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Australian Institute for Primary Care & Ageing

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50+ in Darebin: A data story

Report for Darebin agencies

Part 2: Community Care

Commissioned by the North East Primary Care Partnership

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Suggested reference:

Wells, Y. (2016). *50+ in Darebin: A data story. Report for Darebin 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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Thanks are also due to Hayden Brown, Social Planner, City of Greater Dandenong, for providing data for table 19.

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 Darebin.
- Provide Darebin 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, 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, 7,670 clients were provided with a HACC service in the Darebin area. The proportion of residents using HACC services increased with age, from eight per 1000 in the 0–49 age group to nearly one-half (460 per 1000) in the age group 80 years and over.

The largest HACC program in Darebin in terms of hours of service is Planned Activity Groups, while the largest in terms of number of clients is Domestic Assistance. Forty-two per cent of clients are aged over 80 years, and over three-quarters (77%) are aged over 65 years. About 39% prefer to use a language other than English at home and the most common non-English languages used are Italian, Greek and Macedonian.

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 237.

Client-to-population ratio was highest for the suburb of Preston, where 30% of clients aged over 60 years were receiving a service in 2014, but did not vary a great deal between the other suburbs (range 23% to 25%).

Summary of HACC agencies and funding

A total of 39 different agencies were funded to provide HACC services to Darebin residents in 2015, eight of which were funded to provide Allied Health services. Overall, funding for HACC in Darebin grew by 6.7% from 2013 to 2015. The biggest increases in terms of raw figures were for Allied Health and Nursing. However, the largest increase in funds 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:

- Volunteer Social Support
- Personal Care
- Allied Health
- Respite
- Assessment
- Case Management
- Care Coordination

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

- Domestic Assistance (hours and 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)
- Property Maintenance

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

- Planned Activity Groups

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

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	7,670 This total does not include people for whom key details were missing.		
Service types		Hours/Meals	Clients
	Planned Activity Group	124,521	880
	Domestic Assistance	95,071	2,972
(Note: Clients may receive more than one service)	Personal Care	48,361	967
	Respite	29,666	387
	Allied Health services	21,960	2,426
	Nursing Care	34,904	1,450
	Volunteer Social Support	25,102	369
	Property Maintenance	7,601	1,529
	Assessment	10,931	3,065
	Case Management (Linkages)	5,597	183
	Client Care Coordination	2,836	124
	Delivered Meals	69,545	675
Age		N	%
	0–49 years	807	10.5
	50–59 years	587	7.7
	60–69 years	939	12.2
	70–79 years	2,083	27.2
	80+ years	3,429	42.4
Service age cohort	0–64 years	1,777	23.2
	65+ years	5,888	76.8
Language diversity	2,995 clients preferred to speak a language other than English (38.5%) The three most common non-English languages preferred were: Italian: 1,274 clients (16.6%) Greek: 742 clients (9.7%) Macedonian: 139 clients (1.8%) 1,782 clients (23.2%) required an interpreter		
Indigenous	150 clients identified as Indigenous (2.0%)		
Accommodation and living arrangements	3,116 clients (40.6%) lived alone 5,164 clients (67.3%) owned or were purchasing their own home		
Carer availability	2,558 clients (33.4%) had an informal carer		
Income	4,769 clients (62.2%) received the Age pension		
Referral source (5 most common)		N	%
	Self	2,208	28.8
	Family/friend/significant other	1,426	18.6
	Hospital	1,316	17.2
	GP/medical practitioner	495	6.5
	Community nursing or community health	386	5.0
Quick reference population statistics	50+ years	42,772	
	65+ years	21,104	
	0-64 years	125,018	
	85+ years	3,514	
	Total population	146,120	

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 DAREBIN

A total of 39 different agencies were funded to provide HACC services to Darebin LGA residents in 2014-15. 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 Darebin residents at delivery settings located outside the municipality.

