data collected by HACC and other related data collections.

4.20 The HACC MDS Data Dictionary is based on the National Community Service Data Dictionary. The Data Dictionary defines and explains individual data items and codes. Other programs developing a data dictionary will also use the National Community Service Data Dictionary as a base. Therefore, all MDSs will theoretically be compatible, reducing the administrative burden on service providers. The HACC MDS Implementation Committee is shortly to conduct a review of the current data dictionary.

Conclusion

4.21 The impact on service providers when prescribing accountability and data requirements is an ongoing consideration for Health. Health has advised the ANAO that the data items collected for the HACC MDS are as far as practicable, compatible with other aged and community care programs, thereby minimising the burden on service providers in the collection process.

4.22 The introduction of the HACC MDS, in combination with the fact that consideration of the administrative burden on service providers is an ongoing activity, has led the ANAO to conclude that this recommendation has been implemented.

Recommendation 8 of Audit Report No.36, 1999–2000

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.

Background

4.23 In the course of the previous audit, the ANAO found that the poor quality of filing systems in both national office and some State/Territory offices was impeding effective administration of the HACC program. In some cases, Health officers were unable to find key documents.

Findings of the follow-up audit

4.24 The ANAO found that an effective records management system had been implemented in Health's national office

4.25 The ANAO examined a number of HACC files in the national office. The requested files were easily located. On examination of the present filing system, the ANAO found files are folioed, filing cabinets have contents sheets,

colour coded manilla folders are used for work in progress (for example, annual plans, funding packages) with coded registry files where appropriate. Files are also reviewed annually, with older files relocated so files for the current year may be easily accessed. HACC officers have access to an up-to-date consolidated filing list in electronic or paper form.

Conclusion

4.26 Recommendation 8 has been implemented. An effective record management system has been implemented for national office HACC program administration.

Recommendation 9 of Audit Report No.36, 1999–2000

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)'.

Background

4.27 One of the HACC program objectives is:

> *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.*[19]

4.28 The equity performance measure to assess this objective is:

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

4.29 The previous audit noted that:

> *this performance measure gives no information of whether services are provided equitably between regions.*[20]

4.30 In their response to the recommendation, Health agreed:

> *to discuss this issue with the states and territories and highlight that the issue requires further consideration and negotiation. Although differences in cost structures for services across the states and territories may suggest that*

[19] Clause 3.(1)(f), HACC Amending Agreement.
[20] Australian National Audit Office, 2000, *Home and Community Care: Department of Health and Aged Care*, the Auditor-General Audit Report, No. 36 1999–2000, Canberra, p. 79.

inequities exist in service outputs across regions, the basis of the resource allocations in the program is relative need for service through a strategic planning process. The issues of regional inequities are complex.

Findings of the follow-up audit

4.31 The HACC program objective and equity performance measure referred to in the previous audit and stated above, remain unchanged. The ANAO notes that the equity measure is not included in the Portfolio Budget Statements 2001–02.

4.32 The issue was discussed at the HACC Officials meeting in June 2000 with the overall view expressed that the differences in levels of need that are prevalent across regions require more complex responses than just service output *equity*. Complexities discussed, as reported in the meeting minutes, include:

- the issue of providing funding on a relative needs basis;
- regional composition of disability levels and aged population, affecting need for funds;
- the costs of servicing rural and remote areas; and
- the issue of benchmarking and determining an appropriate level of output to be achieved through inputs provided.

4.33 As a result, a decision was made not to take the issue further at that time. The equity performance measure has not been discussed at any HACC Officials meeting since June 2000.

4.34 Health has advised the ANAO that a number of States and Territories are seeking to redress historical inequities between HACC regions. Some States are introducing the use of a formula which attempts to address the issues above. For example, South Australia's 2001–02 Annual Plan provides details on the formula used for allocating growth funds to regions. This formula contains a disadvantage weighting that takes into account relevant socioeconomic, geographic and cultural factors. Their experience to date demonstrates that this is a complex issue.

4.35 While the ANAO appreciates the complexity of the issue, non-alignment of the objective and the performance measure unduly complicates performance assessment at regional level.

Conclusion

4.36 Health has considered varying the HACC equity output indicator. Accordingly, this recommendation is classed as 'implemented'. However, the question of regional equity is an issue that has not yet been resolved.

Canberra ACT
14 February 2002

P.J. Barrett
Auditor-General

Appendices

Appendix 1

Progress against the recommendations

Recommendations of Audit Report No.36, 1999–2000, Home and Community Care	Status	Conclusions against the recommendations
1. 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.	✓	Recommendation 1 has been implemented. Health has moved to using the 1998 ABS Survey of Disability, Ageing and Carers as the basis for distribution of Commonwealth HACC funding between the States. The 2001–2002 offer of funding to State Governments was based on this data.
2. 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.	℘	Considerable progress has been made against Recommendation 2. With respect to the first part of the recommendation, the Targeting Working Group, a sub-committee of the HACC Officials, is responsible for refining HACC eligibility guidelines. The work of this committee is ongoing. With respect to the second part of the recommendation, the National Program Guidelines and Summary Guidelines were developed in consultation with peak bodies. They have been endorsed by HACC Officials and were provided to the former Minister for Aged Care for approval. Health has advised that they will resubmit the Guidelines to the current Minister for approval in early March 2002. Implementation of this recommendation will be complete when approved program guidelines are issued.
3. 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.	✓	Recommendation 3 has been implemented. Health has negotiated the inclusion of information on the level of fees collected with the States and this information has been incorporated into reporting arrangements. Health has stated that the recommendation to incorporate fees information into the Amending Agreements will be considered in 2003 when the Agreements are reviewed.
4. 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.	℘	Progress is being made against Recommendations 4 and 5. A review of planning practices across Health is a substantial first step towards implementing the recommendations. However, Recommendation 4 will not be implemented until Health has coordinated, at national level, the planning of HACC and CACPs in order to ensure that HACC services and CACPs are cost-effective, adequately integrated and avoid unnecessary duplication.
5. 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.		While progress has been made in the coordination of the HACC program with CSDA through the formation of a Joint DSSC/HACC Officials Working Group, Recommendation 5 is yet to be implemented. It will be implemented when Health and other relevant Commonwealth and State/Territory agencies have promulgated joint national guidelines in areas in which HACC and CSDA intersect.

