LA TROBE UNIVERSITY

Australian Institute for Primary Care & Ageing

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50+ in Banyule: A data story

Report for Banyule agencies

Part 2: Community Care

Commissioned by the North East Primary Care Partnership

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Suggested reference:

Wells, Y. (2016). *50+ in Banyule: A data story. Report for Banyule agencies. Part 2: Community Care.* Report commissioned by the North East Primary Care Partnership. Melbourne: NEPCP.

GLOSSARY

ABS	Australian Bureau of Statistics
CALD	Culturally and Linguistically Diverse
DHHS	Department of Health and Human Services
DHS	Department of Human Services
LGA	Local Government Area
MDS	Minimum Data Set
NEPCP	North East Primary Care Partnership
PAG	Planned Activity Group
PCP	Primary Care Partnership

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Julie Watson, Executive Officer, North East Primary Care Partnership (NEPCP)

Executive Summary

AIM

The aim of this resource is to:

- Capture data specific to the population and local government area of Banyule.
- Provide Banyule services with a useful tool to support planning and change.
- Make available a resource that can be utilised to advocate for the services our communities require, to ensure its members are living life to the full.

METHOD

In this section of the report, the data sources used were the HACC Minimum Data Set (2011 to 2014), population projections, and supplementary data provided by the Department of Health and Human Services on agencies funded to provide HACC in the area, as well as the amount of state government funding allocated to each HACC service.

RESULTS

Summary of HACC clients

During the calendar year 2014, 6,885 clients were provided with a HACC service in the Banyule area. The proportion of residents using HACC services increased with age, from 9.6 per 1000 in the 0–49 age group to nearly one-half (484.4 per 1000) in the age group 80 years and over.

The largest HACC program in Banyule in terms of hours of service is Planned Activity Groups, while the largest in terms of number of clients is Allied Health services. Over half HACC clients (57%) are aged over 80 years, and over three-quarters (76%) are aged over 65 years. About 15% prefer to use a language other than English at home and the most common non-English languages used are Italian, Greek and Mandarin.

Service densities varied a great deal by suburb in Banyule. In Bundoora and Heidelberg West/Bellfield, almost 40% of people aged over 60 were provided with a service in 2014, whereas this was true for less than 10% of those living in St Helena/Eltham North and Watsonia North.

When service provision (total hours or meals provided) was examined by age group and service type, it was clear that the steepest curve by age group was for Planned Activity Group hours. However, increase in the client-to-population ratio was particularly strong for Assessment, where provision per year per 1000 people aged 85 and over rose to 222.

Summary of HACC agencies and funding

A total of 38 different agencies were funded to provide HACC services to Banyule residents in 2015, seven of which were funded to provide Allied Health services. Overall, funding for HACC in Banyule grew by 11.8% from 2013 to 2015. The biggest increases in terms of raw figures were for Allied

Health and Nursing. However, the largest increase in funding by far was for Delivered Meals, which more than doubled. This increase in funding is surprising but may reflect government recognition of increased costs.

Projections of future demand/provision

Projections of future provision of HACC services depend on what is used to estimate change. Modelling using constant service-to-population and client-to-population ratios shows strong growth in demand for all service types to 2019 and 2024, particularly for Domestic Assistance, Care Coordination, and Property Maintenance.

However, comparing changes in service use with population growth between 2011 and 2014 showed that service provision in some cases has been growing more strongly than the population, while provision of other services (hours and/or clients) fell between 2011 and 2014. If historical trends continued, the following services would grow more strongly than changes in the population would suggest:

- Domestic Assistance (hours and clients)
- Personal Care (hours only)
- Allied Health (hours and clients)
- Planned Activity Groups (hours and clients)
- Assessment (hours and clients)
- Care Coordination (hours and clients)

The following services would grow less strongly than changes in the population would suggest:

- Personal Care (clients)
- Nursing Care (hours and clients)
- Delivered Meals (hours and clients – noting, however, that state government funding for meals has increased in 2015)
- Respite (hours and clients)

The following services would become more intensely focused on fewer clients:

- Volunteer Social Support
- Property Maintenance

The following service would become more dispersed across clients:

- Case Management

CONCLUSION

It is difficult to predict changes in service provision with any confidence. While changes in the population may cause parallel changes in service provision, this is not always the case. Ultimately, changes in provision of services depend on policy decisions and funding at all three levels of government. In addition, for smaller services, changes may be unpredictable and due to fluctuations in staffing.

Introduction and Methodology

ABOUT US

The North East Primary Care Partnership (NEPCP) is a voluntary alliance of service providers who come together to strengthen relationships across sectors in order to maximise health and wellbeing outcomes. We support activities at a local and network level that have potential to improve population health outcomes.

Our aim is to:

- Learn from leading-edge practice in health and care systems and other industries, and make that knowledge accessible to all
- Build the movement for improvement and safety, making connections across the system, and enthusing and exciting people to engage in change and transformation
- Provide easy access to the latest evidence base, knowledge and training programs
- Help make the most of investment of money and effort across the system, so we all work in alignment.

As part of this remit we seek to develop our work in partnership and co-production with others in the health and care system.

CURATE RATHER THAN CREATE KNOWLEDGE

One of the challenges for service providers and leaders in health and care is keeping up with the amount of information and data as they become available, in the face of multiple and competing demands. Finding the right information and making sense of it is taking an increasing amount of time, attention and focus[1], and the ability to filter and select appropriate information and shape it for a local context is essential. A key role the NEPCP can play is to bring partners together and curate knowledge: reviewing and filtering what is most relevant and connected to our members' experience. In this way we can offer value to others looking for high quality content.

The idea of curation is taken from the NHS White Paper **"The new era of thinking and practice in change and transformation; a call to action for leaders of health and care"** and is defined as "finding things out and determining what's valid from what's just noise . . . quality and coherence, not volume and mass". While this paper looks broadly at large-scale change and transformation in health and care, rather than at local trends, two ideas that really struck us were:

[1] These ideas are expanded at this site: **http://www.nhsiq.nhs.uk/news-events/news/the-new-era-of-thinking-and-practice-in-change-and-transformation.aspx**

- With so much information and data available we do not need more, but we need information that is high quality and right for our context.
- While data are important for population health planning, large-scale change also depends on many partners: clients and families, communities, frontline health and community care providers, and leaders uniting around a common cause for client and population health.

We hope that this report provides our members with the quality and coherence required for future adaption to the reform agenda.

ABOUT THIS PROJECT

When considering how to best support our partner agencies in the context of change and growth in aged care, we were impressed by the work undertaken by the City of Whittlesea called *Living well 50+ … a data story*. This report brings together demographic, social, health and wellbeing data important for understanding life stages, population diversity, and social and environment influences on people as they age.

Given projected changes in the population aged 50+ years, we believed a similar project would strengthen our knowledge of people in this age group living in our catchment and give us information about their potential service requirements. Because the information we have collected is based on the original framework used for the Whittlesea Report, we now have consistent data across four local government areas.

WHAT IS DIFFERENT?

One of the great (and challenging) insights we gained with this project is that long-term projections are often unreliable and need to be used with caution. We have still included them but encourage our partners to use them carefully. We also realise that data can quickly become outdated, so have included links to assist partners to easily access information they may need in the future.

THIS REPORT

This report is Part 1 of a two-volume report, outlining the results of a series of data analyses conducted by the Australian Institute for Primary Care & Ageing at La Trobe University for the North East Primary Care Partnership (NEPCP). The report is intended to act as a resource that captures a population-based approach to planning healthy and active living for the population aged 50 years and over living in Banyule.

Part 1 of the report—this volume—is about the health status of people living in Banyule. Part 2 is about the Home and Community Care service use of people living in Banyule. The report is modelled on a similar project completed for the City of Whittlesea in February 2014.

This report is intended to provide key health and wellbeing characteristics of the 50+ population to inform service planning and opportunities for health promotion, positive ageing and preventative strategies.

METHODOLOGY

The analyses in Part 2 of the report rely on two sources:

- HACC Minimum Data Set (MDS) for the years 2010 to 2014, supplied by the Victorian Department of Human Services (DHS; now DHHS, Department of Health and Human Services).
- DHS expenditure on HACC services, 2015, provided by Victorian DHHS.
- Population data supplied by Profile.ID.[2]

[2] http://profile.id.com.au/banyule/population

Quick statistics: HACC use 2014

Number of clients	6,885 This total does not include people for whom key details were missing.		
Service type (Note: Clients may receive more than one service)		Hours/Meals	Clients
	Planned Activity Group	100,329	808
	Domestic Assistance	54,326	1,865
	Personal Care	29,560	605
	Respite	19,823	231
	Allied Health services	24,671	3,258
	Nursing Care	31,310	1,124
	Volunteer Social Support	19,297	294
	Property Maintenance	6,773	1,195
	Assessment	8,716	2,316
	Case Management (Linkages)	3,544	103
	Client Care Coordination	2,445	561
	Delivered Meals	56,133	602
Age		N	%
	0–49 years	781	11.3
	50–59 years	538	7.8
	60–69 years	825	12.0
	70–79 years	1,029	26.4
	80+ years	3,947	42.4
Service age cohort	0–64 years	1,650	24.0
	65+ years	5,229	76.0
Language diversity	1,014 clients preferred to speak a language other than English (14.7%) The three most common non-English languages preferred were: ▪ Italian: 253 clients (3.7%) ▪ Greek: 137 clients (2.0%) ▪ Mandarin: 83 clients (1.2%) 547 clients (7.9%) required an interpreter		
Indigenous	63 clients identified as Indigenous (0.9%)		
Accommodation and living arrangements	2,330 clients (33.8%) lived alone 4,516 clients (65.6%) owned or were purchasing their own home		
Carer availability	2,149 clients (31,2%) had an informal carer		
Income	4,009 clients (58.2%) received the Age pension		
Referral source (5 most common)		N	%
	Self	2,623	38.1
	Family/friend/significant other	939	13.6
	Hospital	755	11.0
	GP/medical practitioner	562	8.2
	Community nursing or community health	466	6.8
Quick reference population statistics	50+ years	43,687	
	65+ years	20,694	
	0-64 years	104,411	
	85+ years	3,212	
	Total population	125,107	

HACC service system

Information on the HACC service system operating within the municipality, including a profile of service provider, program funding, and service levels, is presented below.

HACC services operate within a broader system that includes packaged care (Home Support Packages), assessment, and a range of medical services. The focus in this report is on HACC services.

HACC SERVICES

The HACC Program provides funding for community services to support frail older people, young people, and adults with a disability, and their carers. These services provide basic support and maintenance to people living at home whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care.

In May 2013, the Victorian and Commonwealth governments announced an agreement to implement the National Disability Insurance Scheme from July 2019. Once fully implemented, DisabilityCare Australia will cover 100,000 Victorians aged under 65 years. As part of this agreement, management of the HACC Program will be split. Services for people aged 65 years and over will be directly managed by the Commonwealth Government. Services for people aged under 65 years will be funded and managed solely by the Victorian Government, until DisabilityCare Australia is in full operation. The HACC Program will continue to be funded jointly by the Commonwealth and Victorian Governments and managed by the Victorian Department of Health and Human Services until July 2016. For this reason, many tables in this report divide clients into two age groups: those aged under and over 65 years of age.

The provision of community services to older people is occurring in a context of major change in Australia and internationally, in terms of both the legislative framework in which services operate and underlying philosophical bases. National reforms are currently occurring in aged care, disability services, primary health and mental health. The Australian Government introduced a ten-year Aged Care Reform package in mid-2013, which involved amendments to the *Aged Care Act (1997).* The aim of the package is to provide sustainable funding, an expanded workforce capacity, higher quality of care, improved access to services, and strengthened protections for care recipients. These changes present an opportunity to adjust the ways in which services are evaluated to incorporate a more person-centred approach.

HACC SERVICE PROVIDERS IN BANYULE

A total of 38 different agencies were funded to provide HACC services to Banyule LGA residents in 2015. Table 1 lists these agencies and indicates which HACC services they were funded to deliver.

It should be noted that some agencies may deliver HACC services to Banyule residents at delivery settings located outside the municipality.

Table 1: Agencies funded to provide HACC services to Banyule residents, 2015

	ALLIED HEALTH	ASSESSMENT	DELIVERED MEALS	DOMESTIC ASSISTANCE	FLEXIBLE SERVICE RESPONSE	LINKAGES PACKAGES	NURSING	PERSONAL CARE	PAG - CORE	PAG - HIGH	PROPERTY MAINTENANCE	RESPITE	SERVICE SYSTEM RESOURCING	VOLUNTEER CO-ORDINATION	RDNS ALLIED HEALTH
Aboriginal Community Elders Services	✓								✓	✓				✓	
Aborigines Advancement League				✓							✓				
Action On Disability Within Ethnic Communities									✓						
Annecto					✓										
arbias					✓										
Austin Health	✓						✓		✓						
Australian Greek Welfare Society									✓	✓		✓		✓	
Banyule City Council		✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	
Banyule Community Health					✓				✓						
Bethlehem Community					✓										
Central Bayside Community Health Services														✓	
Co.As.It. - Italian Assistance Association									✓	✓				✓	
Darebin Community Health Service									✓						
Filipino Community Council of Victoria										✓					
Impact Support Services												✓			
Interchange Northern Region					✓					✓		✓		✓	
Link Community Transport													✓	✓	
McAuley Community Services for Women				✓	✓			✓	✓						
MECWA							✓								
Melbourne City Mission									✓					✓	
Merri Outreach Support Service					✓				✓	✓					
Mill Park Community Services Group										✓					
Nillumbik Community Health Service Ltd						✓				✓					
Northern Health	✓					✓	✓			✓					
Open House Christian Involvement Centres									✓	✓				✓	

	ALLIED HEALTH	ASSESSMENT	DELIVERED MEALS	DOMESTIC ASSISTANCE	FLEXIBLE SERVICE RESPONSE	LINKAGES PACKAGES	NURSING	PERSONAL CARE	PAG - CORE	PAG - HIGH	PROPERTY MAINTENANCE	RESPITE	SERVICE SYSTEM RESOURCING	VOLUNTEER CO-ORDINATION	RDNS ALLIED HEALTH
Peter MacCallum Cancer Institute							✓								
Polish Community Council of Victoria									✓	✓				✓	
Rosanna Fire Station Community House										✓					
Royal District Nursing Service Limited					✓		✓	✓							✓
Spectrum Migrant Resource Centre									✓	✓		✓			
The Finnish Friendly Visiting Service (F.F.V.S.)														✓	
The Victorian Multiethnic Slavic Welfare Assoc.														✓	
Travellers Aid Australia								✓							
Victorian Aboriginal Health Service Co-op.	✓				✓		✓								
Victorian Arabic Social Services														✓	
VincentCare Victoria					✓									✓	
Vision Australia	✓													✓	
Wesley Mission Victoria									✓					✓	
Grand Total	**6**	**1**	**1**	**3**	**10**	**2**	**6**	**4**	**15**	**14**	**2**	**5**	**2**	**16**	**1**

In 2015, seven agencies were funded to provide Allied Health services in Banyule LGA. These are listed in Table 2 below. (Other agencies also provided Allied Health services to people living in Banyule, including community health services in Nillumbik and Plenty Valley.)

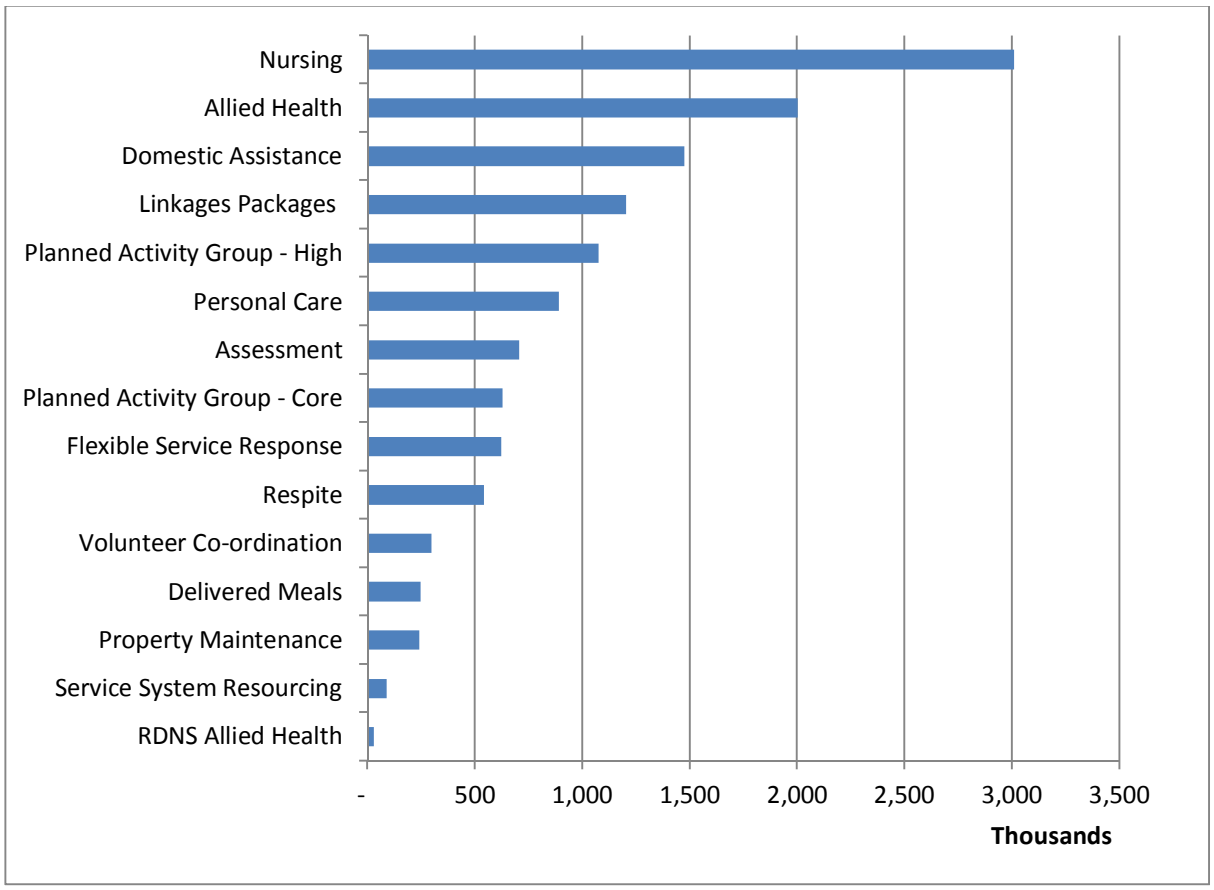
Table 2: Agencies funded to provide Allied Health services, 2015, and Service provision 2013–14

AGENCY	DIETETICS	OCCUPATIONAL THERAPY	PHYSIOTHERAPY	PODIATRY	SPEECH THERAPY
Aboriginal Community Elders Services Inc.			✓		
Victorian Aboriginal Health Service Co-operative Limited	✓	✓	✓	✓	
Austin Health	✓	✓	✓	✓	
Royal District Nursing Service Limited			✓		
Banyule Community Health		✓	✓	✓	
Northern Health	✓	✓	✓	✓	✓
Vision Australia Limited		✓			

HACC FUNDING

In 2014-15, the Victorian state government allocated $13,056,674 for HACC funding to Banyule residents. The service with the highest allocation was Nursing.[3]

Figure 1: HACC funding ($, thousands) by service, Banyule 2014-15

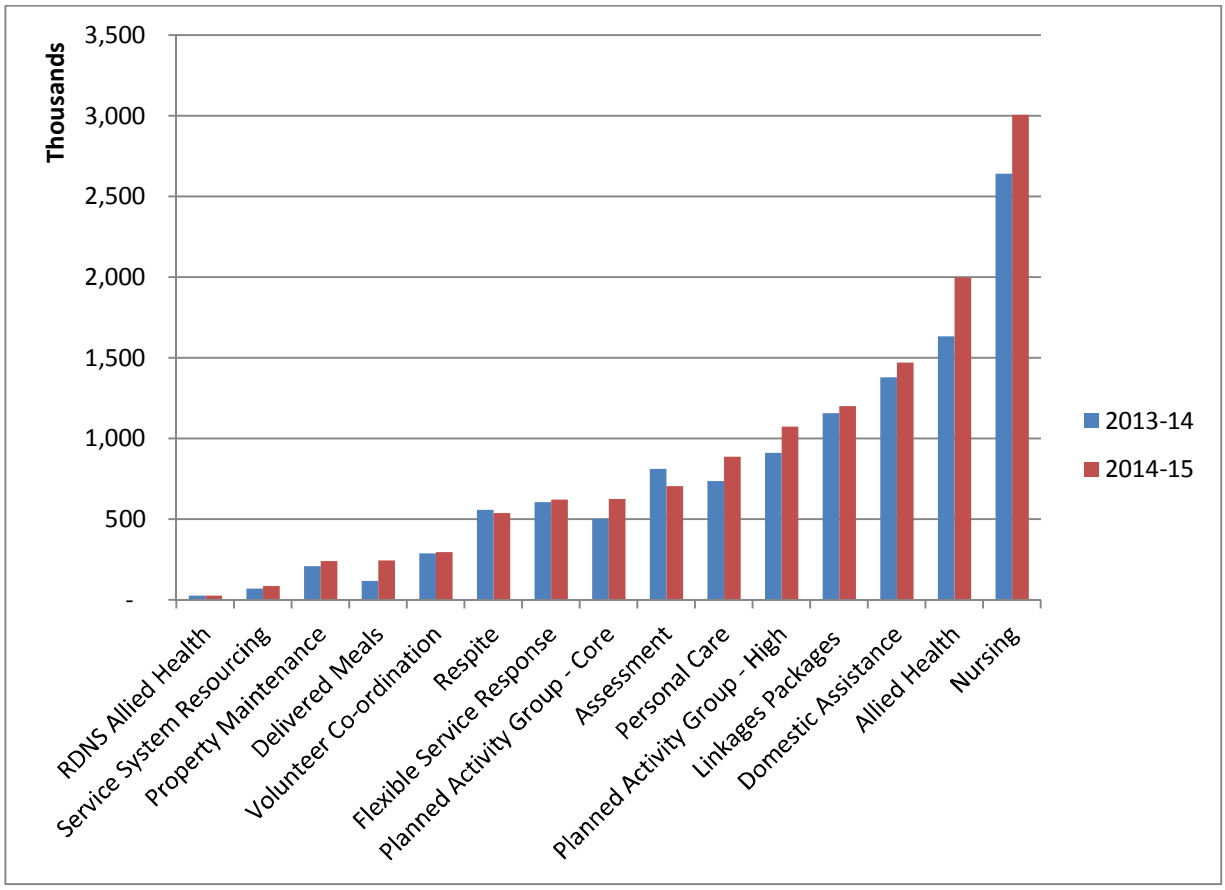


[3] Figures are comparable to those used in the Whittlesea report.