Table 1: Agencies funded to provide HACC services to Darebin residents, 2014-15

	ALLIED HEALTH	ASSESSMENT	DELIVERED MEALS	DOMESTIC ASSISTANCE	FLEXIBLE SERVICE	LINKAGES PACKAGES	NURSING	PERSONAL CARE	PAG - CORE	PAG - HIGH	PROPERTY	RESPITE	SERVICE SYSTEM	VOLUNTEER CO-	RDNS ALLIED HEALTH
Aboriginal Community Elders Services	✓								✓	✓				✓	
Aborigines Advancement League		✓		✓	✓						✓			✓	
Action On Disability Within Ethnic Communities									✓	✓					
Annecto					✓										
arbias					✓										
Arts Access Society Inc.					✓										
Austin Health	✓						✓								
Australian Greek Welfare Society									✓	✓		✓		✓	
Bethlehem Community					✓										
Brotherhood of St Laurence					✓										
Care Connect Limited					✓										
Central Bayside Community Health Services														✓	
City of Darebin		✓	✓	✓				✓		✓	✓	✓	✓		
Co.As.It. – Italian Assistance Association						✓			✓	✓				✓	
Darebin Community Health Service	✓				✓				✓	✓			✓		
Filipino Community Council of Victoria										✓					
Impact Support Services												✓			
Interchange Northern Region					✓					✓		✓	✓	✓	
Linc Church Services Network (Northern Region)											✓			✓	
Link Community Transport													✓	✓	
MECWA							✓								
Melbourne City Mission														✓	
Mental Illness Fellowship Victoria														✓	
Merri Outreach Support Service					✓				✓						
Mill Park Community Services Group										✓					

	ALLIED HEALTH	ASSESSMENT	DELIVERED MEALS	DOMESTIC ASSISTANCE	FLEXIBLE SERVICE	LINKAGES PACKAGES	NURSING	PERSONAL CARE	PAG - CORE	PAG - HIGH	PROPERTY	RESPITE	SERVICE SYSTEM	VOLUNTEER CO-	RDNS ALLIED HEALTH
Nillumbik Community Health Service Ltd						✓									
Northern Health	✓					✓	✓			✓					
Peter MacCallum Cancer Institute							✓								
Royal District Nursing Service Limited					✓		✓	✓							✓
SPAN Community House					✓										
Spectrum Migrant Resource Centre									✓	✓		✓			
St Vincent's Hospital (Melbourne)	✓						✓			✓					
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	**7**	**2**	**1**	**2**	**14**	**3**	**7**	**3**	**7**	**12**	**3**	**5**	**4**	**15**	**1**

In 2014-15, eight agencies were funded to provide Allied Health services in Darebin LGA. These are listed in Table 2 below. (Other agencies also provided Allied Health services to people living in Darebin, including community health services in Banyule, Plenty Valley, North Yarra, and Moreland.)