	Recommendations of Audit Report No.36, 1999–2000, Home and Community Care	Status	Conclusions against the recommendations
6.	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.	℘	Recommendation 6 is being implemented. Health has adopted a strategy to eliminate the backlog of acquittals under the prior HACC agreements, with a target for finalisation of February 2002. The recommendation will be implemented when all outstanding acquittals under the prior HACC agreements are eliminated.
7.	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.	✓	The impact on service providers when prescribing accountability and data requirements is an ongoing consideration for Health. Health has advised the ANAO that the data items collected for the HACC MDS are a far as practicable, compatible with other aged and community care programs, thereby minimising the burden on service providers in the collection process. The introduction of the HACC MDS, in combination with the fact that consideration of the administrative burden on service providers is an ongoing activity, has led the ANAO to conclude that his recommendation has been implemented.
8.	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.	✓	Recommendation 8 has been implemented. An effective record management system has been implemented for national office HACC program administration.
9.	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 has considered varying the HACC equity output indicator. Accordingly, this recommendation is classed as 'implemented'. However, the question of regional equity is an issue that has not yet been resolved.

Legend	
✓	Recommendation implemented
℘	Progress being made against Recommendation

Appendix 2

Goals of the Home and Community Care Program

Clause 3.(1) of the HACC Amending Agreements between the Commonwealth and the States and Territories lists the following goals of the HACC Program:

- 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 and, where appropriate, to their carers, to assist them to enhance their independence in the community and avoid their premature or inappropriate admission to long term residential care;*
- *to develop home and community care services through the joint cooperation of the Commonwealth, the State, and organisations representing consumers and service providers;*
- *to ensure access to home and community care services among all groups within the target population, including persons of non-English speaking background, persons living in rural and remote areas, Aboriginal and Torres Islander peoples, persons with dementia and financially disadvantaged persons;*
- *to ensure that, within available resources, priority is directed to persons within the target population most in need of, and/or who would benefit most from, home and community care;*
- *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 that, within available resources, and in the context of the broader service delivery framework, home and community care services are provided equitably between regions and are responsive to regional differences;*
- *to ensure that high quality home and community care services are delivered in an efficient and effective manner that promotes independent living in the community and avoids duplication of services;*
- *to enable the testing and evaluation of new and differing approaches to planning, coordination and service delivery;*
- *to enable regular and systematic consumer focused monitoring of the effectiveness and efficiency of the program and the assessment of priorities;*

- *to promote an integrated and coordinated approach between the delivery of home and community care and related health and welfare programs, including programs providing residential or institutional care;*
- *to facilitate the involvement of organisations representing consumers and service providers in the provision of advice to the Commonwealth Minister and the State Minister on needs and priorities under the program;*
- *to ensure data is collected that will facilitate planning, evaluation and accountability of the program at national, State and regional levels; and*
- *to ensure that effective planning and coordination arrangements are established that enable the above principles and goals to be achieved in a cooperative manner.*

Appendix 3

Programs overlapping with HACC

1. The following paragraphs briefly describe a number of programs which overlap with the HACC program.

2. Community Aged Care Packages (CACPs), formerly referred to as Community Care Packages (CCPs), provide low-level care to older people in their own homes. Administered by Health and providing similar services to those provided under HACC, CACPs are available as individually tailored packages that may include: personal care; meal preparation; house cleaning; home maintenance; and special transport. As at June 2001, Health had allocated 24 694 CACPs since the inception of the program. The Commonwealth budget estimate for CACPs in 2001–02 is $248.4 million.

3. The Extended Aged Care at Home (EACH) pilot program, administered by Health, commenced in July 1998. The aim of EACH is to provide high-level aged care to people in their own homes. As at 30 June 2001, ten care services operated nationwide, providing 278 care packages. An evaluation of the pilot was completed in 2001 and funding was provided in the 2001–02 Commonwealth Budget for developmental work to consolidate the program and address quality and accountability issues. The Commonwealth budget estimate for the EACH program in 2001–02 is $9.1 million.

4. National Respite for Carers Program, administered by Health, provides support for carers. Like the HACC program, Respite for Carers provides carers with respite from their caring duties. Under the program, carers are assisted through respite service grants, Carer Respite Centres, and Carer Resources Centres. The Commonwealth budget estimate for the National Respite for Carers Program is $72.9 million in 2001–02.

5. The Commonwealth State Disability Agreement (CSDA) is designed to assist people of employment age with disabilities. Under the CSDA, the Commonwealth funds employment support services and assists the States and Territories with funds to provide and administer accommodation support, respite care, day services and other support for clients of the program. The combined Commonwealth/State/Territory budget for the CSDA in 2001–02 is $2495.4 million, with the Commonwealth contributing $790.4 million of the total.

6. The Department of Veterans' Affairs launched the Veterans' Home Care program in January 2001. Similar to the HACC program, Veterans' Home Care provides a wide range of home care services to eligible veterans and war widows/widowers. Services available include: domestic assistance; personal care; home and garden maintenance; and respite care. The Commonwealth budget estimate for Veteran's Home Care in 2001–02 is $59.6 million.

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