Victorian DHHS also provided figures for 2012-13 and 2013-14, which allows a comparison of growth in funding across two years. Overall, funding for HACC in Banyule grew by 11.8% from 2012-13 to 2014-15. The biggest increases in terms of raw figures (dollars) were for Allied Health and Nursing. However, the largest growth in percentage terms was in Delivered Meals,[4] funding for which more than doubled, from $120,924 to $247,970 (though the target number of meals did not change from 76,534).[5]

A few services received lower funding in 2014-15 than in 2012-13 (Assessment, Respite, and RDNS Allied Health).

Figure 1b: HACC funding ($, thousands) by service, Banyule 2012-13 to 2014-15



These figures are reproduced in Table 3.

[4] In this report, Delivered Meals refers to both home-delivered meals and centre-based meals.

[5] The same pattern is evident for Darebin and Nillumbik, and may reflect government recognition of the real cost of providing Delivered Meals.

Table 3: State HACC funding ($) by service, 2012-13 to 2014-15.

SERVICE	2012-13	2013-14	2014-15	CHANGE $	CHANGE %
Allied Health	1,633,802	1,917,783	2,001,818	368,016	22.5
Assessment	813,706	877,854	706,085	-107,621	-13.2[6]
Delivered Meals	120,924	123,220	247,970	127,046	105.1
Domestic Assistance	1,382,328	1,446,372	1,473,435	91,108	6.6
Flexible service response	607,660	611,440	622,935	15,275	2.5
Linkages packages	1,158,138	1,181,304	1,203,498	45,360	3.9
Nursing	2,641,042	2,738,825	3,009,077	368,035	13.9
Personal Care	740,456	874,046	890,485	150,029	20.3
Planned Activity Group - core	505,740	601,894	628,366	122,626	24.3
Planned Activity Group - high	913,075	1,042,837	1,074,285	161,210	17.7
Property Maintenance	210,181	237,302	241,756	31,575	15.0
Respite	559,957	531,150	541,170	-18,787	-3.4
Service System Resourcing	70,399	88,127	89,784	19,385	27.5
Volunteer Co-ordination	291,011	291,799	297,267	6,257	2.2
RDNS Allied Health	29,928	30,528	28,743	-1,185	-4.0
Total	**11,678,344**	**12,594,481**	**13,056,674**	**1,378,330**	**11.8**

Service providers are funded to deliver a specific number of outputs—the funding target. For most services the target is based on the number of hours of service delivered. However, for delivered meals the funding target refers to the number of meals delivered, and for Linkages the target refers to the number of packages.

The following figure and table provide the funding targets by service for three years, 2012-13 to 2014-15.

Assessment, Flexible service response, and Service System Resourcing were not assigned targets in 2012-13 so are not included in this section.

The table and figure show that the largest increase in funded outputs by far was for Delivered Meals, which more than doubled.

[6] RDNS were no longer funded to provide HACC Assessment in 2014-15. Without this change, the pattern is of steadily increasing funding for HACC Assessment provided to two agencies: Banyule City Council and Aborigines Advancement League.

Figure 2: State HACC funding (outputs) by service, Banyule 2012-13 to 2014-15

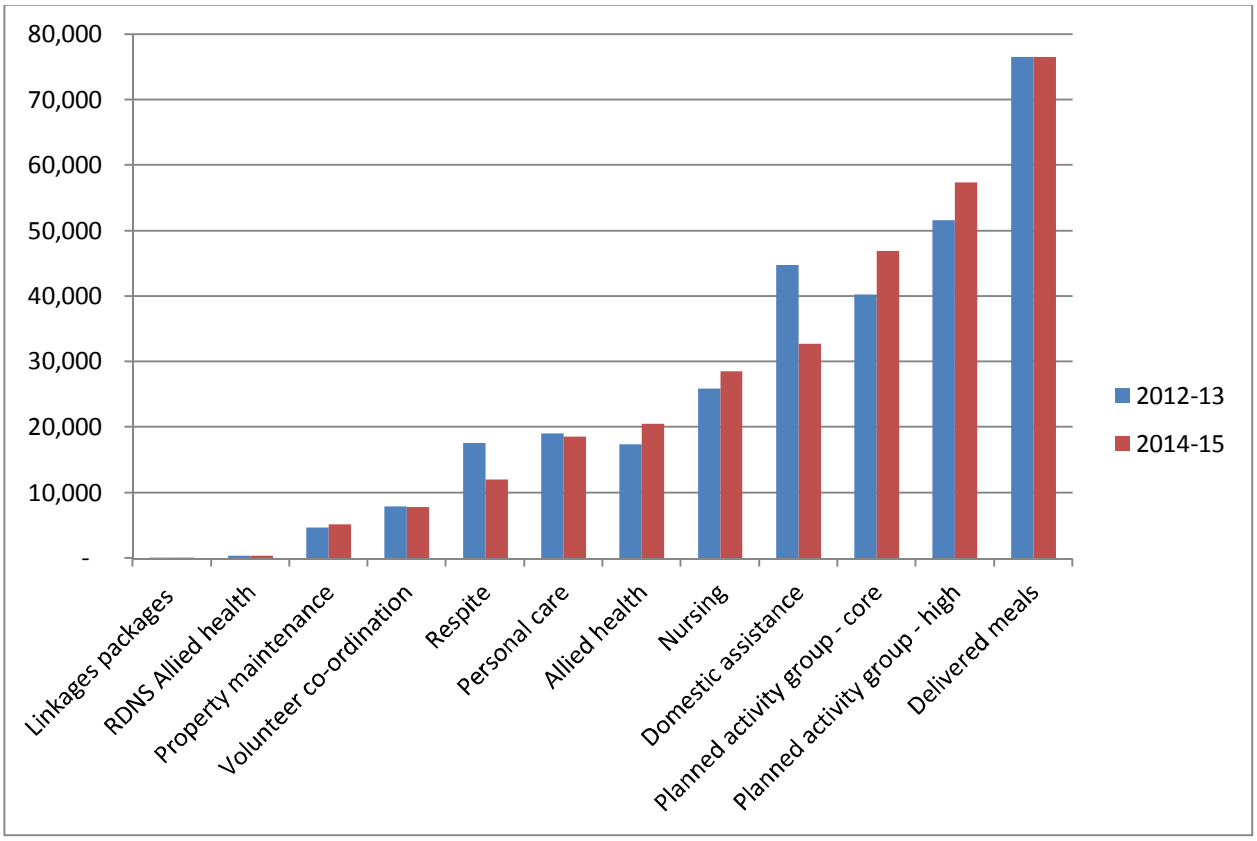


Table 4: State HACC funding (outputs) by service, 2012-13 to 2014-15.

SERVICE	2012-13	2013-14	2014-15	CHANGE N	CHANGE %
Allied Health	17,424	20,050	20,542	3,119	17.9
Delivered Meals	76,534	76,534	76,534	0	0.0
Domestic Assistance	44,750	45,902	32,743	-12,007	-26.8
Linkages Packages	81	81	81	0	0.0
Nursing	25,892	26,409	28,517	2,626	10.1
Personal Care	19,036	22,333	18,597	-439	-2.3
Planned Activity Group - core	40,298	47,023	46,893	6,595	16.4
Planned Activity Group - high	51,645	57,839	57,387	5,743	11.1
Property Maintenance	4,679	5,179	5,179	500	10.7
Respite	17,554	16,323	12,026	-5,528	-31.5
Volunteer Co-ordination	7,947	7,813	7,813	-134	-1.7
RDNS Allied Health	435	435	402	-33	-7.6
Total	306,272	335,672	486,056	179,783	58.7

SERVICES DELIVERED (ALL CLIENTS)

During the calendar year 2014, a total of 6,885 clients were provided with a HACC service, most of whom (n = 5,566, 81%) were aged 60 years or over.

The proportion of Banyule's population aged 60 years and over provided with a HACC service was 20.1%.

The most accessed service (i.e., used by the greatest number of clients) during 2014 was Allied Health.

Table 5: Number of clients by service, 2014

SERVICE	NUMBER OF CLIENTS
Allied Health	3,258
Assessment	2,316
Domestic Assistance	1,865
Property Maintenance	1,195
Nursing Care	1,124
Planned Activity Group	808
Personal Care	605
Respite	231
Volunteer Social Support	294
Client Care Coordination	561
Delivered Meals	602
Case Management	103
Counselling/support, information and advocacy	16

Individuals who received the same service from more than one agency were counted only once when determining the total number of clients per service.

The following table provides the total number of hours delivered by service for the 2014 year. The largest HACC services by number of hours/meals were Planned Activity Groups and Delivered Meals.

Table 6: Number of hours/meals delivered by service, 2014

SERVICE	NUMBER OF HOURS/MEALS
Planned Activity Group -- total	100,329
Delivered Meals	56,133
Domestic Assistance	54,326
Nursing Care	31,310
Personal Care	29,560
Allied Health	24,671
Respite	19,823
Volunteer Social Support	19,297
Assessment	8,716
Property Maintenance	6,773
Case Management	3,544
Client Care Coordination	2,445
Counselling/support, information and advocacy	109

Counselling/support, information and advocacy is not included as a general HACC service type in any further analyses, because of its small size as a HACC service.

Hours of service are also provided for PAG core and PAG high separately in the table below; however, the figures in this table do not exactly sum to those in the table above because the period of reporting is slightly different. The table below is included here to give an indication of how PAG hours in Banyule are divided between core and high provision.

Table 6a: Number of hours core and high PAG, 2013–14

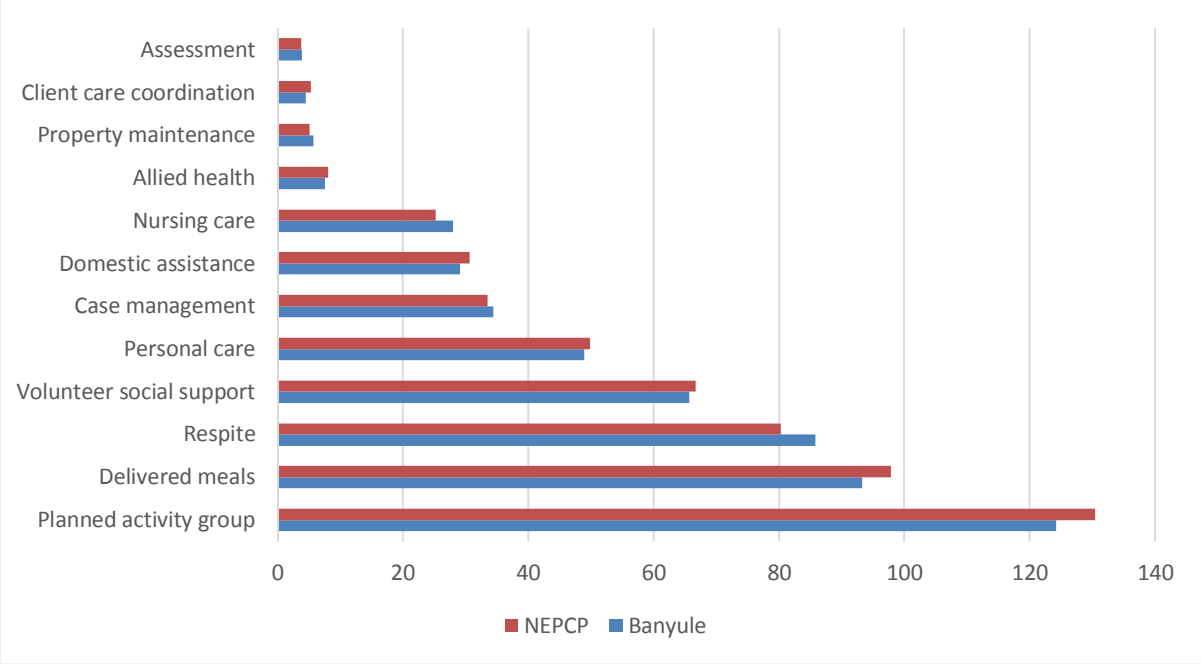
SERVICE	NUMBER OF HOURS	% OF TOTAL
Planned Activity Group – core	47,038	47.2
Planned Activity Group – high	52,559	52.8
Total	99,597	100.0

The following table provides the average number of hours/meals within the year delivered to clients within the 12 months for 2014. Planned Activity Groups provided the highest number of hours per client, followed by Delivered Meals and Respite.

Table 6b: Average number of hours/meals per client within the year delivered by service, 2014

SERVICE	AVERAGE HOURS PER CLIENT: BANYULE	AVERAGE HOURS PER CLIENT: NEPCP
Planned Activity Group	124.2	130.4
Delivered Meals	93.2	97.8
Respite	85.8	80.2
Volunteer Social Support	65.6	66.6
Personal Care	48.9	49.8
Case Management	34.4	33.5
Domestic Assistance	29.1	30.6
Nursing Care	27.9	25.2
Allied Health	7.5	8.0
Property Maintenance	5.7	5.1
Client Care Coordination	4.4	5.3
Assessment	3.8	3.7

Figure 2: Average number of hours/meals per client within the year delivered by service, Banyule and NEPCP, 2014



Average per client provision of respite and Nursing Care were noticeably higher in Banyule than across the PCP, but average hours of most other services were lower.

Occupational Therapy was the most frequent Allied Health service provided, followed by Physiotherapy and Podiatry. The majority of Allied Health services were delivered at a centre rather than at clients' homes (75%).[7] However, some services—Dietetics, Speech Therapy, and counselling—were more likely to be delivered in clients' homes than at a centre.

Table 7: Hours of Allied Health services delivered by type and location, 2013–14

ALLIED HEALTH SERVICES	HOURS – HOME	HOURS – CENTRE	TOTAL HOURS
Occupational Therapy	1,970	9,273	11,243
Physiotherapy	1,231	4,738	5,969
Podiatry	1,147	3,576	4,723
Dietetics	981	513	1,493
Speech Therapy	161	108	269
Counselling	224	41	265
Audiology	-	-	-
Total specified	5,714	18,248	23,962
Not specified	364	87	451
Total	6,078	18,336	24,413

[7] This result is puzzling: anecdotal evidence suggest that the vast majority of one-to-one Occupational Therapy services are provided in clients' homes. Centre-based hours reflect follow-up for equipment and home modifications.

Client profile

A profile of HACC clients is presented including:

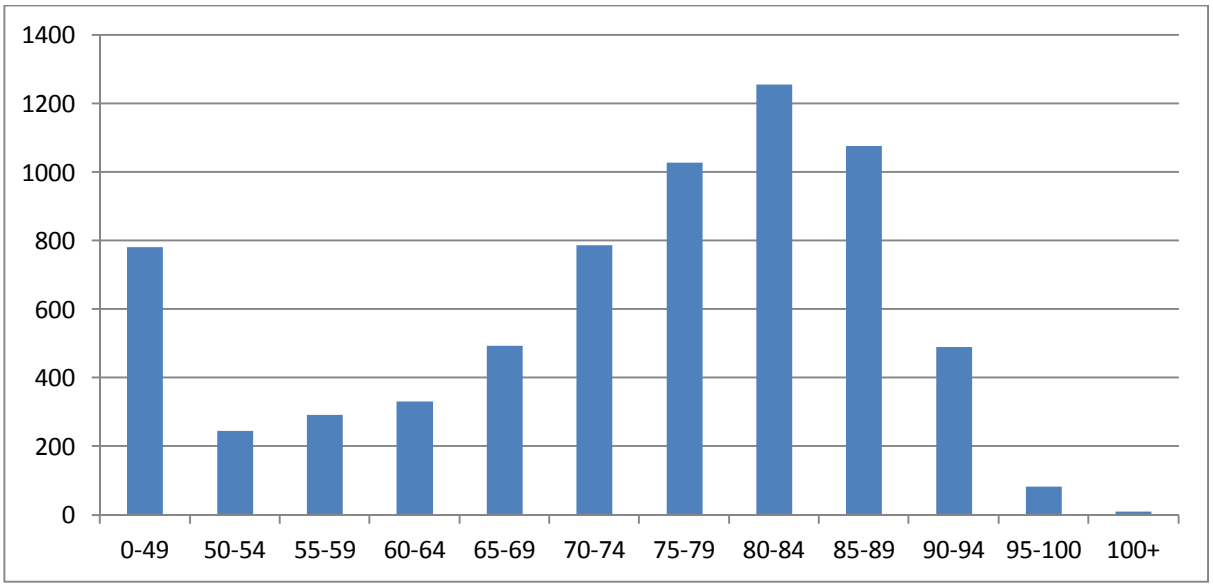
- Age
- Language diversity
- Indigenous status
- Living arrangements
- Carer availability
- Income source
- Usual accommodation.

The data are examined by the number of clients, the number of service hours, average annual hours of service per client, and client-to-population ratio.

AGE

Although eligibility for HACC services does not depend on age, in 2014, most (80.8%) were over 60 years of age and a substantial proportion (42.4%) were over 80 years of age.

Figure 3: Number of HACC clients by age group



The client-to-population ratio by age (below) shows that the proportion of residents using HACC services increases with age, from 9.6 per 1000 in the 0–49 age group to nearly one-half (484.4 per 1000) in the age group 80 years and over.

Table 8: HACC clients per 1,000 residents by age (10-year cohorts), 2014

AGE GROUP	RESIDENTS N	RESIDENTS %	HACC CLIENTS N	HACC CLIENTS %	RATIO (HACC CLIENTS PER 1000 RESIDENTS)
0-49	81,418	65.1	781	11.3	9.6
50-59	15,970	12.8	538	7.8	33.7
60-69	13,469	10.8	825	12.0	61.3
70-79	8,229	6.6	1817	26.4	220.8
80+	6,019	4.8	2918	42.4	484.8
Unknown	2	0.0	6	0.1	
Total	125,107	100	6885	100	55.0

In the future, the HACC service target group will be divided into two, with those aged 65 years and over provided with services through HACC and those under 65 years of age with disability through the state-based National Disability Insurance Scheme (NDIS). The following table examines service provision by these two age groups.

Table 9: HACC clients per 1,000 residents by age (0–64 years and 65+ years), 2014

AGE GROUP	RESIDENTS N	RESIDENTS %	HACC CLIENTS N	HACC CLIENTS %	RATIO (HACC CLIENTS PER 1000 RESIDENTS)
0–64	104,411	83.5	1,650	24.0	15.8
65+	20,694	16.5	5,229	75.9	252.7
Unknown	2	0.0	6	0.1	
Total	125,107	100	6,885	100	55.0

Age profile by service

The age profile of clients varies significantly by service. A relatively high proportion of clients aged under 50 years is evident for Respite (reflecting relatively young carers who access a service in their own right). In contrast, Delivered Meals services, Personal Care, Domestic Assistance and Property Maintenance have relatively old profiles, with over 80% aged 70 years or over.

Figure 4: Number of clients per service type, 0–49 years, and in 10-year age brackets

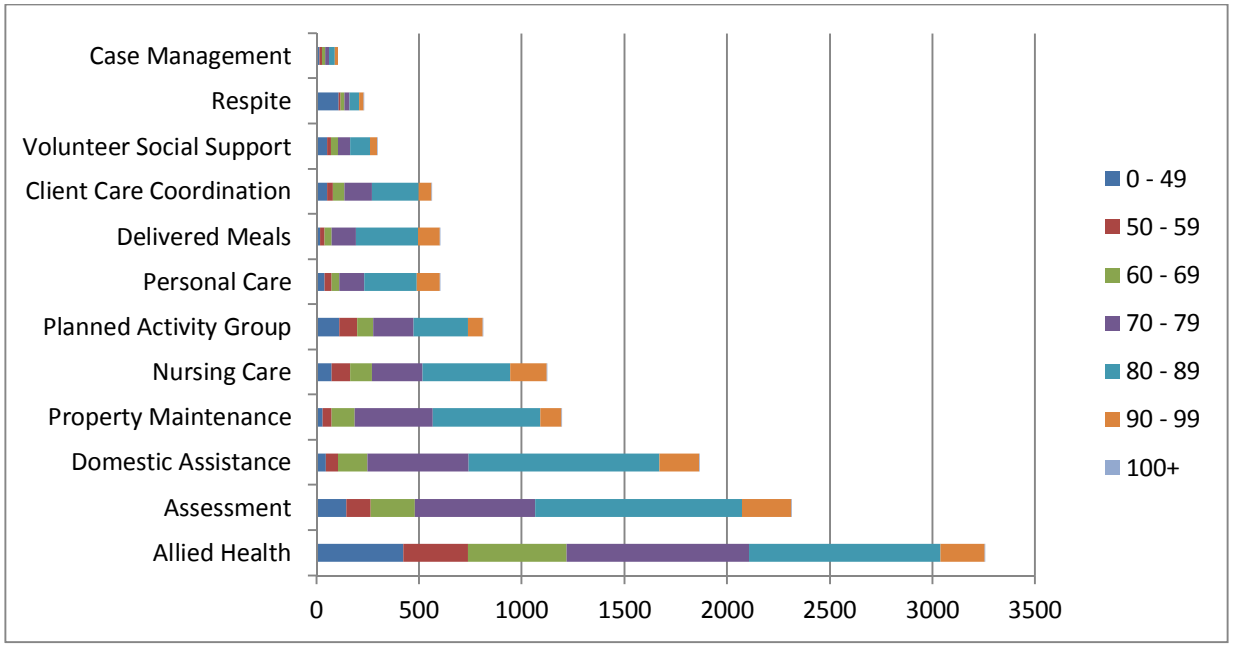


Table 10: Number of clients

SERVICE	0–49 YEARS	50–59 YEARS	60–69 YEARS	70–79 YEARS	80–89 YEARS	90–99 YEARS	100+ YEARS	TOTAL	% 50+ YEARS	% 70+ YEARS
Allied Health	423	314	479	888	932	215	2	3,253	87.0	62.6
Assessment	144	119	214	588	1005	242	3	2,315	93.8	79.4
Domestic Assistance	45	58	145	491	930	193	3	1,865	97.6	86.7
Property Maintenance	30	44	111	379	525	104	2	1,195	97.5	84.5
Nursing Care	72	90	108	246	426	179	2	1,123	93.6	76.0
Planned Activity Group	110	89	75	199	263	71	1	808	86.4	66.1
Personal Care	38	36	35	123	255	113	4	604	93.7	82.0
Delivered Meals	18	21	33	119	302	108	1	602	97.0	88.0
Client Care Coordination	51	29	54	136	228	62	1	561	90.9	76.1
Volunteer Social Support	51	20	34	58	97	33	1	294	82.7	64.3
Respite	106	11	17	25	49	22	1	231	54.1	42.0
Case Management	13	13	17	18	28	14		103	87.4	58.3

Age profile by outputs

The number of outputs (hours or meals) delivered by age cohort shows that younger clients (aged under 50 years) access more Respite and Planned Activity Group hours (raw totals) than other age groups, but more Respite and Case Management as a proportion of total service offered.