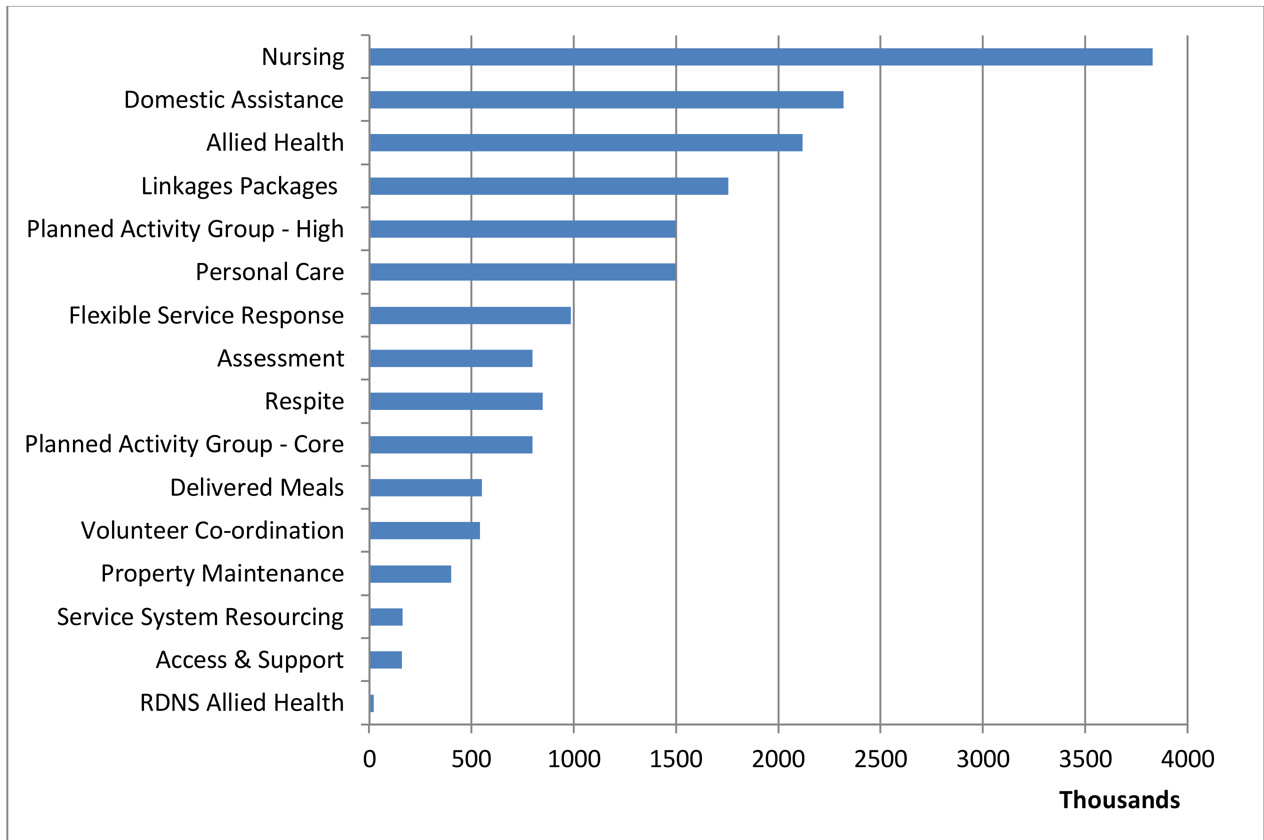
Table 2: Agencies funded to provide Allied Health services, 2014-15, and Service provision 2014

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

HACC FUNDING

In 2014-15, the Victorian state government allocated $ 17,576,187 for HACC funding to Darebin residents. The service with the highest allocation was Nursing.[3]