Figure 5: Number of outputs (hours/meals) per service type, 0–49 years, and in 10-year age brackets

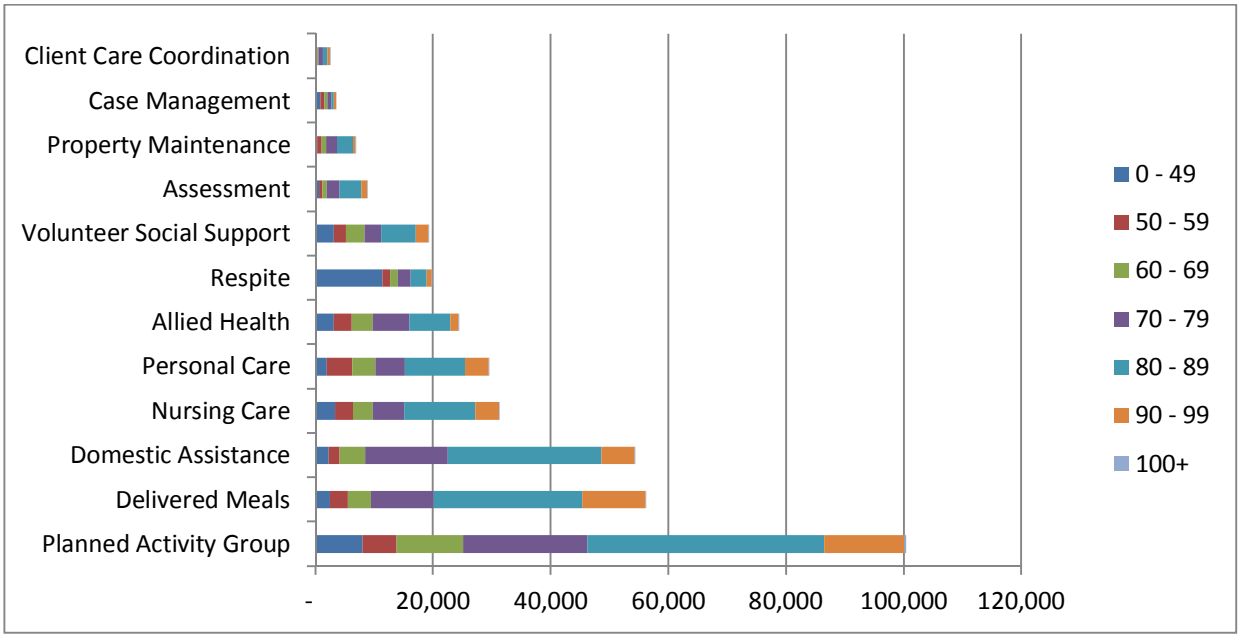


Table 11: Number of outputs (hours/meals)

SERVICE	0–49 YEARS	50–59 YEARS	60–69 YEARS	70–79 YEARS	80–89 YEARS	90–99 YEARS	100+ YEARS	TOTAL	% 50+ YEARS	% 70+ YEARS
Planned Activity Group	7,941	5,817	11,367	21,024	40,310	13,645	225	100,329	92.1	75.0
Delivered Meals	2,427	3,108	3,914	10,606	25,308	10,730	40	56,133	95.7	83.2
Domestic Assistance	2,165	1,863	4,397	14,017	26,137	5,615	132	54,326	96.0	84.5
Nursing Care	3,272	3,068	3,365	5,369	12,115	3,997	110	31,296	89.5	69.0
Personal Care	1,890	4,401	3,844	5,015	10,227	4,007	175	29,559	93.6	65.7
Allied Health	3,087	3,021	3,596	6,236	6,907	1,489	10	24,345	87.3	60.1
Respite	11,309	1,342	1,291	2,172	2,797	862	50	19,823	43.0	29.7
Volunteer Social Support	3,123	2,048	3,147	2,861	5,881	2,179	58	19,296	83.8	56.9
Assessment	556	540	840	2,170	3,698	896	14	8,714	93.6	77.8
Property Maintenance	232	801	731	1,848	2,778	372	11	6,773	96.6	74.0
Case Management	850	584	609	575	507	419	-	3,544	76.0	42.4
Client Care Coordination	98	160	252	729	734	472	1	2,445	96.0	79.2

The following table provides the number of hours of Allied Health delivered by age group for the five largest Allied Health services. The service with the oldest age profile was Podiatry, while that with the youngest clients was Speech therapy.

Table 12: Number of outputs (hours) by Allied Health Service, by age group

SERVICE	0–49	50–59	60–69	70–79	80–89	90+	TOTAL	50+ %	70+ %
Occupational therapy	1,338	1,652	1,489	2,753	3,325	683	11,239	88.1	60.1
Physiotherapy	1,083	755	1,232	1,417	1,244	217	5,948	81.8	48.4
Podiatry	276	387	668	1,375	1,581	435	4,723	94.2	71.8
Speech therapy	62	33	18	122	33	2	269	76.9	58.1
Dietetics	196	113	142	449	487	106	1,493	86.8	69.8

Service delivery by age

A comparison of the average number of hours/meals delivered per client across age groups provides an insight into key patterns in individual service across a year. These data do not represent typical service levels at a specific point in time, but service use within a 12-month period.

- Several service types allocated a large number of hours to people aged 0–49 years and/or 50–59 years age group. These service types include Allied Health, Assessment, Domestic Assistance, Property Maintenance, Nursing Care, Respite, Care Coordination, Delivered Meals, and Case Management (Linkages).
- Planned Activity Groups have a different pattern of allocation, with higher numbers of hours in the older age groups, particularly those aged 90 years and over.
- Volunteer Social Support also allocates more hours to older clients, especially those in the 90–99 years group.

Table 13: Average number of hours/meals delivered per client by service by age

SERVICE	0–49 YEARS	50–59 YEARS	60–69 YEARS	70–79 YEARS	80–89 YEARS	90–99 YEARS	100+ YEARS	TOTAL
Allied Health	7.3	9.6	7.5	7.0	7.4	6.9	4.8	7.5
Assessment	3.9	4.5	3.9	3.7	3.7	3.7	4.7	3.8
Domestic Assistance	48.1	32.1	30.3	28.5	28.1	29.1	44.0	29.1
Property Maintenance	7.7	18.2	6.6	4.9	5.3	3.6	5.5	5.7
Nursing Care	45.4	34.1	31.2	21.8	28.4	22.3	55.0	27.9
Planned Activity Group	72.2	65.4	151.6	105.6	153.3	192.2	225.0	124.2
Personal Care	49.7	122.3	109.8	40.8	40.1	35.5	43.8	48.9
Respite	134.8	148.0	118.6	89.1	83.8	99.4	40.0	93.2
Volunteer Social Support	1.9	5.5	4.7	5.4	3.2	7.6	0.5	4.4
Client Care Coordination	61.2	102.4	92.6	49.3	60.6	66.0	58.3	65.6
Delivered Meals	106.7	122.0	75.9	86.9	57.1	39.2	50.0	85.8
Case Management	65.4	44.9	35.8	31.9	18.1	29.9	0.0	34.4

CULTURAL AND LINGUISTIC DIVERSITY

Country of birth

Australia was the recorded country of birth for nearly two-thirds of clients in the Banyule area, while just over one-quarter were born in non-English-speaking countries.

Table 14: Number of clients by country of birth

COUNTRY OF BIRTH	NO. OF CLIENTS	% OF ALL CLIENTS*
Australia	4,359	63.3
Main English Speaking Countries	400	5.8
Non-English Speaking Countries	1,818	26.4
Missing Data	308	4.5
Total	6,885	100.0

*Missing data have been included in the denominator for these percentages

Overseas-born clients come from a range of countries (94 countries, not counting Australia). The largest number of clients came from Italy (7.5%), followed by England (3.5%) and Greece (3.1%).

Table 15: Top 10 Countries of Birth (other than Australia)

COUNTRY OF BIRTH	NO. OF CLIENTS	% OF ALL CLIENTS
Italy	514	7.5
England	243	3.5
Greece	216	3.1
China	140	2.0
Lebanon	72	1.0
Former Yugoslav Republic of Macedonia	67	1.0
Germany	66	1.0
Sri Lanka	63	0.9
Croatia	56	0.8
Somalia	52	0.8

Language

Almost 15% of clients were known to prefer a language other than English.

Table 16: Language preferred

LANGUAGE PREFERRED	NO. OF CLIENTS	% OF ALL CLIENTS
English Preferred Language	5,667	82.3
Non-English Language Preferred	1,014	14.7
Missing	204	3.0
Total	6,885	100.0

The most common non-English language preferred by clients was Italian, followed by Greek and Mandarin.

Table 17: Top 10 preferred non-English languages

TOP 10 NON-ENGLISH LANGUAGES	NO. OF CLIENTS	% OF ALL CLIENTS
Italian	253	3.7
Greek	137	2.0
Mandarin	83	1.2
Arabic	61	0.9
Macedonian	55	0.8
Cantonese	48	0.7
Somali	43	0.6
Croatian	30	0.4
Vietnamese	14	0.2
Serbian	13	0.2
Polish	13	0.2

Need for an interpreter was explored by preferred language for the 10 most common languages. One-third of Italian speakers needed an interpreter. Much higher proportions were recorded for the other languages.

Table 18: Need for an interpreter by preferred non-English language

PREFERRED LANGUAGE	INTERPRETER NEEDED	INTERPRETER NOT NEEDED	MISSING DATA	TOTAL	% NEEDED INTERPRETER
Italian	75	154	24	253	33
Greek	68	65	4	137	51
Mandarin	79	4	0	83	95
Arabic	40	21	0	61	66
Macedonian	26	29	0	55	47
Cantonese	43	5	0	48	90
Somali	18	25	0	43	42
Croatian	14	14	2	30	50
Vietnamese	6	7	1	14	46
Serbian	10	3	0	13	77
Polish	7	6	0	13	54

% of all clients includes 'missing'

Relative access to HACC services can be assessed by comparing service use with the number of clients in the community who use that language (or were born in that country). This comparison indicates some issues with coding of language use in the HACC MDS, as in one case (Mandarin), more clients were coded as using HACC services than were living in Banyule.

Table 19: HACC service usage of people aged 70+ years by preferred language

LANGUAGE SPOKEN AT HOME	POPULATION AGED 70+[8]	% OF POPULATION AGED 70+	NO. OF CLIENTS AGED 70+	% OF CLIENTS AGED 70+	CLIENTS AGED 70+ PER 1000 POPULATION 70+
English Preferred Language	9,644	72.8	3,809	80.4	395
Non-English Language Preferred	2,920	22.0	807	17.0	276
Missing	682	5.1	119	2.5	174
Italian	1,150	8.7	236	5.0	205
Greek	402	3.0	117	2.5	291
Mandarin	64	0.5	74	1.6	1,156
Arabic	82	0.6	40	1.0	488
Macedonian	125	0.9	47	0.8	376
Cantonese	71	0.5	40	0.8	563
Somali	12	0.1	7	0.5	583
Croatian	121	0.9	26	0.3	215
Vietnamese	24	0.2	4	0.2	167
Serbian	14	0.1	10	0.1	714
Polish	73	0.6	12	0.1	164
Other non-English languages	782	5.9	194	4.1	248
Total	**13,246**		**4,735**	**100.0**	**357**

[8] Numbers and percentages provided by Hayden Brown, Social Planner, City of Greater Dandenong.

Some service types have a much higher proportion of clients whose preferred language is not English than others. Service types with particularly high proportions of clients whose preferred language is other than English include Planned Activity Groups and Volunteer Social Support. On the other hand, relatively few clients of Delivered Meals prefer to use a language other than English.

Table 20: Number of clients by preferred language by service

	ENGLISH	NON-ENGLISH LANGUAGE	NOT SPECIFIED	TOTAL	% OF CLIENTS NON-ENGLISH LANGUAGE
Planned Activity Group	509	275	24	808	35.1
Personal Care	484	98	23	605	16.8
Domestic Assistance	1594	230	41	1,865	12.6
Property Maintenance	1005	161	29	1,195	13.8
Allied Health	2754	431	73	3,258	13.5
Case Management (Linkages)	87	14	2	103	13.9
Volunteer Social Support	182	85	27	294	31.8
Assessment	1,954	304	58	2,316	13.5
Client Care Coordination	447	93	21	561	17.2
Nursing Care	908	127	89	1124	12.3
Respite	186	41	4	231	18.1
Delivered Meals	555	32	15	602	5.5

When the three largest language groups are analysed separately, it is clear that most Mandarin-speaking HACC clients (82%) used a Planned Activity Group, with some using Allied Health. Clients who preferred Greek are distributed throughout a range of services, including Allied Health, Assessment, Domestic Assistance and Planned Activity Group. Clients who preferred Italian were even more widely spread among service types, with some representation among all service types.

Table 21: Number of clients by top three languages other than English

	ITALIAN CLIENTS		GREEK CLIENTS		MANDARIN-SPEAKING CLIENTS	
	N	%	N	%	N	%
Planned Activity Group	53	6.6	25	3.1	68	8.4
Personal Care	29	4.8	6	1.0	1	0.2
Domestic Assistance	77	4.1	35	1.9	1	0.1
Property Maintenance	40	3.3	28	2.3	2	0.2
Allied Health	92	2.8	46	1.4	12	0.4
Case Management (Linkages)	3	2.9	0	0.0	0	0.0
Volunteer Social Support	24	8.2	5	1.7	2	0.7
Assessment	81	3.5	44	1.9	1	0.0
Client Care Coordination	19	3.4	8	1.4	0	0.0
Nursing Care	21	1.9	18	1.6	2	0.2
Respite	7	3.0	5	2.2	0	0.0
Delivered Meals	7	1.2	1	0.2	0	0.0
N clients in the language group	253		137		83	

Some services types provided a higher proportion of service hours to people whose preferred language was not English than others. High proportions of services hours to people whose preferred language was not English were evident for Planned Activity Groups, whereas low service was provided to non-English speakers by Delivered Meals services.

Table 22: Number of outputs (hours/meals) by preferred language by service

	ENGLISH	NON-ENGLISH LANGUAGE	NOT SPECIFIED	TOTAL	% OF HOURS NON-ENGLISH LANGUAGE
Planned Activity Group	58,892	39,416	2,021	100,329	40.1
Volunteer Social Support	13,611	4,374	1,311	19,296	24.3
Property Maintenance	5,020	1,212	541	6,773	19.4
Client Care Coordination	1,933	450	62	2,445	18.9
Respite	15,852	3,656	315	19,823	18.7
Personal Care	23,980	5,397	183	29,560	18.4
Case Management	2,969	548	27	3,544	15.6
Allied Health	20,221	3,651	498	24,371	15.3
Assessment	7,310	1,203	204	8,716	14.1
Domestic Assistance	46,755	6,291	1,280	54,326	11.9
Nursing Care	27,640	3,104	566	31,310	10.1
Delivered Meals	53,413	1,837	883	56,133	3.3

When the three most common language groups were examined, a similar picture emerged, with relatively high proportions of Planned Activity Group hours provided to clients whose preferred language was Italian or Greek. However, Client Care Coordination provided the highest proportion of hours to Mandarin-speaking clients.

Table 23: Number of hours/meals delivered by preferred language (Italian, Greek, and Mandarin) by service

	ITALIAN CLIENTS		GREEK CLIENTS		MANDARIN-SPEAKING CLIENTS	
	N hours	% of all hours	N hours	% of all hours	N hours	% of all hours
Domestic Assistance	2,230	4.1	788	1.5	8	0.4
Volunteer Social Support	1,342	7.0	202	1.0	27	0.5
Personal Care	1,183	4.0	239	0.8	13	0.7
Nursing Care	507	1.6	502	1.6	2	0.1
Allied Health	497	2.0	325	1.3	171	0.1
Planned Activity Group	14,446	14.4	4,307	4.3	2,195	0.6
Delivered Meals	508	0.9	1	0.0	0	0.0
Respite	200	1.0	485	2.4	0	1.1
Assessment	302	3.5	165	1.9	1	0.6
Case Management	80	2.2	0	0.0	0	1.5
Client Care Coordination	35	1.4	5	0.2	0	2.3
Property Maintenance	169	2.5	151	2.2	7	0.6

The average number of hours per clients within the year for English and non-English speakers was also examined, and the difference was computed as a percentage (with English preferred language as the denominator). This shows that the difference in average number of hours as a proportion of hours used in a year was actually highest for Property Maintenance, and then for Planned Activity Groups. Clients who preferred a language other than English were generally provided with higher levels of service within a year than clients whose first language was English, for all service services except Domestic Assistance, Nursing Care, Volunteer Social Support, and Delivered Meals.

Table 24: Average number of hours/meals per client by preferred language

	ENGLISH	NON-ENGLISH LANGUAGE	DIFFERENCE	% DIFFERENCE
Property Maintenance	5.0	7.5	2.5	50.0
Planned Activity Group	115.7	143.3	27.6	23.9
Allied Health	7.3	8.5	1.2	16.4
Case Management	34.1	39.1	5.0	14.7
Client Care Coordination	4.3	4.8	0.5	11.6
Personal Care	49.6	55.1	5.5	11.1
Assessment	3.7	4.0	0.3	8.1
Respite	85.2	89.2	4.0	4.7
Domestic Assistance	29.3	27.4	-1.9	-6.5
Nursing Care	30.4	24.4	-6.0	-19.7
Volunteer Social Support	74.8	51.5	-23.3	-31.1
Delivered Meals	96.2	57.4	-38.8	-40.3

The analysis of average hours of service (or average number of meals) was repeated for the three main non-English speaking groups. This showed very different patterns for the three groups:

- Italian speakers had very similar amounts to the average per client of Domestic Assistance and Assessment, but high use of Planned Activity Groups and low use of other services.
- Greek speakers had similar amounts to the average client of Nursing Care, Property Maintenance and Assessment, but high use of Planned Activity Groups and Respite, and low use of other services.
- Mandarin speakers had high average use per client of Allied Health but low use of other services.

Table 25: Average hours/meals per client by preferred language (Italian, Greek, Mandarin)

	ITALIAN	GREEK	MANDARIN	ALL CLIENTS
Domestic Assistance	29.0	22.5	8.0	29.1
Volunteer Social Support	55.9	40.4	13.5	65.6
Personal Care	40.8	39.8	13.0	48.9
Nursing Care	24.1	27.9	1.0	27.9
Allied Health	5.4	7.1	14.2	7.5
Planned Activity Group	272.6	172.3	32.3	124.2
Delivered Meals	72.6	1.0	0.0	93.2
Respite	28.6	97.0	0.0	85.8
Assessment	3.7	3.7	0.7	3.8
Case Management	26.5	0.0	0.0	34.4
Client Care Coordination	1.8	0.6	0.0	4.4
Property Maintenance	4.2	5.4	3.5	5.7

Indigenous clients

Both demographic and service use data for Indigenous people may be unreliable, as they rely on individuals choosing to identify as Indigenous. Figures presented in this section should be treated with caution. In the HACC MDS, 63 clients from Banyule (0.9%) identified as Aboriginal or Torres Strait Islander (Indigenous).

The number of people in the city of Banyule aged 50 years or over who identify as Indigenous is 107.

Indigenous clients do not form a large proportion of the clientele of any HACC services, but they are best represented in Planned Activity Groups.

Table 26: Number of clients identified as Indigenous by service

	NO	YES	NOT SPECIFIED	TOTAL	% CLIENTS INDIGENOUS
Planned Activity Group	742	18	48	808	2.2
Property Maintenance	1,146	22	27	1,195	1.8
Domestic Assistance	1,802	27	36	1,865	1.4
Client Care Coordination	536	8	17	561	1.4
Assessment	2,196	25	95	2,316	1.1
Volunteer Social Support	242	3	49	294	1.0
Allied Health	3,099	33	126	3,258	1.0
Case Management	100	1	2	103	1.0
Nursing Care	954	7	163	1,124	0.6
Delivered Meals	587	2	13	602	0.3
Personal Care	567	1	37	605	0.2
Respite	222	0	9	231	0.0

The proportion of hours allocated to Indigenous clients within the year is also relatively low, but highest for Client Care Coordination and Property Maintenance.

Table 27: Number of hours/meals by Indigenous status

	NO	YES	NOT SPECIFIED	TOTAL	% HOURS TO INDIGENOUS CLIENTS
Client Care Coordination	2,180	236	29	2,445	9.7
Property Maintenance	6,217	473	83	6,773	7.0
Assessment	8,135	264	318	8,716	3.0
Domestic Assistance	52,504	1055	767	54,326	1.9
Allied Health	23,295	279	797	24,371	1.1
Nursing Care	29,432	317	1,561	31,310	1.0
Case Management	3,423	29	91	3,544	0.8
Volunteer Social Support	17,365	103	1,828	19,296	0.5
Delivered Meals	55,493	156	484	56,133	0.3
Planned Activity Group	96,385	249	3,695	100,329	0.2
Personal Care	29,073	5	482	29,560	0.0
Respite	19,304	0	519	19,823	0.0

Allocation of hours within a year was compared for Indigenous and Non-Indigenous clients; the % difference used the allocation for Non-Indigenous clients as the denominator.

When the average allocation of hours to Indigenous clients was examined by service in comparison to non-Indigenous clients, interesting differences emerged. Indigenous clients were allocated more hours within the year on average than non-Indigenous clients of Client Care Coordination, Property Maintenance, Assessment, Nursing, Domestic Assistance, and Allied Health, but lower hours of other services, and much less of Volunteer Social Support, Planned Activity Group, Personal Care, and Respite. This pattern is in sharp contrast to that for clients from non-English speaking backgrounds.

Table 28: Average number of hours/meals per client by Indigenous status

	NON-INDIGENOUS	INDIGENOUS	DIFFERENCE	% DIFFERENCE
Client Care Coordination	4.1	29.5	25.4	619.5
Property Maintenance	5.4	21.5	16.1	298.1
Assessment	3.7	10.6	6.9	186.5
Nursing Care	30.9	45.3	14.4	46.6
Domestic Assistance	29.1	39.1	10.0	34.4
Allied Health	7.5	8.4	0.9	12.0
Case Management	34.2	29.0	-5.2	-15.2
Delivered Meals	94.5	78.0	-16.5	-17.5
Volunteer Social Support	71.8	34.4	-37.4	-52.1
Planned Activity Group	129.9	13.8	-116.1	-89.4
Personal Care	51.3	5.0	-46.3	-90.3
Respite	87.0	0	-87.0	NA

OTHER CLIENT CHARACTERISTICS

Carer availability

Overall, the proportion of clients who had an informal carer was 31.2%; however, the level of missing data on this item was quite high, at 11.6%. The percentages in the table below include missing data in the denominator, so are likely to be under-estimates.

The proportion of clients who had a carer was highest for Respite and Case Management, and lowest for Allied Health and Volunteer Social Support. A similar picture emerges when hours of service rather than number of clients is examined—service hours were most likely to be allocated to clients of Respite and Case Management with carers, but relatively few hours to clients of Volunteer Social Support and Property Maintenance.

Respite is a service that is offered to carers and to people who have carers.[9] The small number of people said to be receiving respite but to have no carer (n = 19) may reflect carers in the dataset who are clients in their own right due to their own frailty or disability, or inaccurate coding of carer availability in the data set.

Table 29: Carer availability by service, number of clients

	HAS A CARER	HAS NO CARER	NOT STATED	TOTAL	% OF CLIENTS WITH A CARER
Respite	206	19	6	231	89.2
Case Management	77	26	-	103	74.8
Personal Care	404	154	47	605	66.8
Client Care Coordination	315	234	12	561	56.1
Nursing Care	631	484	9	1,124	56.1
Assessment	1,127	1,163	26	2,316	48.7
Delivered Meals	277	311	14	602	46.0
Planned Activity Group	342	346	120	808	42.3
Domestic Assistance	741	1,107	17	1,865	39.7
Property Maintenance	460	664	71	1,195	38.5
Volunteer Social Support	97	126	71	294	33.0
Allied Health	790	1,983	485	3,258	24.2

[9] http://www.myagedcare.gov.au/caring-someone/respite-care

Table 30: Number of hours/meals to clients with and without a carer

	HAS A CARER	HAS NO CARER	NOT STATED	TOTAL	% OF HOURS TO CLIENTS WITH A CARER
Respite	16,959	2,041	823	19,823	85.6
Case Management	2,723	821	-	3,544	76.8
Personal Care	21,752	7,767	41	29,560	73.6
Nursing Care	21,712	9,564	34	31,310	69.3
Client Care Coordination	1,639	600	206	2,445	67.0
Assessment	4,683	3,854	179	8,716	53.7
Planned Activity Group	51,002	37,110	12,217	100,329	50.8
Delivered Meals	25,316	30,020	797	56,133	45.1
Domestic Assistance	22,669	30,957	700	54,326	41.7
Allied Health	9,859	12,362	2,451	24,371	40.5
Property Maintenance	2,563	3,857	353	6773	37.8
Volunteer Social Support	6,014	7,987	5,295	19,296	31.2

When the ratio of hours or meals per client (within 12 months) was compared for clients with and without carers,[10] clients received more hours of care if they had a carer for Care Coordination and Allied Health, and, to a lesser degree, this was also true of most other services. However, clients received fewer hours of service if they had a carer for Volunteer Social Support, Property Maintenance, Delivered Meals, and Respite. (In other words, on average, fewer hours of respite were offered to clients **with** carers than to clients who **were** carers.)

Table 31: Average number of hours/meals per client by carer availability

	HAS A CARER	HAS NO CARER	DIFFERENCE	% DIFFERENCE
Client Care Coordination	5.2	2.6	2.6	102.7
Allied Health	12.5	6.2	6.2	100.2
Nursing Care	34.4	19.8	14.6	74.1
Planned Activity Group	149.1	107.3	41.9	39.0
Assessment	4.2	3.3	0.8	25.4
Case Management	35.4	31.6	3.8	12.0
Domestic Assistance	30.6	28.0	2.6	9.4
Personal Care	53.8	50.4	3.4	6.8
Volunteer Social Support	62.0	63.4	-1.4	-2.2
Property Maintenance	5.6	5.8	-0.2	-4.1
Delivered Meals	91.4	96.5	-5.1	-5.3
Respite	82.3	107.4	-25.1	-23.4

[10] The denominator for this analysis was allocation for clients with no carer.

Living arrangements

Over half of Banyule's HACC clients (53.1%) lived with family rather than alone or with others. This is likely to be an under-estimate because of the relatively high level of missing data on this item (8.7%).

Table 32: Living arrangements of HACC clients

LIVING ARRANGEMENT	NO. OF CLIENTS	% OF CLIENTS
Lives Alone	2,330	33.8
Lives with Family	3,653	53.1
Lives with Others	302	4.4
Not stated	600	8.7
Total	6,885	100.0

Examining the living arrangements of clients in comparison with the population aged 70 years and over living alone indicates that over one-half of the people aged 70 and over living alone in Banyule received a service.

Table 33: Living arrangements of HACC clients for those aged 70 years and over

LIVING ARRANGEMENT	NO. OF POPULATION AGED 70+	% OF POPULATION AGED 70+	NO. OF CLIENTS AGED 70+	% OF CLIENTS AGED 70+	CLIENTS 70+ PER 1,000 POP AGED 70+
Lives alone	3,410	25.7	1,939	41.0	569

Living arrangements of clients varied by service type. Over half of the clients of Domestic Assistance, Delivered Meals and Property Maintenance lived alone. On the other hand, clients of Respite services were unlikely to live alone.

Table 34: Living arrangements by service type

	LIVES ALONE	LIVES WITH FAMILY	LIVES WITH OTHERS	NOT STATED	TOTAL	% OF CLIENTS LIVE ALONE
Domestic Assistance	1,144	687	19	15	1,865	61.3
Delivered Meals	334	252	5	11	602	55.5
Property Maintenance	647	470	14	64	1,195	54.1
Assessment	1,043	1,090	50	133	2,316	45.0
Client Care Coordination	245	296	6	14	561	43.7
Volunteer Social Support	128	126	16	24	294	43.5
Personal Care	252	277	10	66	605	41.7
Case Management	38	65	-	-	103	36.9
Nursing Care	413	443	69	199	1,124	36.7
Planned Activity Group	254	449	60	45	808	31.4
Allied Health	948	2,022	166	122	3,258	29.1
Respite	19	206	2	4	231	8.2

When number of hours is examined rather than number of clients, the picture is similar. Overall, total hours of Domestic Assistance and Property Maintenance provided and number of Delivered were weighted towards clients who lived alone rather than to those who lived with family or others. In contrast, Respite hours were relatively unlikely to be delivered to clients who lived alone.

Table 35: Number of hours by service type

	LIVES ALONE	LIVES WITH FAMILY	LIVES WITH OTHERS	NOT STATED	TOTAL	% OF HOURS TO CLIENTS WHO LIVE ALONE
Domestic Assistance	33,724	19,493	465	644	54,326	62.1
Delivered Meals	34,625	20,814	459	235	56,133	61.7
Property Maintenance	3,726	2,736	66	245	6,773	55.0
Nursing Care	15,137	12,740	2,874	559	31,310	48.3
Assessment	4,047	4,024	176	470	8,716	46.4
Client Care Coordination	1,070	1,160	7	207	2,445	43.8
Planned Activity Group	43,701	47,627	6,510	2,491	100,329	43.6
Volunteer Social Support	7,813	8,944	1,597	942	19,296	40.5
Personal Care	11,003	18,101	241	215	29,560	37.2
Case Management	1,238	2,306	-	-	3,544	34.9
Allied Health	7,714	15,062	1,146	450	24,371	31.7
Respite	1,065	18,276	96	386	19,823	5.4

When average number of hours per client (within the year) is examined, the biggest different that living alone made to the allocated hours of service within a year was to clients attending a Planned Activity Group, who were given about 68% more hours than those who lived with family or others. For some services, fewer hours of service on average were allocated to clients who lived alone: Case Management, Volunteer Social Support, Personal Care and Respite.

Table 36: Average number of hours/meals per client by living arrangement

	LIVES ALONE	LIVES WITH FAMILY OR OTHERS	DIFFERENCE	% DIFFERENCE
Planned Activity Group	172.1	102.2	69.8	68.3
Nursing Care	36.7	22.8	13.9	61.1
Delivered Meals	103.7	80.3	23.4	29.2
Allied Health	8.1	7.2	0.9	12.9
Assessment	3.9	3.7	0.2	5.8
Property Maintenance	5.8	5.6	0.2	3.6
Domestic Assistance	29.5	28.6	0.9	3.1
Client Care Coordination	4.4	4.4	0.0	0.4
Case Management	32.6	35.5	-2.9	-8.1
Volunteer Social Support	61.0	69.2	-8.1	-11.8
Personal Care	43.7	52.6	-8.9	-16.9
Respite	56.1	88.5	-32.4	-36.7

Accommodation

The majority of clients lived in a private residence that they owned or were purchasing (66%). The level of missing data on Accommodation setting was relatively high, at 15%

Table 37: Usual accommodation setting

ACCOMMODATION	NO. OF CLIENTS	% OF CLIENTS
Private residence – owned/purchasing	4,516	65.6
Private residence – private rental	373	5.4
Private residence – public rental	496	7.2
Independent living unit within a retirement village	190	2.8
Boarding house/private hotel	5	0.1
Short term crisis, emergency or transitional accommodation facility	5	0.1
Supported accommodation or supported living facility	170	2.5
Institutional setting	12	0.2
Public place/temporary shelter	4	0.1
Private residence rented from Aboriginal Community	2	0.0
Alcohol and drug treatment residence	11	0.2
Other	65	0.9
Not stated/inadequately described	1,036	15.0
Total	6,885	100.0

Income source

A majority of clients were on the Age pension (58%). Level of missing data on Income source was relatively high, at 12%.

Table 38: Clients' main income source

INCOME SOURCE	NO OF CLIENTS	% OF CLIENTS
Age Pension	4,009	58.2
Veterans' Affairs Pension	264	3.8
Disability Support Pension	835	12.1
Carer Payment (Pension)	90	1.3
Unemployment related benefits	61	0.9
Other government pension or benefit	284	4.1
No government pension or benefit	527	7.7
Not stated/inadequately described	815	11.8
Total	6,885	100.0

Client referral source

The most common source of referrals to HACC was the person themselves (38%), followed by a family member, friend, or significant other (14%).

Table 39: Client referral source

SOURCE OF REFERRAL	CLIENTS REFERRED N	CLIENTS REFERRED %
Self	2,623	38.1
Family, significant other, friend	939	13.6
Hospital	755	11.0
GP/medical practitioner – community based	562	8.2
Community nursing or health service	466	6.8
Aged Care Assessment Service	336	4.9
Other	252	3.7
Palliative care facility/hospice	121	1.8
Other community-based service	109	1.6
Extended care/rehabilitation facility	88	1.3
Other medical/health service	32	0.5
Disability support service	31	0.5
Psychiatric/mental health service or facility	12	0.2
Residential aged care facility	17	0.2
Accommodation provider	10	0.1
Aboriginal health service	2	0.0
Missing	530	7.7
Total	6,885	100.0

Referral pathways differed across HACC service types. The six most common sources of referrals are listed in the table below, by HACC service type. (The denominator for percentages is the number of clients of each service.)

- Self-referral was a significant source of clients for Allied Health (55%) and Property Maintenance (44%).
- Family, significant others, and friends were a relatively common referral source for Planned Activity Groups (40%).
- Referrals from GPs were relatively uncommon, but most associated with referrals to Nursing Care and Allied Health.
- ACAS was a significant source of referrals for Case Management (24%).

Table 40: Referral source (% of clients referred)

	SELF	FAMILY, SIGNIFICANT OTHER, FRIEND	HOSPITAL	GP/ MEDICAL	COMMUNITY NURSING / HEALTH	ACAS
Domestic Assistance	39.5	14.9	14.5	5.7	11.6	5.0
Volunteer Social Support	38.8	25.5	4.4	2.7	2.7	2.0
Personal Care	22.4	16.4	18.5	4.6	12.6	7.5
Nursing Care	18.9	13.0	15.9	12.1	4.2	13.1
Allied Health	55.1	6.9	6.3	11.2	4.7	3.5
Planned Activity Group	23.1	39.7	5.1	2.8	3.8	5.3
Delivered Meals	39.2	20.1	13.8	3.5	9.8	8.3
Respite	15.6	30.7	8.7	1.3	15.2	13.0
Assessment	32.9	16.1	13.4	6.5	9.4	8.6
Case Management	19.4	12.6	9.7	2.9	8.7	24.3
Client Care Coordination	34.4	17.1	16.0	3.6	10.5	8.9
Property Maintenance	43.7	10.2	16.8	5.9	12.0	4.5

Cessation of HACC services

During 2014, a valid reason for cessation was recorded for 1,299 clients. A further 3,234 clients were coded 99, Not stated/inadequately described. The validity of data on this item is questionable, and the numbers and proportions reproduced below are unlikely to be reliable.

Table 41: Reasons for cessation

REASON FOR CESSATION	N CLIENTS	% OF CLIENTS
Client no longer needs assistance – improved status	554	8.0
Client no longer needs assistance from agency – improved status	153	2.2
Client's needs have not changed but agency cannot or will no longer provide assistance	39	0.6
Care recipient moved to residential aged care	79	1.1
Care recipient moved to other institutional setting	91	1.3
Care recipient moved to other community-based service	21	0.3
Care recipient moved out of area	23	0.3
Care recipient terminated service	45	0.7
Client died	137	2.0
Other reason	157	2.3
Not stated/inadequately described	3,234	47.0
Missing	2,352	34.2
Total	6,885	100.0

HACC service demand projections

The methodology for determining future service demand relies on several assumptions, including that change in provision of services relies on change in the population. This assumption is tested for each service later in this section. If change in service provision in the past (2011 through 2014) parallels change in the population, it may be valid to project service provision into the future. We have produced a series of projections, but would caution against their reliability.

1. Similar to the report prepared for Whittlesea, we have produced figures for the next five years and 10 years based on service provision ratios for 2014 and population growth rates in each five-year age group. These projections uniformly anticipate increase in service provision.
2. We have also produced demand estimates based on average change from 2011 to 2014, which "iron out" some of the year-to-year variation in service provision and allow for the fact that provision of some services has been growing faster than the population while others have decreased despite increases in the target population. The projections assume that changes in the recent past will continue into the future.
3. Given the wildly different projections produced by the two methods described above, we also produced "compromise" projections, which take an average of the change rates and apply them to 2014 provision.

HACC is operating in an environment of very rapid policy change, and it is unlikely to be valid to project service use beyond the next five years.

SERVICE-TO-POPULATION RATIO

The first step in examining future need for services is to calculate service levels by age group. The table below provides the following data by age cohort:

- Residential population of Banyule in 2014 (based on population projections)
- The service level for each service in 2014
- The service-to-population ratio for each service (number of hours or meals per 1,000 residents).

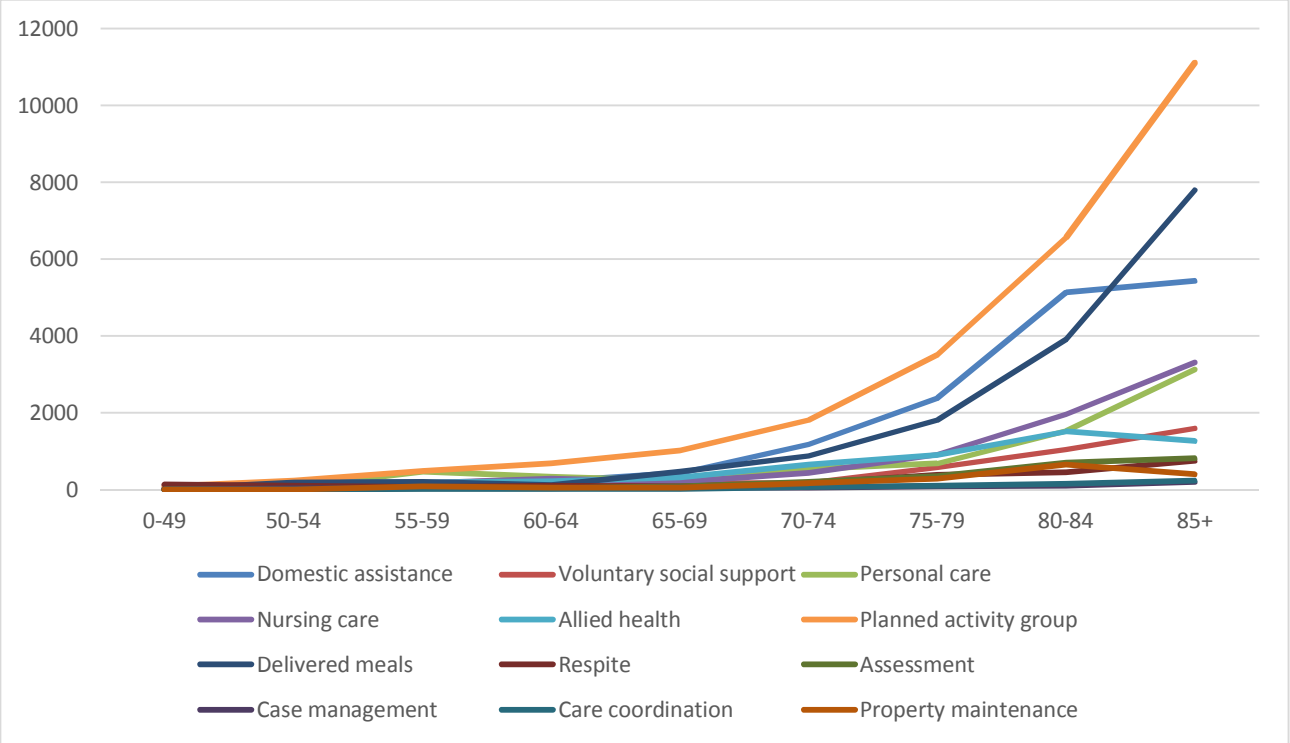
The service-to-population ratio increases significantly with age. The rate of increase in the service-to-population by age for a given service is impacted by both the increase in the number of clients and the increase in individual service levels with age.

Table 42: Residential population, service level and service-to-population ratio by age and service, 2014

	0–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85+
Population 2014	81,418	8,195	7,775	7,023	6,446	4,695	3,534	2,807	3,212
N clients per age group	781	245	293	331	494	788	1,029	1,256	1,662
Age-specific provision (total hours/meals)									
Domestic Assistance	2,165	752	1,111	1,610	2,787	5,593	8,424	14,433	17,451
Volunteer soc. support	3,123	790	1,258	2,015	1,132	805	2,056	2,966	5,152
Personal Care	1,890	660	3,740	2,327	1,517	2,550	2,466	4,320	10,090
Nursing Care	3,272	1,750	1,318	2,085	1,280	2,088	3,281	5,543	10,679
Allied Health	3,087	1,508	1,513	1,547	2,050	3,043	3,193	4,291	4,114
Planned Activity Group	7,941	1,975	3,842	4,792	6,574	8,586	12,438	18,451	35,729
Delivered Meals	2,427	1,497	1,611	898	3,016	4,169	6,437	11,017	25,061
Respite	11,309	817	525	720	571	783	1,389	1,271	2,438
Assessment	556	240	301	316	524	938	1,233	1,972	2,636
Case Management	850	339	245	284	325	273	302	288	638
Care Coordination	98	26	134	118	134	357	373	418	788
Property Maintenance	232	82	719	337	394	811	1,037	1,842	1,319
Service hours or meals to population ratio									
Domestic Assistance	26.6	91.8	142.9	229.2	432.4	1,191.3	2,383.7	5,141.8	5,433.1
Volunteer soc. support	38.4	96.4	161.8	286.9	175.6	171.4	581.7	1,056.8	1,604.0
Personal Care	23.2	80.6	481.1	331.3	235.4	543.1	697.7	1,539.0	3,141.3
Nursing Care	40.2	213.5	169.5	296.9	198.6	444.7	928.4	1,974.7	3,324.7
Allied Health	37.9	184.0	194.6	220.2	318.0	648.2	903.4	1,528.8	1,280.7
Planned Activity Group	97.5	241.0	494.1	682.4	1,019.9	1,828.7	3,519.6	6,573.2	11,123.7
Delivered Meals	29.8	182.7	207.2	127.9	467.9	888.0	1,821.4	3,924.8	7,802.3
Respite	138.9	99.7	67.5	102.5	88.6	166.8	393.0	452.8	759.0
Assessment	6.8	29.3	38.7	45.0	81.4	199.7	348.8	702.4	820.6
Case Management	10.4	41.4	31.5	40.4	50.4	58.0	85.5	102.6	198.6
Care Coordination	1.2	3.1	17.2	16.8	20.8	76.0	105.4	148.8	245.4
Property Maintenance	2.8	10.0	92.5	48.0	61.1	172.7	293.4	656.2	410.6

If the service provision (total hours or meals provided) is graphed by age group and service type, it is clear that the steepest curve by age group is for Planned Activity Group hours.

Figure 6: Service hours/meals per 1000 population by age group and service type, 2014



CLIENT-TO-POPULATION RATIO

The table below provides the following data by age cohort:

- Residential population 2014
- Number of clients by service
- Client-to-population ratio for each service (number of clients per 1,000 residents).

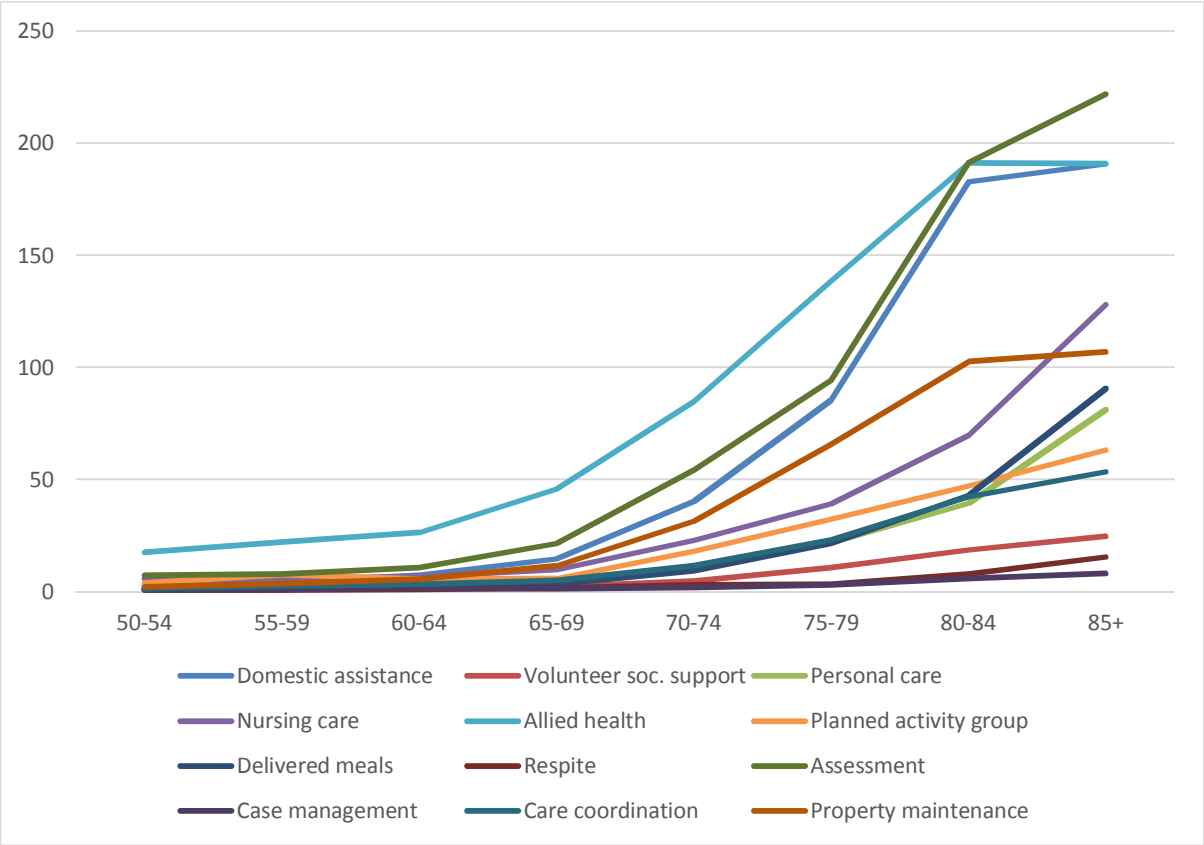
As expected, the client-to-population ratio increases with age for all HACC services. However, the rate of increase is much steeper for some service types than others (see figure 7 below). The trend is particularly strong for Assessment, where provision per year per 1000 people aged 85 and over rises to 222.

Table 43: Residential population, number of clients and clients-to-population ratio by age and service, 2014

	0–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85+
Population 2014	81,418	8195	7775	7023	6446	4695	3534	2807	3212
N clients per age group	781	245	293	331	494	788	1029	1256	1662
Age-specific provision (clients)									
Domestic Assistance	45	24	34	50	95	189	302	513	613
Volunteer soc. support	51	9	11	21	13	21	37	52	79
Personal Care	38	19	17	15	20	46	77	111	261
Nursing Care	72	47	43	46	62	108	138	196	411
Allied Health	423	143	171	185	294	398	490	536	613
Planned Activity Group	110	31	58	38	37	85	114	132	203
Delivered Meals	18	9	12	12	21	43	76	120	291
Respite	106	6	5	7	10	14	11	22	50
Assessment	144	58	61	75	139	255	333	537	713
Case Management	13	6	7	10	7	8	10	16	26
Care Coordination	51	10	19	22	32	54	82	119	172
Property Maintenance	30	17	27	38	73	147	232	288	343
Client-to-population ratio									
Domestic Assistance	0.6	2.9	4.4	7.1	14.7	40.3	85.5	182.8	190.8
Volunteer soc. support	0.6	1.1	1.4	3.0	2.0	4.5	10.5	18.5	24.6
Personal Care	0.5	2.3	2.2	2.1	3.1	9.8	21.8	39.5	81.3
Nursing Care	0.9	5.7	5.5	6.5	9.6	23.0	39.0	69.8	128.0
Allied Health	5.2	17.4	22.0	26.3	45.6	84.8	138.7	191.0	190.8
Planned Activity Group	1.4	3.8	7.5	5.4	5.7	18.1	32.3	47.0	63.2
Delivered Meals	0.2	1.1	1.5	1.7	3.3	9.2	21.5	42.8	90.6
Respite	1.3	0.7	0.6	1.0	1.6	3.0	3.1	7.8	15.6
Assessment	1.8	7.1	7.8	10.7	21.6	54.3	94.2	191.3	222.0
Case Management	0.2	0.7	0.9	1.4	1.1	1.7	2.8	5.7	8.1
Care Coordination	0.6	1.2	2.4	3.1	5.0	11.5	23.2	42.4	53.5
Property Maintenance	0.4	2.1	3.5	5.4	11.3	31.3	65.6	102.6	106.8

The intensity of service provision to the population in Banyule rose steadily in older age groups. Service intensity increased most dramatically with age for Assessment.

Figure 7: Client-to-population ratio by service and age group



DEMAND PROJECTIONS

This section provides demand projections for each HACC service, assuming a constant service-to-population ratio, **based on changes in the population structure and service provision in 2014 only**.[11] (Later sections of this report take a different approach to forecasting demand.)

This modelling shows particularly strong growth in demand for all services to 2019 and 2024, particularly for Domestic Assistance, Care Coordination and Property Maintenance.

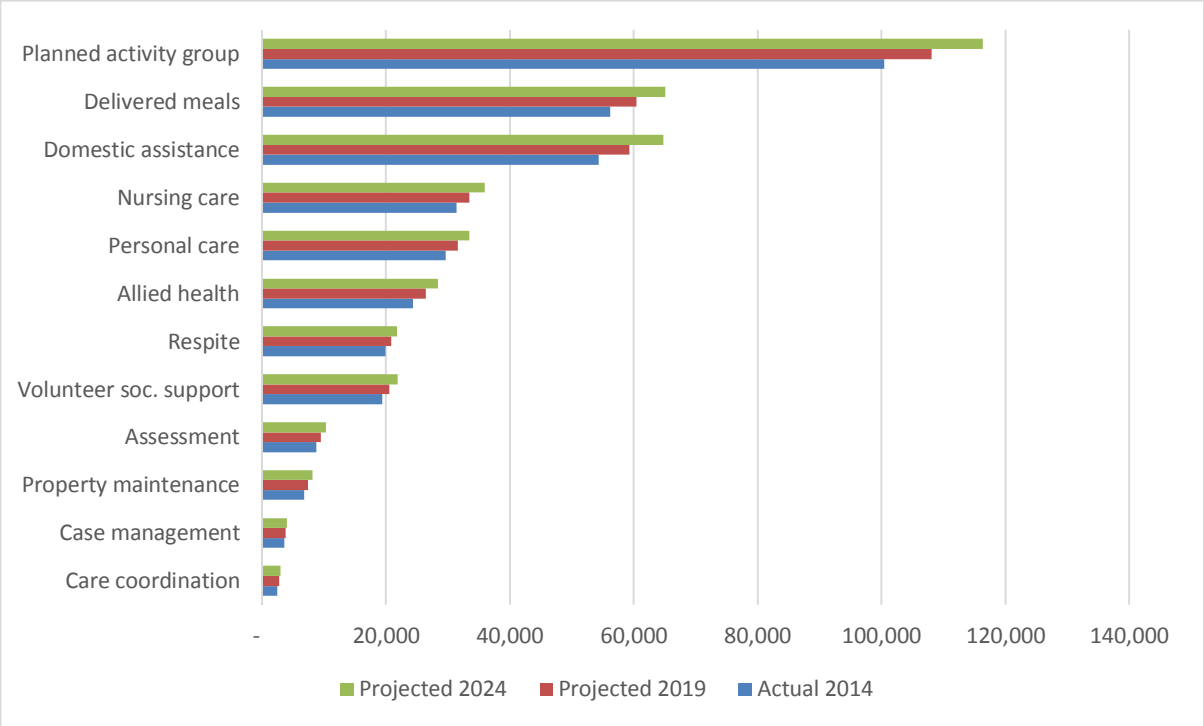
Table 44: Service level (hours or meals) by service, 2014, projected 2019, and projected 2024

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
Domestic Assistance	54,326	59,216	64,755	4,890	9.0	10,429	19.2
Volunteer Social Support	19,296	20,476	21,874	1,179	6.1	2,578	13.4
Personal Care	29,559	31,541	33,434	1,982	6.7	3,875	13.1
Nursing Care	31,296	33,434	35,860	2,138	6.8	4,564	14.6
Allied Health	24,345	26,330	28,366	1,986	8.2	4,021	16.5
Planned Activity Group	100,329	108,065	116,312	7,736	7.7	15,983	15.9
Delivered Meals	56,133	60,327	64,989	4,194	7.5	8,856	15.8
Respite	19,823	20,760	21,759	937	4.7	1,936	9.8
Assessment	8,714	9,462	10,273	747	8.6	1,559	17.9
Case Management	3,544	3,747	3,959	204	5.7	415	11.7
Care Coordination	2,445	2,675	2,885	231	9.4	441	18.0
Property Maintenance	6,773	7,383	8,057	610	9.0	1,284	19.0

[11] This methodology is consistent with that used in the Whittlesea Data Story report.

The following graph illustrates this increase in service demand by service type

Figure 8: Service level, 2014, and projected 2019 and 2024

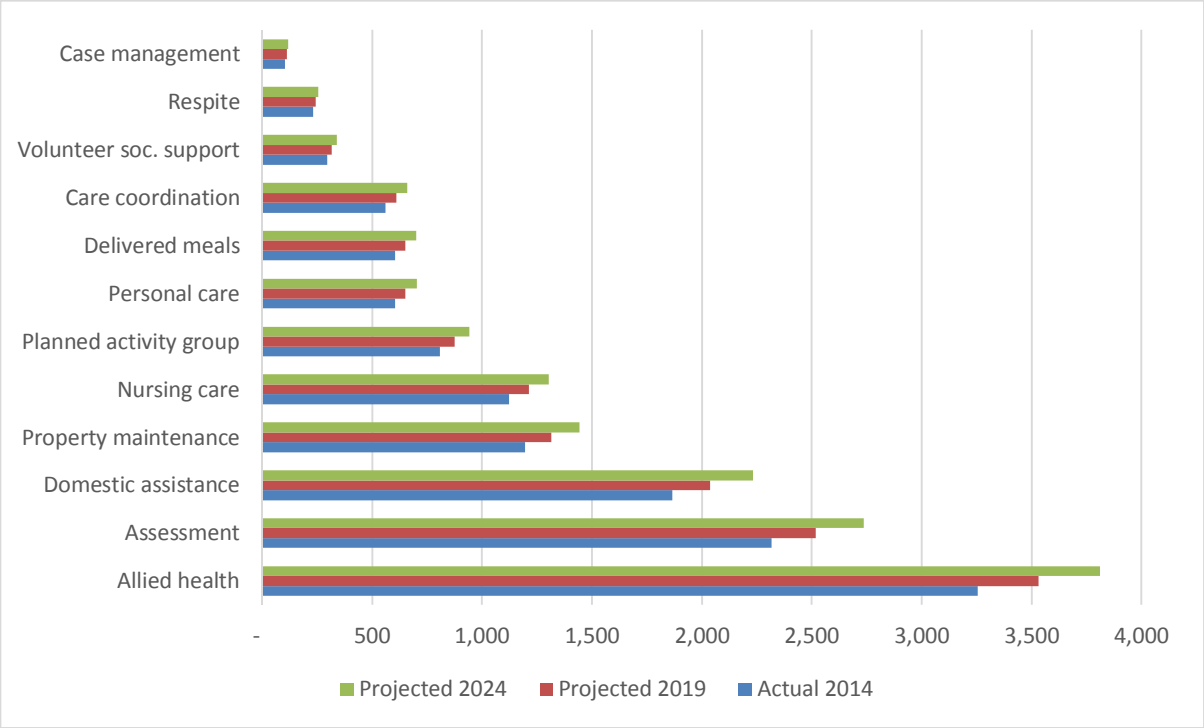


The number of clients is also likely to increase. The following table and graph illustrate projected increases in client numbers. Increases in numbers of clients are particularly strong for Property Maintenance and Domestic Assistance.

Table 45: Client level (N clients) by service, 2014, projected 2019, and projected 2024

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
Property Maintenance	1,195	1,314	1,442	119	9.9	247	20.7
Domestic Assistance	1,865	2,036	2,232	171	9.1	367	19.7
Assessment	2,315	2,517	2,736	202	8.7	421	18.2
Care Coordination	561	608	659	47	8.4	98	17.5
Allied Health	3,253	3,529	3,809	276	8.5	556	17.1
Planned Activity Group	808	873	940	65	8.1	132	16.3
Delivered Meals	602	649	700	47	7.8	98	16.3
Personal Care	604	650	701	46	7.7	97	16.1
Nursing Care	1,123	1,211	1,303	88	7.8	180	16.0
Volunteer soc. support	294	315	339	21	7.3	45	15.4
Case Management	103	110	117	7	6.6	14	13.8
Respite	231	243	254	12	5.1	23	10.2

Figure 9: Client numbers, 2014, and projected 2019 and 2024



DEMAND PROJECTIONS BY AGE FOR EACH SERVICE

In this section of the report, demand projections are provided by age for each service; first for service level and then by number of clients. Changes in demand are also calculated for people aged 0–64 and those aged 65+.

Each subsection of this part of the report does three things:

1. Projections are provided that rely on assumptions of invariant ratios of service provision by age group. Projected service demand is based on 2014 provision and changes in the population structure, consistent with the Whittlesea data story report. These projections assume that service provision in 2014 is a good basis from which to project future demand.
2. This section of the report examines those assumptions by looking at whether change over the previous four years (2011 to 2014) in service provision matches changes in the population for the population aged 70+.
   Generally, over the past few years, change in service provision has echoed change in the population aged 85 and over for some services (e.g., Domestic Assistance), but not others. Provision of services has fallen for Delivered Meals and Nursing Care.
3. A second set of projections is provided that averages out service provision from 2011 to 2014 and applies rates of change to service provision in 2014. This set of projections assumes that whatever happened from 2011 to 2014 will continue, but “irons out” yearly variation.
4. A third set of projections averages the results of the above two methods of estimating future service provision.

DOMESTIC ASSISTANCE

Table 46: Service level by age, 2014, and projected 2019 and 2024, Domestic Assistance

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019	% INCREASE TO 2019	INCREASE TO 2024	% INCREASE TO 2024
0–49	2,165	2,214	2,260	49	2.2	95	4.4
50–54	752	744	799	-8	-1.0	47	6.3
55–59	1,111	1,115	1,111	4	0.3	0	0.0
60–64	1,610	1,675	1,691	65	4.0	81	5.0
65–69	2,787	2,815	2,935	28	1.0	148	5.3
70–74	5,593	6,965	7,100	1,372	24.5	1,507	26.9
75–79	8,424	10,095	12,278	1,671	19.8	3,854	45.8
80–84	14,433	15,431	17,945	998	6.9	3,512	24.3
85+	17,451	18,163	18,635	712	4.1	1,184	6.8
0-64	5,638	5,747	5,862	109	1.9	224	4.0
65+	48,688	53,468	58,894	4,780	9.8	10,206	21.0
Total	54,326	59,216	64,755	4,890		10,429	

Table 47: Number of clients by age, 2014, and projected 2019 and 2024, Domestic Assistance

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019	% INCREASE TO 2019	INCREASE TO 2024	% INCREASE TO 2024
0–49	2,165	2,214	2,260	49	2.2	95	4.4
50–54	752	744	799	-8	-1.0	47	6.3
55–59	1,111	1,115	1,111	4	0.3	0	0.0
60–64	1,610	1,675	1,691	65	4.0	81	5.0
65–69	2,787	2,815	2,935	28	1.0	148	5.3
70–74	5,593	6,965	7,100	1,372	24.5	1,507	26.9
75–79	8,424	10,095	12,278	1,671	19.8	3,854	45.8
80–84	14,433	15,431	17,945	998	6.9	3,512	24.3
85+	17,451	18,163	18,635	712	4.1	1,184	6.8
0–64	5,638	5,747	5,862	109	1.9	224	4.0
65+	48,688	53,468	58,894	4,780	9.8	10,206	21.0
Total	54,326	59,216	64,755	4,890		10,429	

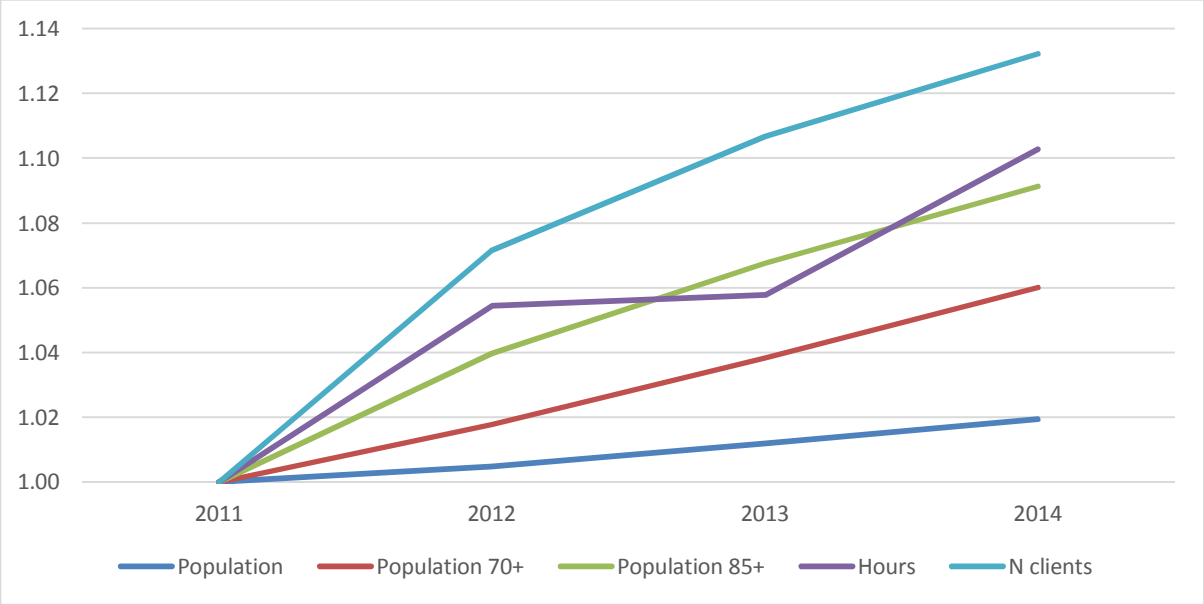
The figures in the following section of the report use growth curves to illustrate change from a pre-determined point—in this case, 2011. The numbers in the graph are ratios of the number for each year in comparison to the number in 2011. The purpose of constructing these figures is to test the assumption that changes in the population can be used to predict change in service demand.

The figure below illustrates growth curves for the years 2011 to 2014 for three populations and two measures of service demand. The population curves are for the whole Banyule population, the population aged 70 and over and the population aged 85 and over. The demand curves are for hours and numbers of clients.

This figure shows that increase in the population aged 85 years and over broadly correlated with change in the number of Domestic Assistance clients, but under-estimated the change in hours provided. Changes in the size of the population overall and the population aged 70 years and over were not closely related to change in demand for Domestic Assistance.

The conclusion is that growth in the population aged 85 years and over may drive change in the numbers of Domestic Assistance clients, but under-estimate the total number of hours of Domestic Assistance that may be required.

Figure 10: Growth curves for population and service provision: Domestic Assistance, 2011-2014



The numbers on which this figure is based are provided below:

Table 47b: Hours and number of clients, Domestic Assistance, 2011–2014

	2011	2012	2013	2014
Hours	49,263	51,940	52,108	54,326
N clients	1,647	1,765	1,823	1,865

The following table compares estimates of change in service provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of growth in Domestic Assistance result in much higher estimates of growth than estimates based on population growth only.

Table 47c: Projected service provision, Domestic Assistance, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
Hours	59,216	64,755	64,019	75,441	61,617	70,098
Clients	1,880	2,073	2,297	2,828	2,088	2,450
% increase in hours	9.0	19.2	17.8	38.9	13.4	29.0
% increase in clients	9.8	21.1	34.1	65.2	22.0	43.1

VOLUNTEER SOCIAL SUPPORT

Table 48: Service level by age, 2014, and projected 2019 and 2024, Volunteer Social Support

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	3,123	3,193	3,260	70	2.2	137	4.4
50–54	790	782	839	-8	-1.0	49	6.3
55–59	1,258	1,263	1,259	4	0.3	0	0.0
60–64	2,015	2,096	2,117	81	4.0	102	5.0
65–69	1,132	1,143	1,192	11	1.0	60	5.3
70–74	805	1,002	1,022	197	24.5	217	26.9
75–79	2,056	2,463	2,996	408	19.8	941	45.8
80–84	2,966	3,171	3,688	205	6.9	722	24.3
85+	5,152	5,362	5,502	210	4.1	350	6.8
0–64	7,186	7,333	7,474	147	2.1	289	4.0
65+	12,111	13,142	14,400	1,032	8.5	2,289	18.9
Total	19,296	20,476	21,874	1,179		2,578	

Table 49: Number of clients by age, 2014, and projected 2019 and 2024, Volunteer Social Support

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019	INCREASE TO 2019 %	INCREASE TO 2024	INCREASE TO 2024 %
0–49	51	52	53	1	2.2	2	4.4
50–54	9	9	10	-0	-1.0	1	6.3
55–59	11	11	11	0	0.3	0	0.0
60–64	21	22	22	1	4.0	1	5.0
65–69	13	13	14	0	1.0	1	5.3
70–74	21	26	27	5	24.5	6	26.9
75–79	37	44	54	7	19.8	17	45.8
80–84	52	56	65	4	6.9	13	24.3
85+	79	82	84	3	4.1	5	6.8
0–64	92	94	96	2	2.1	4	4.2
65+	202	221	243	19	9.6	41	20.4
Total	294	315	339	21		45	

The growth curves for provision of Volunteer Social Support bear little resemblance to those for change in the population. This suggests that factors other than change in population affect provision of Volunteer Social Support and that projections for demand for this service are not reliable.

Figure 11: Growth curves for population and service provision: Volunteer Social Support, 2011-2014

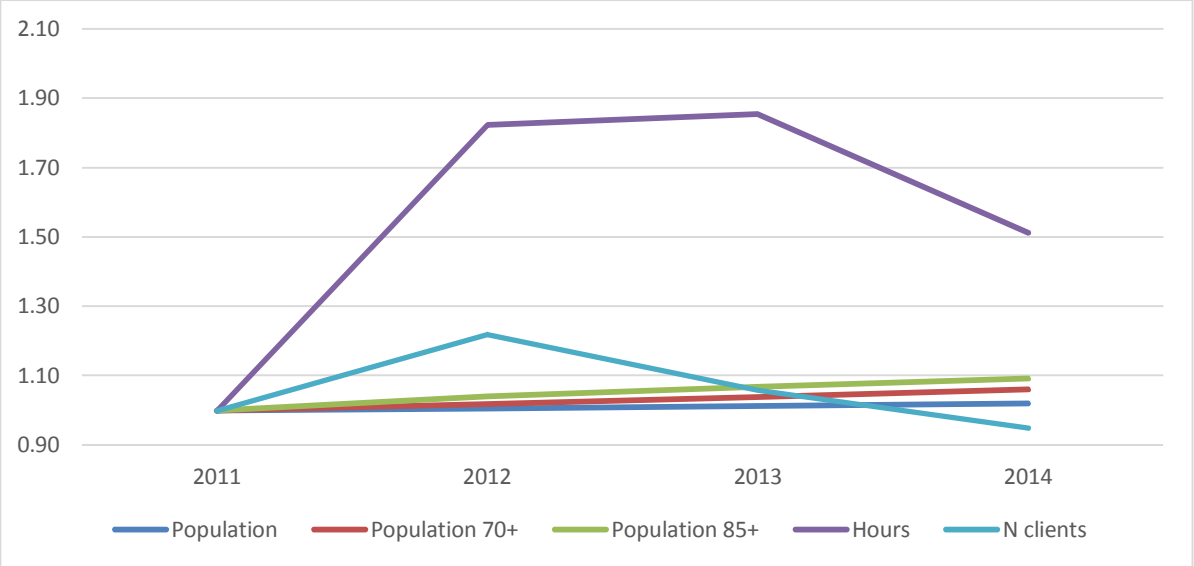


Table 49b: Hours and number of clients, Volunteer Social Support, 2011–2014

	2011	2012	2013	2014
Hours	12,754	23,260	23,647	19,296
N clients	310	378	328	294

The following table compares estimates of change in service provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of growth in Volunteer Social Support result in much higher estimates of growth in hours than estimates based on population growth only, but a decline in the number of clients.

Table 49c: Projected service provision, Volunteer Social Support, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
Hours	20,476	21,874	51,894	139,557	3,497	7,853
Clients	315	339	286	278	19,734	20,258
% increase in hours	6.1	18.9	168.9	623.2	87.5	321.1
% increase in clients	7.3	15.4	-2.7	-5.4	2.3	5.0

PERSONAL CARE

Table 50: Service level by age, 2014, and projected 2019 and 2024, Personal Care

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	1,890	1,932	1,973	42	2.2	83	4.4
50–54	660	654	702	-7	-1.0	41	6.3
55–59	3,740	3,753	3,742	13	0.3	1	0.0
60–64	2,327	2,421	2,444	94	4.0	117	5.0
65–69	1,517	1,532	1,598	15	1.0	80	5.3
70–74	2,550	3,175	3,237	626	24.5	687	26.9
75–79	2,466	2,955	3,594	489	19.8	1,128	45.8
80–84	4,320	4,619	5,371	299	6.9	1,051	24.3
85+	10,090	10,501	10,775	412	4.1	685	6.8
0–64	8,617	8,759	8,860	142	1.7	243	2.8
65+	20,942	22,782	24,574	1,840	8.8	3,632	17.3
Total	29,559	31,541	33,434	1,982		3,875	

Table 51: Number of clients by age, 2014, and projected 2019 and 2024, Personal Care

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	38	39	40	1	2.2	2	4.4
50–54	19	19	20	-0	-1.0	1	6.3
55–59	17	17	17	0	0.3	0	0.0
60–64	15	16	16	1	4.0	1	5.0
65–69	20	20	21	0	1.0	1	5.3
70–74	46	57	58	11	24.5	12	26.9
75–79	77	92	112	15	19.8	35	45.8
80–84	111	119	138	8	6.9	27	24.3
85+	261	272	279	11	4.1	18	6.8
0–64	89	90	93	1	1.5	4	4.1
65+	515	560	608	45	8.8	93	18.1
Total	604	650	701	46		97	

Growth curves for provision of Personal Care show that from 2011 to 2013 change in the number of clients paralleled growth in the population aged 85 years and over, while hours of Personal Care provided remained close to 2011 levels. This pattern changed abruptly in 2014, when the number of clients decreased but service hours increased. While growth in the population aged 85 years and may predict longer-term change in demand, it is not a reliable indicator on a year-to-year basis.

Figure 12: Growth curves for population and service provision: Personal Care, 2011-2014

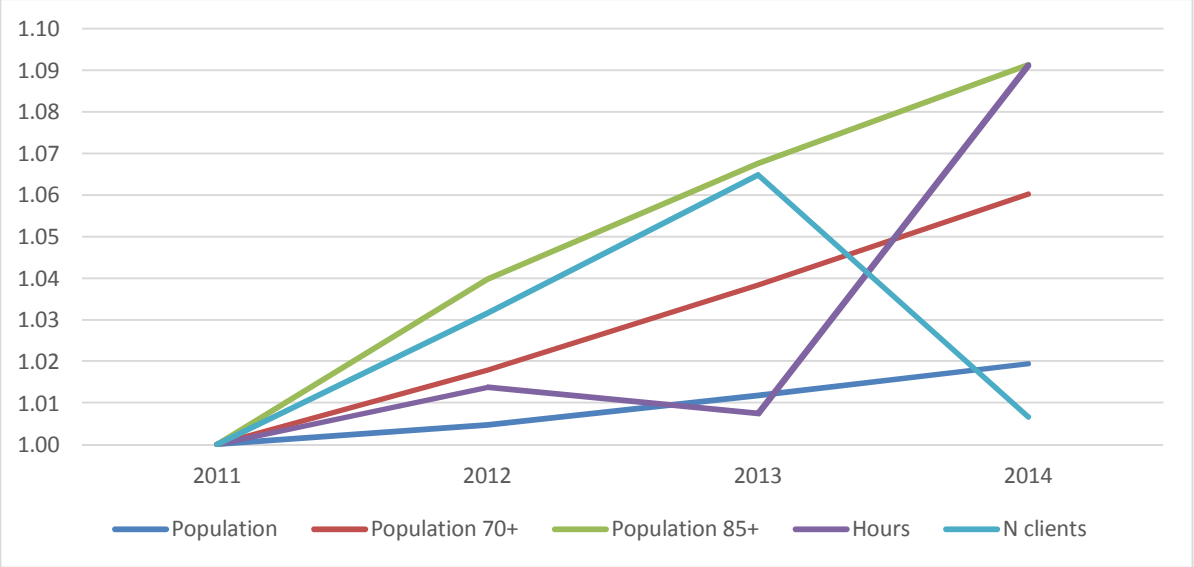


Table 51b: Hours and number of clients, Personal Care, 2011–2014

	2011	2012	2013	2014
Hours	27,088	27,463	27,291	29,560
N clients	601	620	640	605

The following table shows estimates of change in service provision based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent growth in Personal Care result in much higher estimates of hours than estimates based on population growth only, but lower estimates of client numbers.

Table 51c: Projected service provision, Personal Care, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
Hours	31,541	33,434	34,308	39,818	32,924	36,625
Clients	650	701	614	624	632	662
% increase in hours	6.7	13.1	16.1	34.7	11.4	23.9
% increase in clients	7.7	16.1	1.5	3.1	4.6	9.6

NURSING CARE

Table 52: Service level by age, 2014, and projected 2019 and 2024, Nursing

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	3,272	3,345	3,415	73	2.2	144	4.4
50–54	1,750	1,732	1,860	-18	-1.0	110	6.3
55–59	1,318	1,323	1,319	5	0.3	1	0.0
60–64	2,085	2,169	2,190	84	4.0	105	5.0
65–69	1,280	1,293	1,348	13	1.0	68	5.3
70–74	2,088	2,600	2,651	512	24.5	563	26.9
75–79	3,281	3,932	4,782	651	19.8	1,501	45.8
80–84	5,543	5,926	6,892	383	6.9	1,349	24.3
85+	10,679	11,115	11,404	436	4.1	725	6.8
0–64	8,425	8,568	8,784	144	1.7	359	4.3
65+	22,871	24,865	27,076	1,994	8.7	4,205	18.4
Total	31,296	33,434	35,860	2,138		4,564	

Table 53: Number of clients by age, 2014, and projected 2019 and 2024, Nursing

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	72	74	75	2	2.2	3	4.4
50–54	47	47	50	-0	-1.0	3	6.3
55–59	43	43	43	0	0.3	0	0.0
60–64	46	48	48	2	4.0	2	5.0
65–69	62	63	65	1	1.0	3	5.3
70–74	108	134	137	26	24.5	29	26.9
75–79	138	165	201	27	19.8	63	45.8
80–84	196	210	244	14	6.9	48	24.3
85+	411	428	439	17	4.1	28	6.8
0–64	208	211	216	3	1.5	8	4.1
65+	915	1,000	1,086	85	9.3	171	18.7
Total	1,123	1,211	1,303	88		180	

The growth curves for Nursing Care indicate that numbers of hours and clients have declined in Banyule from 2011 to 2014, despite growth in the population and in older age groups. Projections of demand based on changes in population are likely to be misleading in the case of Nursing Care.

Figure 13: Growth curves for population and service provision: Nursing Care, 2011-2014

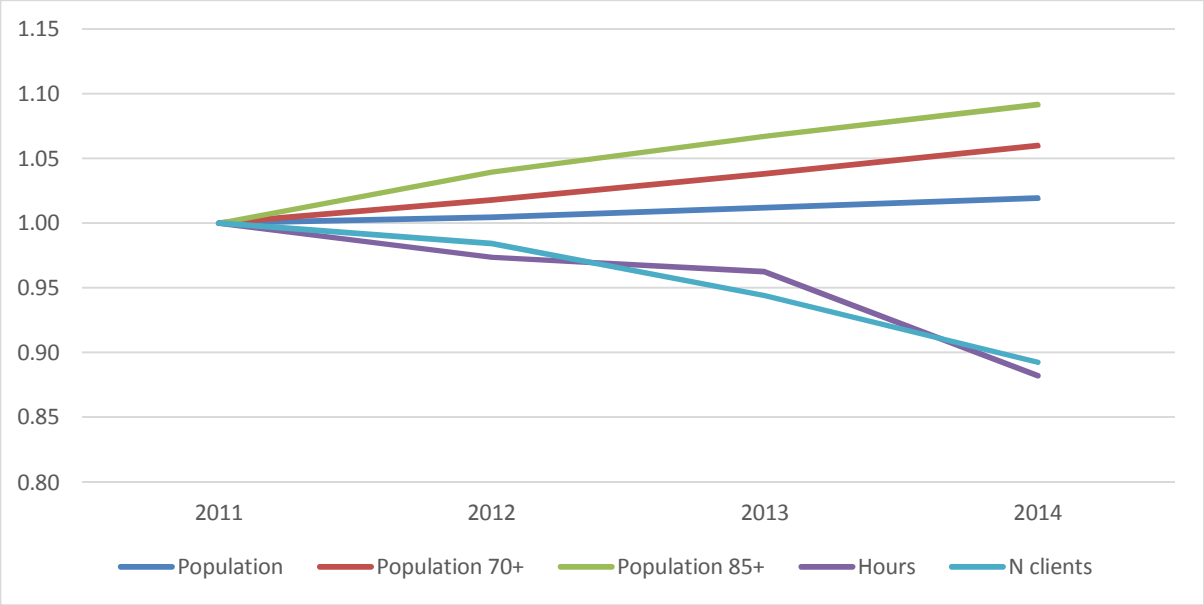


Table 53b: Hours and number of clients, Nursing Care, 2011–2014

	2011	2012	2013	2014
Hours	35,493	34,566	34,159	31,310
N clients	1,259	1,239	1,189	1,124

The following table compares estimates of change in Nursing Care provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in Nursing Care result in further decreases in both hours and client numbers, in contrast with estimates based on population growth.

Table 53c: Projected service provision, Nursing Care, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
Hours	33,434	35,860	25,471	20,721	29,446	28,286
Clients	1,211	1,303	931	771	1,071	1,037
% increase in hours	6.8	14.6	-18.6	-33.8	-5.9	-9.6
% increase in clients	7.8	16.0	-17.2	-31.4	-4.7	-7.7

ALLIED HEALTH

Table 54: Service level by age, 2014, and projected 2019 and 2024, Allied Health

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	3,087	3,156	3,222	69	2.2	136	4.4
50–54	1,508	1,492	1,602	-16	-1.0	94	6.3
55–59	1,513	1,518	1,513	5	0.3	1	0.0
60–64	1,547	1,609	1,625	62	4.0	78	5.0
65–69	2,050	2,070	2,158	20	1.0	109	5.3
70–74	3,043	3,790	3,863	747	24.5	820	26.9
75–79	3,193	3,826	4,653	633	19.8	1,461	45.8
80–84	4,291	4,588	5,336	297	6.9	1,044	24.3
85+	4,114	4,282	4,393	168	4.1	279	6.8
0–64	7,654	7,775	7,962	121	1.6	309	4.0
65+	16,691	18,555	20,404	1,865	11.2	3,713	22.2
Total	24,345	26,330	28,366	1,986		4,021	

Table 55: Number of clients by age, 2014, and projected 2019 and 2024, Allied Health

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	423	433	442	10	2.2	19	4.4
50–54	143	141	152	-2	-1.0	9	6.3
55–59	171	172	171	1	0.3	0	0.0
60–64	185	192	194	7	4.0	9	5.0
65–69	294	297	310	3	1.0	16	5.3
70–74	398	496	505	98	24.5	107	26.9
75–79	490	587	714	97	19.8	224	45.8
80–84	536	573	666	37	6.9	130	24.3
85+	613	638	655	25	4.1	42	6.8
0–64	922	938	959	16	1.7	37	4.0
65+	2,331	2,591	2,850	260	11.1	519	22.3
Total	3,253	3,529	3,809	276		556	

Changes in provision of Allied Health—both hours and clients—outstripped changes in the population. Increases in demand for Allied Health may reflect policy, such as the Active Service Model, that encourage the use of restorative services in HACC. The figure below indicates that further changes in population may under-estimate growth in demand for Allied Health in the future.

Figure 14: Growth curves for population and service provision: Allied Health, 2011-2014

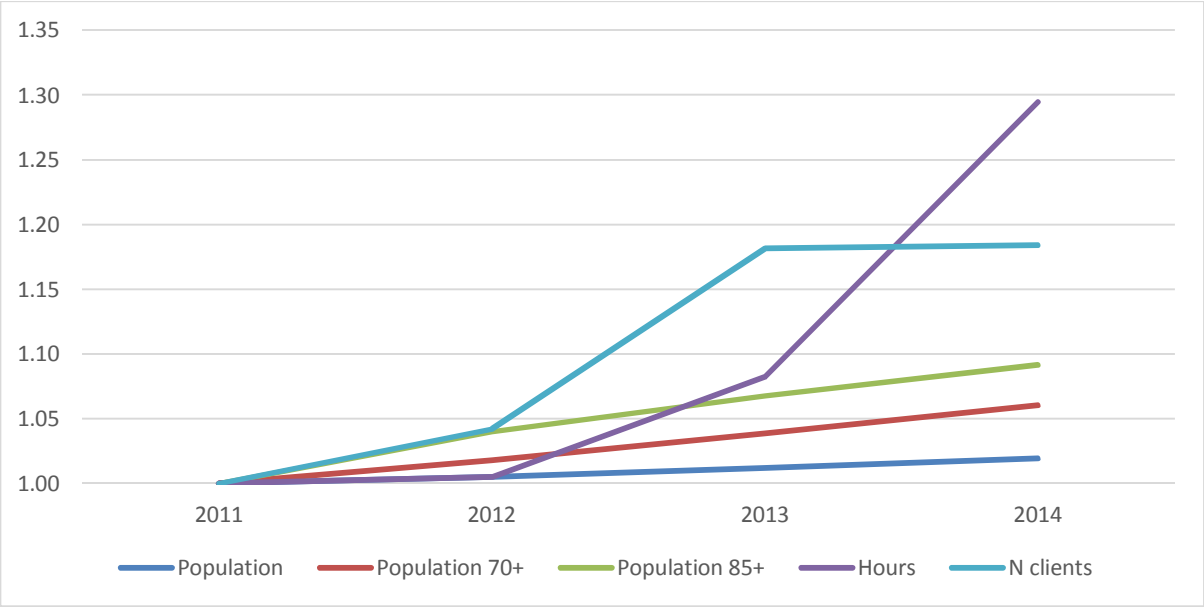


Table 55b: Hours and number of clients, Allied Health, 2011–2014

	2011	2012	2013	2014
Hours	18,820	18,908	20,376	24,371
N clients	2,752	2,867	3,251	3,258

The following table compares estimates of change in Allied Health provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in Allied Health result in much sharper increases in both hours and client numbers than estimates based on population growth.

Table 55c: Projected service provision, Allied Health, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
Hours	26,330	28,366	37,982	59,194	32,135	43,748
Clients	3,529	3,809	4,345	5,796	3,934	4,798
% increase in hours	8.2	16.5	55.8	142.9	32.0	79.7
% increase in clients	8.5	17.1	33.4	77.9	20.9	47.5

PLANNED ACTIVITY GROUP (PAG)

Table 56: Service level by age, 2014, and projected 2019 and 2024, PAG

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	7,941	8,119	8,290	178	2.2	349	4.4
50–54	1,975	1,954	2,099	-21	-1.0	124	6.3
55–59	3,842	3,855	3,843	13	0.3	1	0.0
60–64	4,792	4,986	5,034	193	4.0	242	5.0
65–69	6,574	6,640	6,923	65	1.0	349	5.3
70–74	8,586	10,692	10,899	2,107	24.5	2,313	26.9
75–79	12,438	14,905	18,129	2,467	19.8	5,691	45.8
80–84	18,451	19,726	22,941	1,275	6.9	4,490	24.3
85+	35,729	37,186	38,154	1,457	4.1	2,425	6.8
0–64	18,550	18,914	19,266	364	2.0	716	3.9
65+	81,779	89,150	97,046	7,372	9.0	15,268	18.7
Total	100,329	108,065	116,312	7,736		15,983	

Table 57: Number of clients by age, 2014, and projected 2019 and 2024, PAG

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	110	112	115	2	2.2	5	4.4
50–54	31	31	33	-0	-1.0	2	6.3
55–59	58	58	58	0	0.3	0	0.0
60–64	38	40	40	2	4.0	2	5.0
65–69	37	37	39	0	1.0	2	5.3
70–74	85	106	108	21	24.5	23	26.9
75–79	114	137	166	23	19.8	52	45.8
80–84	132	141	164	9	6.9	32	24.3
85+	203	211	217	8	4.1	14	6.8
0–64	237	241	246	4	1.6	9	3.7
65+	571	632	694	61	10.7	123	21.5
Total	808	873	940	65		132	

The growth curves for Planned Activity Group (PAG) hours and numbers of clients show slow growth from 2011 to 2012, a spike to 2013, and reduction to 2014. The pattern over time has been broadly consistent with increases in the populations aged 70+ years 85+ years, but more erratic. Projections for demand of PAGs in HACC may not be reliable on a year-to-year basis, though some growth may be anticipated.

Figure 15: Growth curves for population and service provision: Planned Activity Groups, 2011-2014

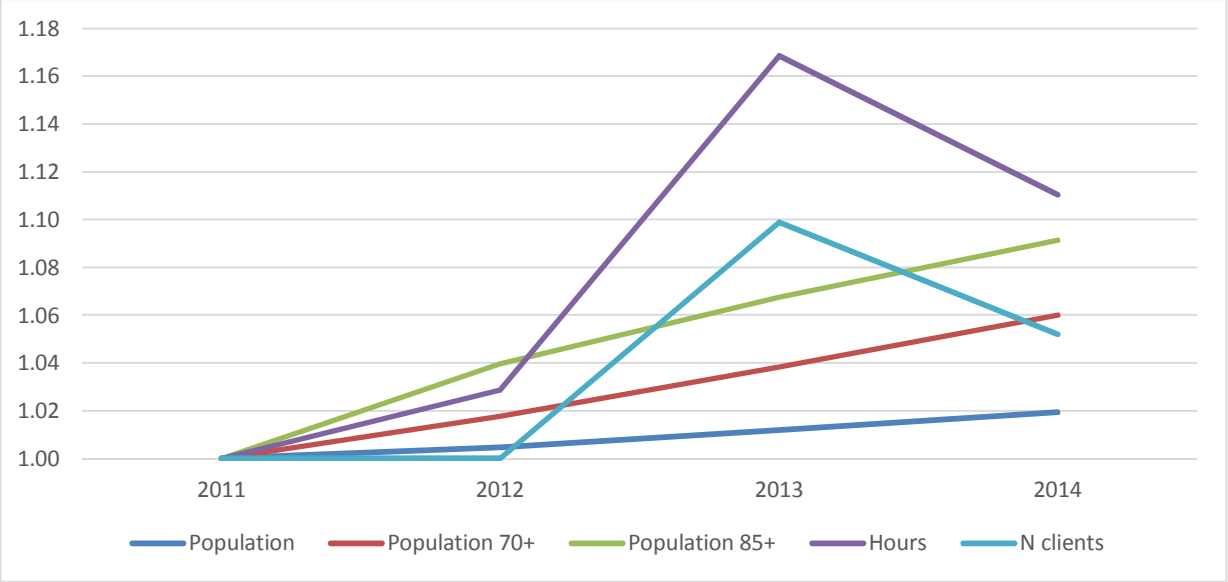


Table 57b: Hours and number of clients, Planned Activity Group, 2011–2014

	2011	2012	2013	2014
Hours	90,346	92,942	105,582	100,329
N clients	768	768	844	808

The following table compares estimates of change in PAG provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in PAGs result in much sharper increases in both hours and client numbers than estimates based on population growth alone.

Table 57c: Projected service provision, Planned Activity Groups, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
Hours	108,065	116,312	121,086	146,137	114,575	131,225
Clients	873	940	887	973	880	956
% increase in hours	7.7	15.9	20.7	45.7	14.2	30.8
% increase in clients	8.1	16.3	9.7	20.4	8.9	18.4

DELIVERED MEALS

Table 58: Service level (N meals) by age, 2014, and projected 2019 and 2024, Delivered Meals

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	2,427	2,482	2,534	55	2.2	107	4.4
50–54	1,497	1,481	1,591	-16	-1.0	94	6.3
55–59	1,611	1,617	1,612	6	0.3	1	0.0
60–64	898	934	943	36	4.0	45	5.0
65–69	3,016	3,046	3,176	30	1.0	160	5.3
70–74	4,169	5,192	5,292	1,023	24.5	1,123	26.9
75–79	6,437	7,714	9,382	1,277	19.8	2,945	45.8
80–84	11,017	11,778	13,698	761	6.9	2,681	24.3
85+	25,061	26,083	26,762	1,022	4.1	1,701	6.8
0–64	6,433	6,514	6,679	81	1.3	246	3.8
65+	49,700	53,813	58,310	4,113	8.3	8,610	17.3
Total	56,133	60,327	64,989	4,194		8,856	

Table 59: Number of clients by age, 2014, and projected 2019 and 2024, Delivered Meals

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	18	18	19	0	2.2	1	4.4
50–54	9	9	10	-0	-1.0	1	6.3
55–59	12	12	12	0	0.3	0	0.0
60–64	12	12	13	0	4.0	1	5.0
65–69	21	21	22	0	1.0	1	5.3
70–74	43	54	55	11	24.5	12	26.9
75–79	76	91	111	15	19.8	35	45.8
80–84	120	128	149	8	6.9	29	24.3
85+	291	303	311	12	4.1	20	6.8
0–64	51	52	53	1	1.6	2	3.9
65+	551	597	647	46	8.3	96	17.5
Total	602	649	700	47		98	

Despite steady increases in the target population, the provision of delivered meals dropped sharply between 2011 and 2014, both in terms of clients and number of meals. In the case of Delivered Meals, further increases in population may well not predict demand for the service.

Figure 16: Growth curves for population and service provision: Delivered Meals, 2011-2014

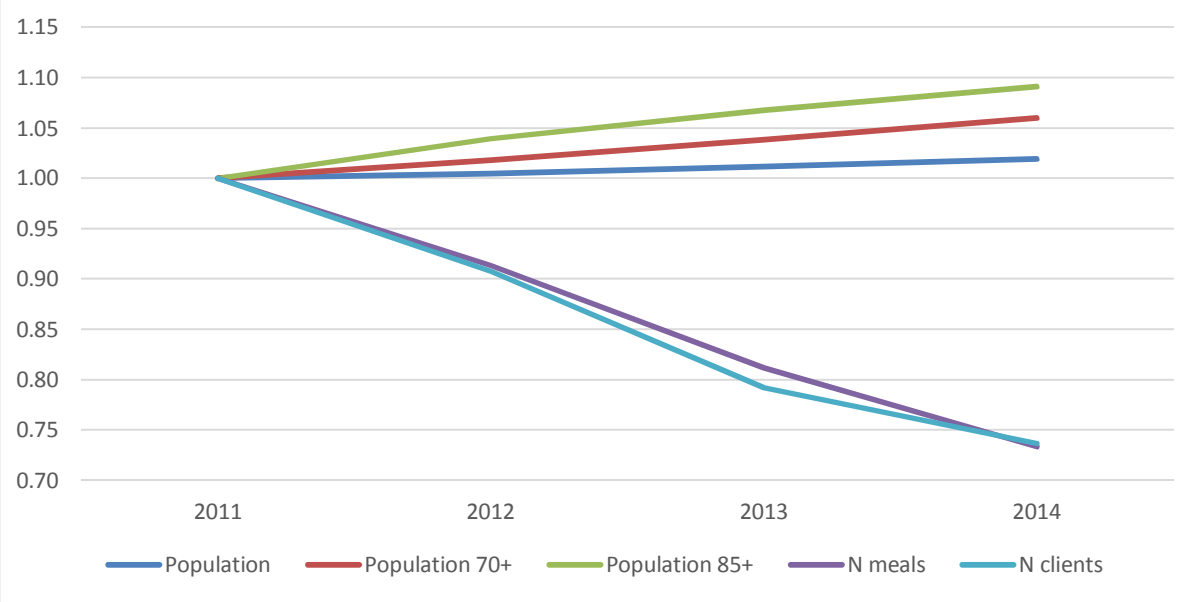


Table 59b: Meals and number of clients, Delivered Meals, 2011–2014

	2011	2012	2013	2014
N meals	76,522	69,911	62,108	56,133
N clients	817	742	647	602

The following table compares estimates of change in Delivered Meals provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in Delivered Meals result in decreases in both hours and client numbers, rather increases based on population growth alone.

Table 59c: Projected service provision, Delivered Meals, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
N meals	60,327	64,989	33,503	19,996	46,915	42,493
N clients	649	700	363	218	506	459
% increase in hours	7.5	15.8	-40.3	-64.4	-16.4	-24.3
% increase in clients	7.8	16.3	-39.8	-63.7	-16.0	-23.7

RESPITE

Table 60: Service level by age, 2014, and projected 2019 and 2024, Respite

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	11,309	11,563	11,806	254	2.2	497	4.4
50–54	817	808	868	-9	-1.0	51	6.3
55–59	525	527	525	2	0.3	0	0.0
60–64	720	749	756	29	4.0	36	5.0
65–69	571	577	601	6	1.0	30	5.3
70–74	783	975	994	192	24.5	211	26.9
75–79	1,389	1,665	2,025	276	19.8	636	45.8
80–84	1,271	1,359	1,580	88	6.9	309	24.3
85+	2,438	2,537	2,603	99	4.1	165	6.8
0–64	13,371	13,647	13,956	276	2.1	585	4.4
65+	6,452	7,113	7,804	661	10.2	1,352	20.9
Total	19,823	20,760	21,759	937		1,936	

Table 61: Number of clients by age, 2014, and projected 2019 and 2024, Respite

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	106	108	111	2	2.2	5	4.4
50–54	6	6	6	-0	-1.0	0	6.3
55–59	5	5	5	0	0.3	0	0.0
60–64	7	7	7	0	4.0	0	5.0
65–69	10	10	11	0	1.0	1	5.3
70–74	14	17	18	3	24.5	4	26.9
75–79	11	13	16	2	19.8	5	45.8
80–84	22	24	27	2	6.9	5	24.3
85+	50	52	53	2	4.1	3	6.8
0–64	124	127	129	3	2.1	5	4.3
65+	107	116	125	9	8.7	18	16.9
Total	231	243	254	12		23	

Provision of Respite in Banyule has not followed population growth curves. The number of clients increased from 2011 to 2013, but dropped suddenly in 2014 to before-2011 levels. The number of hours provided increased in line with the population aged 85 years and over from 2011 to 2012, but has been dropping since then; in 2014 hours provided were below 2011 levels. Increases in population are not likely to be reliable predictors of use of Respite in HACC.

Figure 17: Growth curves for population and service provision: Respite, 2011-2014

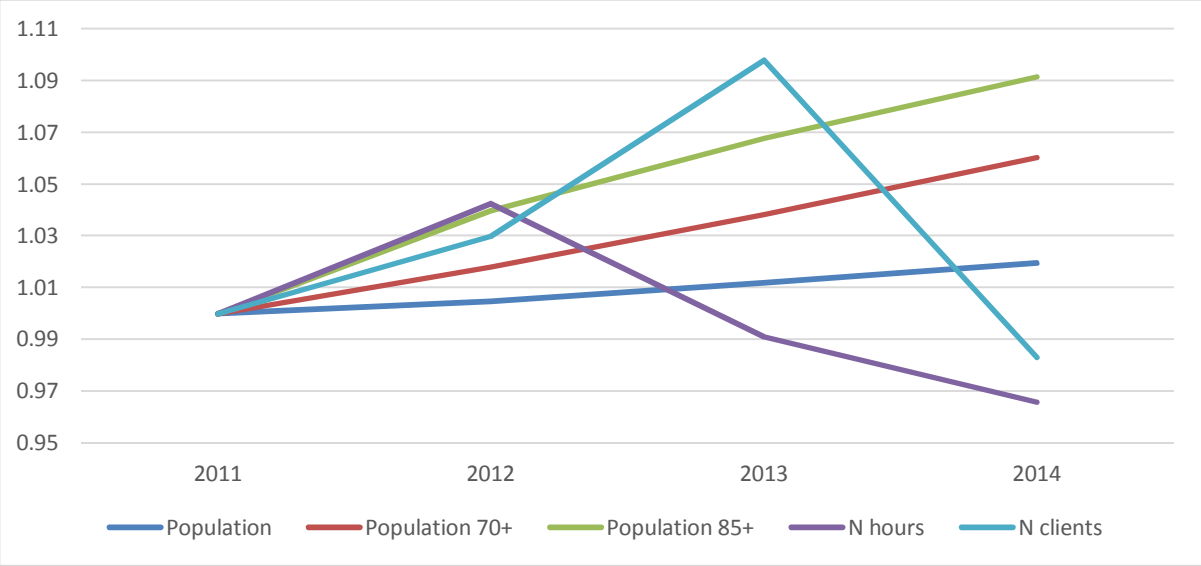


Table 61b: Hours and number of clients, Respite, 2011–2014

	2011	2012	2013	2014
Hours	20,525	21,395	20,342	19,823
N clients	235	242	258	231

The following table compares estimates of change in Respite provision to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in Respite result in decreases in both hours and client numbers, rather than increases predicted by population growth.

Table 61c: Projected service provision, Respite, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
N hours	20,760	21,759	18,777	17,786	19,769	19,773
N clients	243	254	228	224	235	239
% increase in hours	4.7	9.8	-5.3	-10.3	-0.3	-0.3
% increase in clients	5.1	10.2	-1.4	-2.9	1.8	3.6

ASSESSMENT

Table 62: Service level by age, 2014, and projected 2019 and 2024, Assessment

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	556	569	580	12	2.2	24	4.4
50–54	240	237	255	-3	-1.0	15	6.3
55–59	301	302	301	1	0.3	0	0.0
60–64	316	329	332	13	4.0	16	5.0
65–69	524	530	552	5	1.0	28	5.3
70–74	938	1,168	1,190	230	24.5	253	26.9
75–79	1,233	1,477	1,796	244	19.8	564	45.8
80–84	1,972	2,108	2,451	136	6.9	480	24.3
85+	2,636	2,743	2,815	107	4.1	179	6.8
0–64	1,413	1,436	1,468	24	1.7	55	3.9
65+	7,302	8,025	8,805	724	9.9	1,503	20.6
Total	8,714	9,462	10,273	747		1,559	

Table 63: Number of clients by age, 2014, and projected 2019 and 2024, Assessment

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	144	147	150	3	2.2	6	4.4
50–54	58	57	62	-1	-1.0	4	6.3
55–59	61	61	61	0	0.3	0	0.0
60–64	75	78	79	3	4.0	4	5.0
65–69	139	140	146	1	1.0	7	5.3
70–74	255	318	324	63	24.5	69	26.9
75–79	333	399	485	66	19.8	152	45.8
80–84	537	574	668	37	6.9	131	24.3
85+	713	742	761	29	4.1	48	6.8
0–64	338	344	352	6	1.7	14	4.1
65+	1,977	2,173	2,385	196	9.9	408	20.6
Total	2,315	2,517	2,736	202		421	

Provision of HACC assessment in Banyule grew from 2011 to 2014, but not in line with population growth curves. Provision of assessment, especially hours, grew dramatically from 2011 to 2013, but has since contracted. Over time, demand for HACC assessment is likely to grow, more or less in line with the size of the population aged 85 years and over, but there may be unpredictable shifts in demand from year to year.

Figure 18: Growth curves for population and service provision: Assessment, 2011-2014

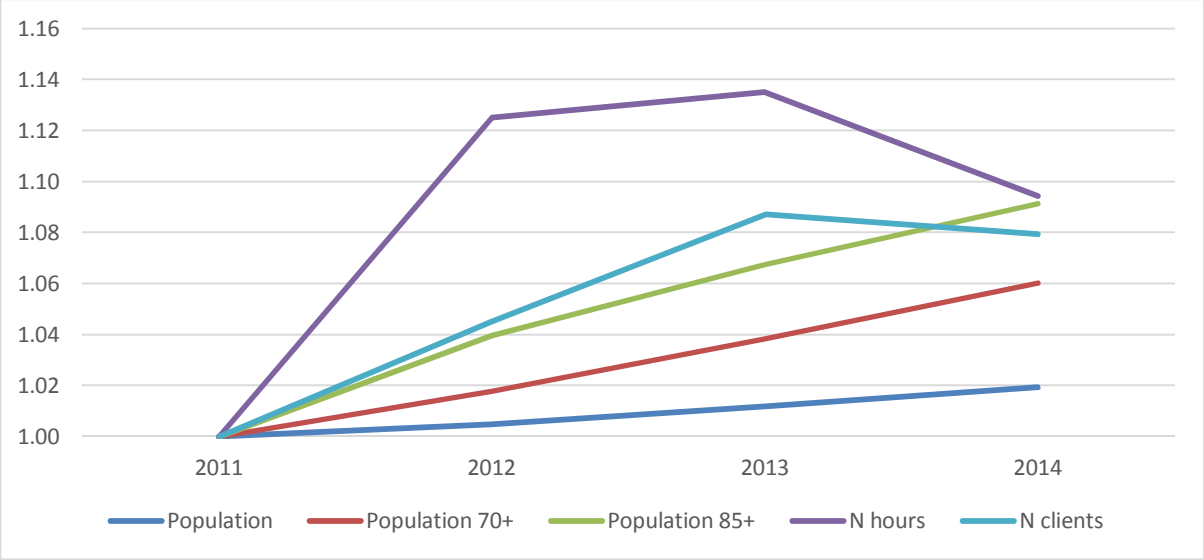


Table 63b: Hours and number of clients, Assessment, 2011–2014

	2011	2012	2013	2014
Hours	7,964	8,960	9,041	8,716
N clients	2,146	2,243	2,333	2,316

The following table compares estimates of change in Assessment to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in Assessment result much sharper increases in both hours and client numbers than estimates based on population growth alone.

Table 63c: Projected service provision, Assessment, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
N hours	9,462	10,273	10,239	12,027	9,849	11,148
N clients	2,517	2,736	2,633	2,994	2,575	2,865
% increase in hours	8.6	17.9	17.5	38.0	13.0	27.9
% increase in clients	8.7	18.2	13.7	29.3	11.2	23.7

CASE MANAGEMENT (LINKAGES)

Table 64: Service level by age, 2014, and projected 2019 and 2024, Case Management

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	850	869	887	19	2.2	37	4.4
50–54	339	335	360	-4	-1.0	21	6.3
55–59	245	246	245	1	0.3	0	0.0
60–64	284	295	298	11	4.0	14	5.0
65–69	325	328	342	3	1.0	17	5.3
70–74	273	339	346	67	24.5	73	26.9
75–79	302	362	440	60	19.8	138	45.8
80–84	288	308	358	20	6.9	70	24.3
85+	638	664	681	26	4.1	43	6.8
0–64	1,718	1,746	1,791	28	1.6	73	4.2
65+	1,826	2,001	2,168	176	9.6	342	18.7
Total	3,544	3,747	3,959	204		415	

Table 65: Number of clients by age, 2014, and projected 2019 and 2024, Case Management

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	13	13	14	0	2.2	1	4.4
50–54	6	6	6	-0	-1.0	0	6.3
55–59	7	7	7	0	0.3	0	0.0
60–64	10	10	11	0	4.0	1	5.0
65–69	7	7	7	0	1.0	0	5.3
70–74	8	10	10	2	24.5	2	26.9
75–79	10	12	15	2	19.8	5	45.8
80–84	16	17	20	1	6.9	4	24.3
85+	26	27	28	1	4.1	2	6.8
0–64	36	37	37	1	1.8	1	4.0
65+	67	73	80	6	9.2	13	19.0
Total	103	110	117	7		14	

Predictability of use of a relatively small, "bounded" program, such as Case Management (Linkages), may well be relatively low, and usage may not respond to changes in the population. This is the case for Case Management. Overall, there has been little change in the number of clients or hours provided in the Case Management program, despite growth in the population.

Figure 19: Growth curves for population and service provision: Case Management, 2011-2014

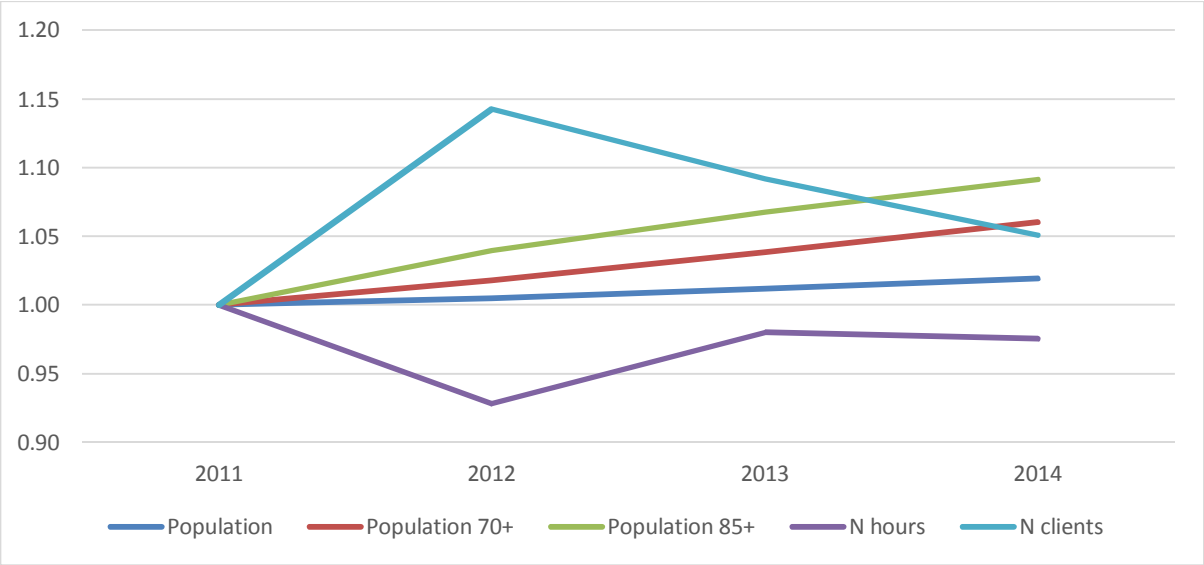


Table 65b: Hours and number of clients, Case Management, 2011–2014

	2011	2012	2013	2014
Hours	3,634	3,373	3,562	3,544
N clients	98	112	107	103

The following table compares estimates of change in Case Management to 2019 and 2025 based on (a) population growth only, (b) change from 2011 to 2014 only, and (c) a "compromise" solution. Estimates of future provision based on recent change in Case Management result in decreases in hours but increases in client numbers, in contrast with projected increases in both hours and clients based on population growth.

Table 65c: Projected service provision, Case Management, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
N hours	3,747	3,959	3,422	3,305	3,585	3,632
N clients	110	117	114	126	112	122
% increase in hours	5.7	11.7	-3.4	-6.7	1.2	2.5
% increase in clients	6.6	13.8	10.6	22.2	8.6	18.0

CARE COORDINATION

Table 66: Service level by age, 2014, and projected 2019 and 2024, Care Coordination

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	98	100	102	2	2.2	4	4.4
50–54	26	25	27	-0	-1.0	2	6.3
55–59	134	135	134	0	0.3	0	0.0
60–64	118	122	124	5	4.0	6	5.0
65–69	134	136	141	1	1.0	7	5.3
70–74	357	444	453	88	24.5	96	26.9
75–79	373	446	543	74	19.8	170	45.8
80–84	418	446	519	29	6.9	102	24.3
85+	788	821	842	32	4.1	54	6.8
0–64	375	382	387	7	1.9	12	3.2
65+	2,070	2,293	2,498	224	10.8	429	20.7
Total	2,445	2,675	2,885	231		441	

Table 67: Number of clients by age, 2014, and projected 2019 and 2024, Care Coordination

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	51	52	53	1	2.2	2	4.4
50–54	10	10	11	-0	-1.0	1	6.3
55–59	19	19	19	0	0.3	0	0.0
60–64	22	23	23	1	4.0	1	5.0
65–69	32	32	34	0	1.0	2	5.3
70–74	54	67	69	13	24.5	15	26.9
75–79	82	98	120	16	19.8	38	45.8
80–84	119	127	148	8	6.9	29	24.3
85+	172	179	184	7	4.1	12	6.8
0–64	102	104	106	2	2.0	4	3.9
65+	459	504	553	45	9.8	94	20.6
Total	561	608	659	47		98	

Growth curves for change in Care Coordination from 2011 to 2014 do not follow population growth curves. While provision of hours of Care Coordination changed very little over this time, the number of clients identified as receiving Care Coordination trebled between 2011 and 2012–2013, and then grew again in 2014. The degree to which changes in the data reflect real changes in service provision is unknown, and future projections for demand based on population growth may not be reliable.

Figure 20: Growth curves for population and service provision: Care Coordination, 2011-2014

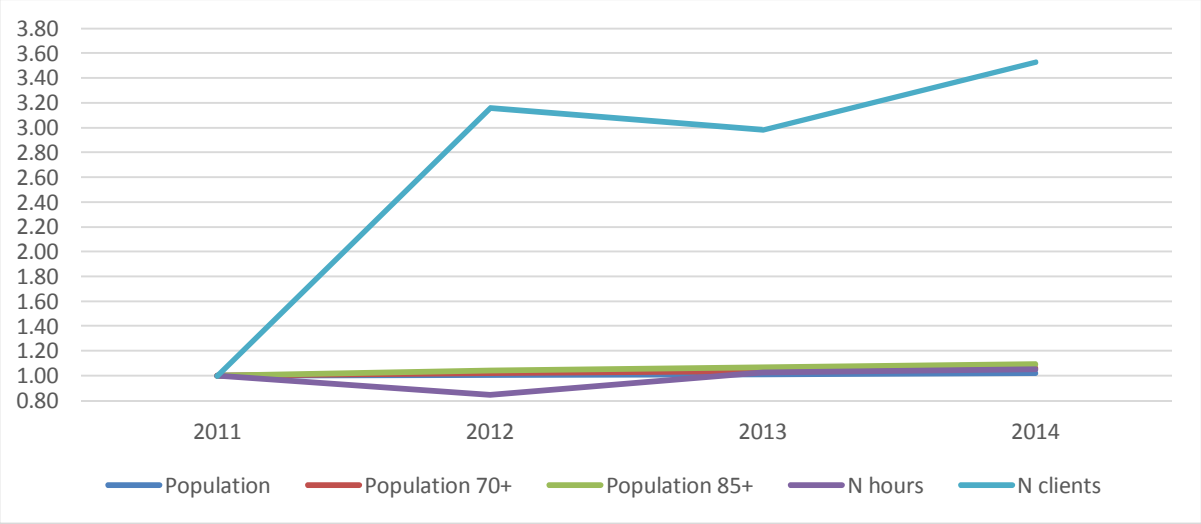


Table 67b: Hours and number of clients, Care Coordination, 2011–2014

	2011	2012	2013	2014
Hours	2,325	1,967	2,384	2,445
N clients	159	502	474	561

The following table compares estimates of change in Care Coordination to 2019 and 2025 based on (a) population growth only, (b) change from 2012 to 2014 (2011 was ignored in this case), and (c) a "compromise" solution. Estimates of future provision based on recent rates of change in Care Coordination result in sharper increases in hours and client numbers than estimates based on population growth alone.

Table 67c: Projected service provision, Care Coordination, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
N hours	2,675	2,885	2,805	3,218	2,740	3,052
N clients	608	659	765	1,042	686	851
% increase in hours	9.4	18.0	14.7	31.6	12.1	24.8
% increase in clients	8.4	17.5	36.3	85.8	22.3	51.6

PROPERTY MAINTENANCE

Table 68: Service level by age, 2014, and projected 2019 and 2024, Property Maintenance

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	232	237	242	5	2.2	10	4.4
50–54	82	81	87	-1	-1.0	5	6.3
55–59	719	721	719	2	0.3	0	0.0
60–64	337	351	354	14	4.0	17	5.0
65–69	394	398	415	4	1.0	21	5.3
70–74	811	1,010	1,030	199	24.5	219	26.9
75–79	1,037	1,243	1,511	206	19.8	474	45.8
80–84	1,842	1,969	2,290	127	6.9	448	24.3
85+	788	821	842	32	4.1	54	6.8
0–64	1,370	1,390	1,403	20	1.5	33	2.4
65+	4,872	5,440	6,088	568	11.7	1,216	24.9
Total	6,242	6,831	7,491	588		1,248	

Table 69a: Number of clients by age, 2014, and projected 2019 and 2024, Property Maintenance

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	30	31	31	1	2.2	1	4.4
50–54	17	17	18	-0	-1.0	1	6.3
55–59	27	27	27	0	0.3	0	0.0
60–64	38	40	40	2	4.0	2	5.0
65–69	73	74	77	1	1.0	4	5.3
70–74	147	183	187	36	24.5	40	26.9
75–79	232	278	338	46	19.8	106	45.8
80-84	288	308	358	20	6.9	70	24.3
85+	172	179	184	7	4.1	12	6.8
0–64	112	114	116	2	1.9	4	3.8
65+	912	1,022	1,143	110	12.0	231	25.4
Total	1,024	1,136	1,260	112		236	

The growth curves in service use for Property Maintenance are steeper than those for the population aged 80 years and over as far as hours are concerned, but the number of clients has fallen since 2011. Projected growth in Property Maintenance based on changes in the population are unlikely to be reliable.

Figure 21: Growth curves for population and service provision: Property Maintenance, 2011-2014

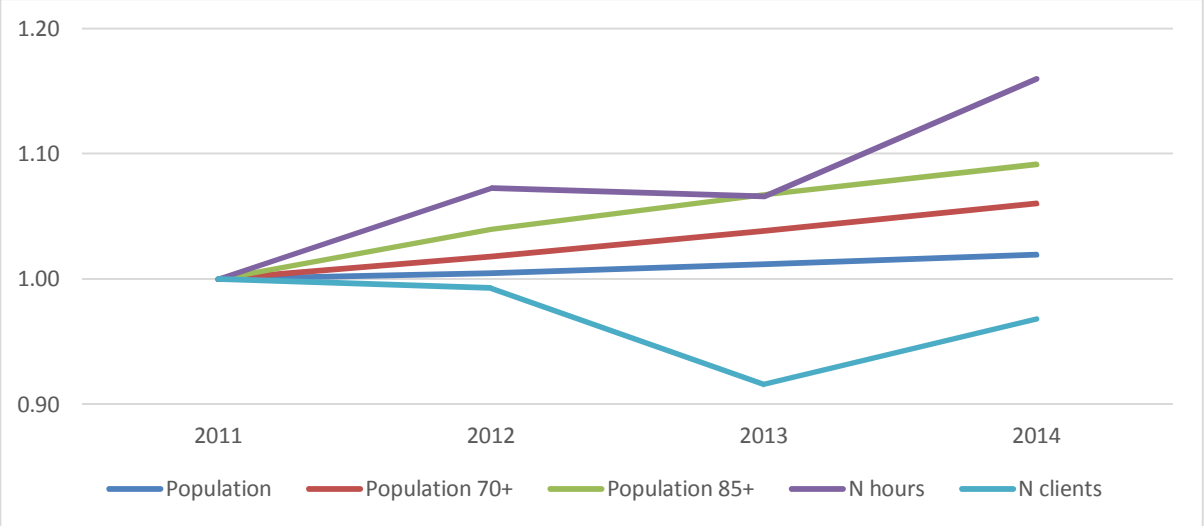


Table 69b: Hours and number of clients, Property Maintenance, 2011–2014

	2011	2012	2013	2014
Hours	5,838	6,264	6,225	6,773
N clients	1,234	1,225	1,131	1,195

The following table compares estimates of change in Property Maintenance to 2019 and 2025 based on (a) population growth only, (b) change from 2012 to 2014, and (c) a "compromise" solution. Estimates of future provision based on recent change in Property Maintenance result in sharper increases in hours but a decrease in client numbers, in contrast with projected increases based on population growth alone.

Table 69c: Projected service provision, Property Maintenance, 2019 and 2015 (three methods)

	ESTIMATES BASED ON GROWTH IN POPULATION		ESTIMATES BASED ON GROWTH IN SERVICES 2011–2014		COMPROMISE ESTIMATES	
	2019	2024	2019	2024	2019	2024
N hours	6,831	7,491	8,710	11,201	7,429	8,907
N clients	1,136	1,260	1,141	1,090	1,057	1,097
% increase in hours	9.4	20.0	28.6	65.4	19.0	42.7
% increase in clients	10.9	23.0	-4.5	-8.8	3.2	7.1

HACC client-to-population ratio by suburb

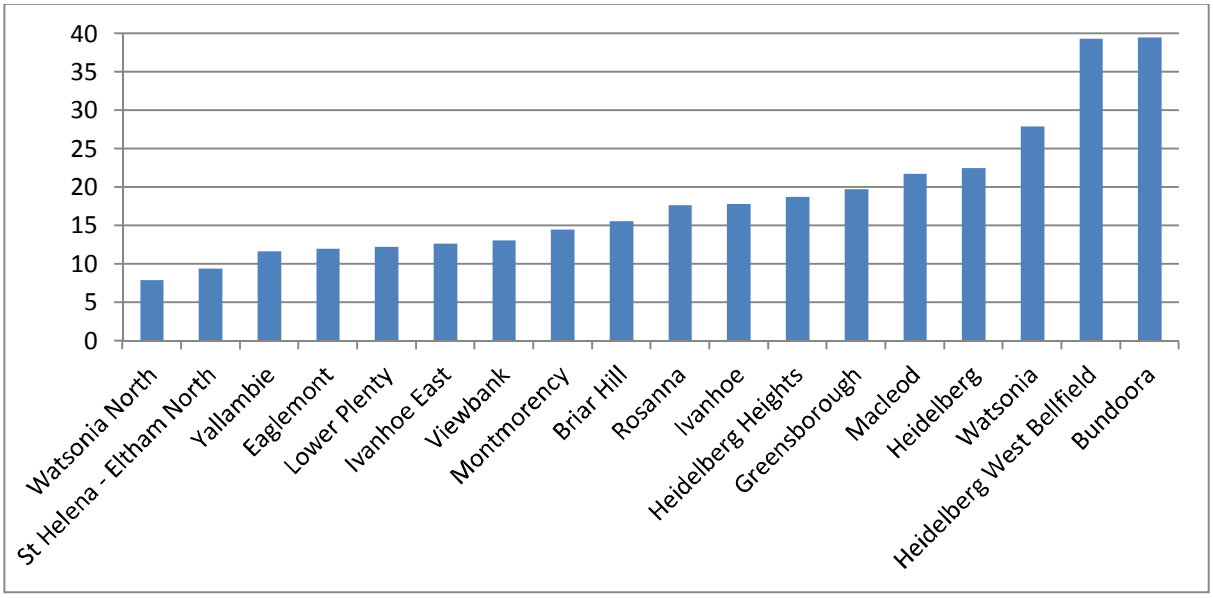
In this report, we have chosen not to attempt to predict future demand for services by suburb, given the volatility in any demand projections at an LGA level.

However, it is worth comparing HACC service provision by suburb. The following figure and table were compiled for each suburb from the number of HACC clients aged 60 and over and the population aged 60 and over. The number of clients was divided by the population to provide a ratio of number of clients per 100 people aged 60 and over in each suburb. The graph orders the suburbs from those with the highest client-to-population ratio to those with the lowest. This shows much higher service densities in some suburbs than others.

Service densities varied a great deal over the Banyule region. In Bundoora and Heidelberg West/Bellfield, almost 40% of people aged over 60 were provided with a service, whereas this was true for less than 10% of those living in St Helena/Eltham North and Watsonia North.[12]

A high proportion of the population receiving services would be expected in suburbs where older people have poorer health and are less able to pay for private services. (Issues with the accuracy of these estimates may be caused by allocation of localities and postcodes to Local Government Areas within the HACC MDS.)

Figure 22: Client-to-population ratio by suburb for people aged 60 and over



[12] One problem is that suburb boundaries do not coincide with LAG boundaries. A further 839 people live in the suburb of Greensborough. Including these in the population would reduce client-to-population ratio to 16.0.

Table 70: Client-to-population ratio, 2014, by suburb

SUBURB	POPULATION AGED 60 AND OVER N	CLIENTS AGED 60 AND OVER N	CLIENT-TO-CLIENT-TO POPULATION RATIO %
Briar Hill	685	107	15.6
Bundoora	2,488	984	39.5
Eaglemont	902	108	12.0
Greensborough	3,593	711	19.8
Heidelberg	1,237	278	22.5
Heidelberg Heights	1,379	259	18.8
Heidelberg West/Bellfield	1,359	535	39.4
Ivanhoe	2,336	417	17.9
Ivanhoe East	894	113	12.6
Lower Plenty	1,042	128	12.3
Macleod	1,942	423	21.8
Montmorency	2,030	294	14.5
Rosanna	2,321	411	17.7
St Helena/Eltham North	1,012	95	9.4
Viewbank	1,770	231	13.1
Watsonia	1,073	300	28.0
Watsonia North	998	79	7.9
Yallambie	797	93	11.7

Discussion and conclusion

The current report focuses on HACC provision now and into the future in the Banyule area. The problem with having a mass of data and analyses to hand is how best to make sense of the information, some of which is contradictory or partial.

SUMMARY OF HACC CLIENTS

During the calendar year 2014, 6,885 clients were provided with a HACC service in the Banyule area. The proportion of residents using HACC services increased with age, from 9.6 per 1000 in the 0–49 age group to nearly one-half (484.4 per 1000) in the age group 80 years and over.

The largest HACC program in Banyule in terms of hours of service was Planned Activity Groups, while the largest in terms of number of clients is Allied Health services. Over half HACC clients (57%) were aged over 80 years, and over three-quarters (76%) were aged over 65 years. About 15% preferred to use a language other than English at home and the most common non-English languages used are Italian, Greek and Mandarin.

When service provision (total hours or meals provided) was examined by age group and service type, it was clear that the steepest curve by age group was for Planned Activity Group hours. However, increase in the client-to-population ratio was particularly strong for Assessment, where provision per year per 1000 people aged 85 and over rose to 222.

One-third of clients overall had a carer, and about one-half lived with family rather than alone or with others. Two-thirds (66%) lived in a private house they own or are purchasing. A majority (58%) are on the Age pension.

In Bundoora and Heidelberg West/Bellfield, almost 40% of people aged over 60 were provided with a service, whereas this was true for less than 10% of those living in St Helena/Eltham North and Watsonia North.

SUMMARY OF HACC AGENCIES AND FUNDING

A total of 38 different agencies were funded to provide HACC services to Banyule residents in 2015, seven of which were funded to provide Allied Health services. Overall, funding for HACC in Banyule grew by 11.8% from 2013 to 2015. The biggest increases in terms of raw figures were for Allied Health and Nursing. However, the largest increase in funded outputs by far was for Delivered Meals, which more than doubled.

PROJECTIONS OF FUTURE DEMAND/PROVISION

Projections of future provision of HACC services depend on what is used to estimate change.

Modelling using constant service-to-population and client-to-population ratios show strong growth in demand for all service types to 2019 and 2024, particularly for Domestic Assistance, Care Coordination, and Property Maintenance.

However, comparing changes in service use with population growth between 2011 and 2014 showed that service provision in some cases has been growing more strongly than the population, while provision of some services (hours and/or clients) fell between 2011 and 2014.

If historical trends continued, the following services would grow more strongly than changes in the population would suggest:

- Domestic Assistance (hours and clients)
- Personal Care (hours only)
- Allied Health (hours and clients)
- Planned Activity Groups (hours and clients)
- Assessment (hours and clients)
- Care Coordination (hours and clients)

The following services would grow less strongly than changes in the population would suggest:

- Personal Care (clients)

The following services would decrease:

- Nursing Care (hours and clients)
- Delivered Meals (hours and clients – noting, however, that state government funding for meals has increased in 2015)
- Respite (hours and clients)

The following services would decrease in clients but increase in hours (i.e., become more intensely focused on a few clients):

- Volunteer Social Support
- Property Maintenance

The following service would decrease in hours but increase in clients (i.e., become more dispersed across clients):

- Case Management

Ultimately, changes in provision of services will depend on both what funding is made available at all three levels of government, and, for smaller services, on unpredictable staffing changes (such as sick leave or maternity leave). Demand on local government will also depend on the extent to which private providers stimulate and are able to respond to demand in the community.

CONCLUSION

The report has provided a picture of current use of HACC services in Banyule, and provided a range of estimates of future demand in the municipality. Ultimately, the level of provision of services depends on policy decisions at all three levels of government. Demand on local government also depends on the extent to which private providers stimulate and are able to respond to demand in the community.

Appendix: HACC Minimum Data Set

Collection of data for the HACC MDS has occurred since January 2001. All service providers receiving HACC funding are required to collect and report data, whether they are small agencies delivering single types of service or larger agencies offering several services. HACC MDS Version 2 was introduced after a comprehensive evaluation and consultation process with state and territory stakeholders and collection of HACC MDS Version 2 commenced from 1 January 2006.

The Home and Community Care (HACC) Minimum Data Set (MDS) is provided to the Australian Department of Health. Some states (including Victoria) maintain a Data Repository that cleans the datasets before forwarding them to the Commonwealth. In other jurisdictions, data are forwarded by agencies directly to the Commonwealth.

HACC MDS data are collected by HACC-funded service providers either electronically or using paper forms. Data are collected progressively and aggregated for transmission on a quarterly basis. Aggregated data are transmitted during the collection months immediately following each quarterly activity period.

HACC MDS data reflect individual clients, their circumstances, and the types and level of assistance they receive from service providers. HACC MDS information is collected on the basis of informed client consent and clients may choose to opt out of the collection. All data in relation to individual clients is de-identified by service providers, ensuring the privacy of individuals is protected.

The **HACC MDS User Guide and Data Dictionary v2.01**[13] provides up-to-date information about individual data items and instructions on how to report them. The Data Dictionary contains definitions of individual data elements, data element concepts, and derived data elements that are required in Version 2.0 of the HACC National Minimum Data Set.

Persons receiving HACC services but who are not known to the Agency as individuals are not part of the HACC MDS collection. For example, individuals may be helped anonymously, or as if unknown to the Agency. This happens when an agency responds to general telephone enquiries, or conducts advocacy work on behalf of clients in general rather than a specific individual client. Similarly, individuals may participate anonymously in group activities, such as an information session.

A list of data elements in the national HACC MDS follows:

[13] https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/for-providers/guidance-for-providers/hacc-governance/hacc-minimum-data-set/hacc-mds-user-guide-and-data-dictionary-v201

A. Information about the care recipient—personal details

First given name[14]

Family/surname

Letters of name

Date of birth

Date of birth estimate flag

Sex

Australian state or territory identifier

Suburb/Town/Locality

Postcode

Country of birth

Main language spoken at home

Indigenous status.

B. Information about the care recipient—circumstances

Living arrangements

Accommodation setting

Government benefit/pension status

Department of Veterans' Affairs (DVA) card status

Functional status

Functional status—additional items.

C. Information about the carer (if one exists)

Carer—existence of

Carer residency status

Relationship of carer to care recipient

[14] The person's full name is not required for reporting, but selected letters are used to form the *Letters of name* for record linkage purposes.

Carer for more than one person

First given name

Family/surname*

Letters of name

Date of birth

Date of birth estimate flag

Sex

Country of birth

Main language spoken at home

Indigenous status

Australian state or territory identifier

Suburb/Town/Locality

Postcode

D. Information about the service episode

A HACC service episode is the period of time during which the care recipient and/or their carer receives HACC-funded assistance. A HACC service episode will always begin and end with an instance or occasion of HACC-funded assistance.

Source of referral

Date of entry into HACC service episode

Date of last update

Date of exit from HACC service episode

Main reason for cessation of services.

E. Information about the assistance provided

Total amount of type of assistance received (quantity)

Total amount of type of assistance received (time)

Total amount of type of assistance received (cost)

Total assistance with goods and equipment received.

Time is used to record amount of assistance for the following assistance types:

Domestic Assistance

Social Support

Nursing Care received at home

Nursing Care received at centre/other

Allied Health Care received at home

Allied Health Care received at centre/other

Personal Care

Assessment

Centre-based Day Care

Other Food Services

Respite Care

Home Maintenance

Client Care Coordination

Counselling/support, Information and Advocacy (care recipient)

Counselling/support, Information and Advocacy (carer).

Quantity is used to record amount of assistance for the following assistance types:

Meals received at home

Meals received at centre/other

Formal linen services

Transport (trips)

Goods and equipment (self-care aids, support and mobility aids, communication aids, aids for reading, medical care aids, car modifications, other goods/equipment).

Cost is used to record the amount of assistance for:

Home modification.

Definitions of key service types follow:

Table 71: Key HACC service types

SERVICE	DESCRIPTION
Domestic Assistance	Domestic Assistance is normally provided in the home, and includes services such as dishwashing, house cleaning, clothes washing, shopping (unaccompanied) and bill paying.
Social support	Social Support refers to assistance provided by a companion (paid worker or volunteer), either within the home environment or while accessing community services, which is primarily directed towards meeting the person's need for social contact and/or accompaniment in order to participate in community life. Social support includes friendly visiting.
Nursing Care at home	Nursing Care is defined as health care provided to a client by a registered or enrolled nurse.
Nursing Care at a centre or other setting	
Allied Health care at home	Allied Health consists of a wide range of specialist services, including podiatry, occupational therapy, physiotherapy, and social work.
Allied Health care at a centre or other setting	
Personal Care	Personal Care is normally provided in the home, and includes helping the client with daily self-care tasks (e.g. eating, bathing, grooming etc.). It may include medication monitoring.
Assessment	Assessment refers to assessment and re-assessment activities that are directly attributable to individual care recipients. Assessment includes activities associated with intake procedures and determination of eligibility for service provision, as well as more comprehensive assessments of a person's need for assistance.
Centre-based day care	Centre-based day care refers to assistance provided to the client to attend/participate in group activities and is conducted in a centre-based setting. It includes group excursions/activities conducted by centre staff but held away from the centre.
Meals provided at home	Meals are prepared and delivered to the client. It does not include meals prepared in the client's home.
Meals provided at a centre	Meals provided at centres are only counted in the MDS where they are the primary reason the client is there or they are the primary service the client receives while there.
Other food services	This means any assistance provided during preparation or cooking of a meal at the client's home. It also includes advice on nutrition, food storage, or preparation.
Formal linen service	A Formal linen service means that both the linen and the laundry services are provided to the client, and the cleaning of the linen is done elsewhere.

SERVICE	*DESCRIPTION*
Respite care	Respite care is assistance provided to carers so they may have relief from their caring role and pursue other activities or interests. Respite Care should only be recorded if there is a carer reported on the MDS record. If the care recipient has no carer then the service type is not respite but normally would be Social support.
Client Care Coordination	Client Care Coordination and Case Management are distinct activities on the same continuum of service delivery. Client Care Coordination is a less intensive form of Case Management.
Case Management	Case Management comprises active assistance received by a client from a formally identified agency worker (case manager or care coordinator) who coordinates the planning and delivery of a suite of services to the individual client. (Where service delivery involves more than one agency, only the activities of the agreed case manager should be recorded against this type of assistance.) Case Management is generally targeted on clients with complex needs.
Home maintenance	Home maintenance refers to assistance with the maintenance and repair of the person's home, garden or yard to keep their home in a safe and habitable condition. Home maintenance includes minor dwelling repairs and maintenance, such as changing light bulbs, carpentry and painting, or replacing tap washers as well as some more major dwelling repairs such as installing a new roof, replacing guttering or roof retiling. Home maintenance also includes garden maintenance, such as lawn mowing and the removal of rubbish.
Counselling/ support, information and advocacy (care recipient)	Counselling/support, information and advocacy covers a number of supportive services to help clients and carers deal with their situation. It includes dementia support and counselling and carer support and counselling, normally provided on a one-to-one basis. Counselling/support, information and advocacy (care recipient) refers to assistance with understanding and managing situations, behaviours and relationships associated with the person's need for care, including advocacy and the provision of advice, information and training Counselling/support, information and advocacy (carer) refers to assistance with understanding and managing situations, behaviours and relationships associated with the caring role, including advocacy and the provision of advice, information and training.
Counselling/ support, information and advocacy (carer)	
Transport	Transport refers to assistance with transportation either directly (e.g. a ride in a vehicle provided or driven by an agency worker or volunteer) or indirectly (e.g. taxi vouchers or subsidies). Transport is counted as the number of one-way trips.

VICTORIAN VERSION OF THE HACC MDS

The Victorian Government jointly funds the HACC program with the Australian Government. During 2005, the Victorian Department of Human Services (DHS) developed a Common Client Data Set (CCDS) in order to improve uniformity in data items collected on key DHS-funded services. To accommodate the CCDS, it has been necessary to make minor modifications to the national HACC MDS for use in Victoria. Some additional data items (service types) have been added.

Victorian HACC agencies submit their HACC MDS directly to the Victorian Government Department of Health and Human Services. The Victorian HACC MDS Transmission protocol[15] describes data elements that are present in the Victorian version of the HACC MDS. Major differences between the national HACC MDS v2 and the Victorian modifications are shown in the table below:

Table 72: Scope of Victorian modifications to the National HACC MDS v2

NATURE OF DIFFERENCE	NATIONAL HACC MDS V2	VICTORIAN MODIFICATION
Name changes	Main language spoken at home	Preferred language
	Carer—existence of	Carer availability
	Suburb/town/locality	Residential locality
Extra data elements		Name of software
		Need for interpreter
	Type of assistance	Up to 20 additional types, including seven types of Allied Health
Code set changes	Functional status	Items re-ordered
	Accommodation setting	Three extra codes
	Source of referral	Three extra codes
	Relationship of carer	Split by male/female

The seven types of Allied Health services (podiatry, occupational therapy, speech pathology, audiology, physiotherapy, and counselling) may each be provided at home or at a centre.

Other changes have been made to the Victorian HACC MDS.

[15] https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/reporting-and-data

- Social support has been re-labelled Volunteer Social Support, and refers to unpaid work done by volunteers, such as friendly visiting, providing transport, helping clients with paperwork, taking them shopping or to attend an appointment, and provide respite care.
- Centre-based day care has been re-labelled Planned Activity Group, and divided into Planned Activity Group—core and Planned Activity Group—high. 'Core' group clients are physically relatively independent and do not require specialist dementia care or Personal Care to participate in activities. 'High' Planned Activity Group clients require assistance with Personal Care and/or specially trained staff for moderate to severe dementia care, and/or have behaviour management problems.
- Other assistance types include:
    - HACC response service (HRS): this service provides a call-out home visit to a consumer of Personal Alert Victoria alarm service in cases where the consumer lacks a family member or other contact who can respond to a call-out. In cases where clients are HRS clients, other data items are recorded, such as whether a confirmation call was received and the time slots in which call-out home visits were made.
    - Aged Care Support for Carers Program (SCP): this program provides services to carers of older people that are similar to some of those funded by HACC, and include daytime respite, overnight respite, residential respite, counselling and support, and goods and equipment (coded in dollar amounts).

The Victorian HACC MDS does not transmit data on Other food services: instead, this is included in hours of Domestic Assistance. Finally, other services not included in the Victorian HACC MDS are Formal linen service and Transport.