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

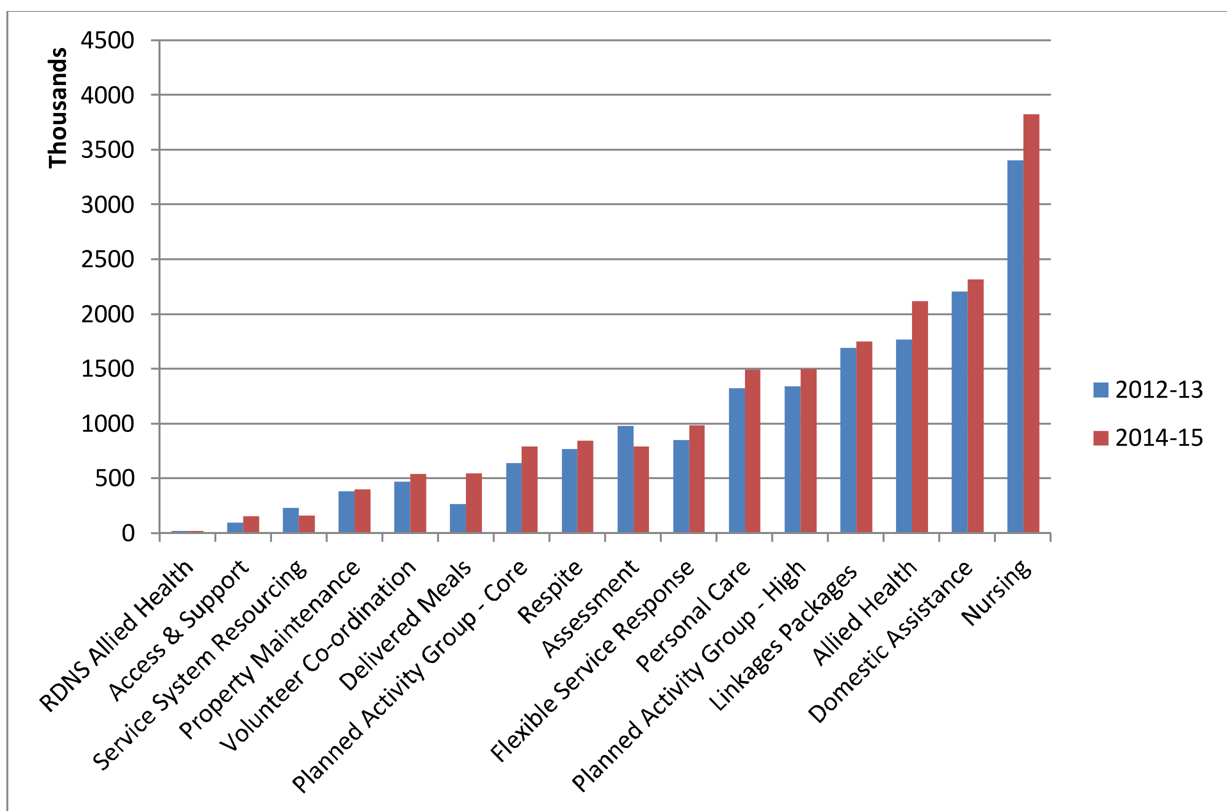


[3] Figures are comparable with those used in the Whittlesea report.

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 Darebin grew by 6.7% 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] for which funding more than doubled, from $268,472 to $550,538 (though the target number of meals did not change from 169,919).[5]

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

Figure 1b: State HACC funding ($, thousands) by service, Darebin 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 Banyule 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 %
Access and support	95,609	155,164	158,079	62,469	65.34
Allied Health	1,768,877	2,013,911	2,118,466	349,588	19.76
Assessment	982,966	1,002,564	978,838	-4,128	-0.4[6]
Delivered Meals	268,472	273,570	550,538	282,066	105.06
Domestic Assistance	2,208,959	2,274,360	2,316,960	108,001	4.89
Flexible service response	852,771	943,199	986,401	133,630	15.67
Linkages packages	1,694,313	1,720,912	1,753,244	58,931	3.48
Nursing	3,406,108	3,503,176	3,829,393	423,284	12.43
Personal Care	1,327,627	1,422,669	1,497,077	169,450	12.76
Planned Activity Group - core	641,976	737,562	795,853	153,876	23.97
Planned Activity Group - high	1,341,691	1,435,747	1,498,068	156,377	11.66
Property Maintenance	384,291	391,990	399,347	15,057	3.92
Respite	767,355	799,020	847,530	80,176	10.45
Service System Resourcing	232,484	237,134	161,183	-71,301	-30.67
Volunteer Co-ordination	474,352	532,637	540,374	66,023	13.92
RDNS Allied Health	22,498	22,949	21,593	-905	-4.02
Total	**16,470,349**	**17,466,563**	**17,576,187**	**1,105,838**	**6.71**

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 2013 so are not included in this section.

The table and figure show that while the largest increase in funded outputs in percentage terms was for HACC Access and support, the largest increase in raw numbers of outputs was for Planned

[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: Darebin City Council and Aborigines Advancement League.

Activity Groups (core). Some service outputs decreased (especially Domestic Assistance, Personal Care and Respite).

Figure 2: State HACC funding (outputs) by service, Darebin 2013–2015

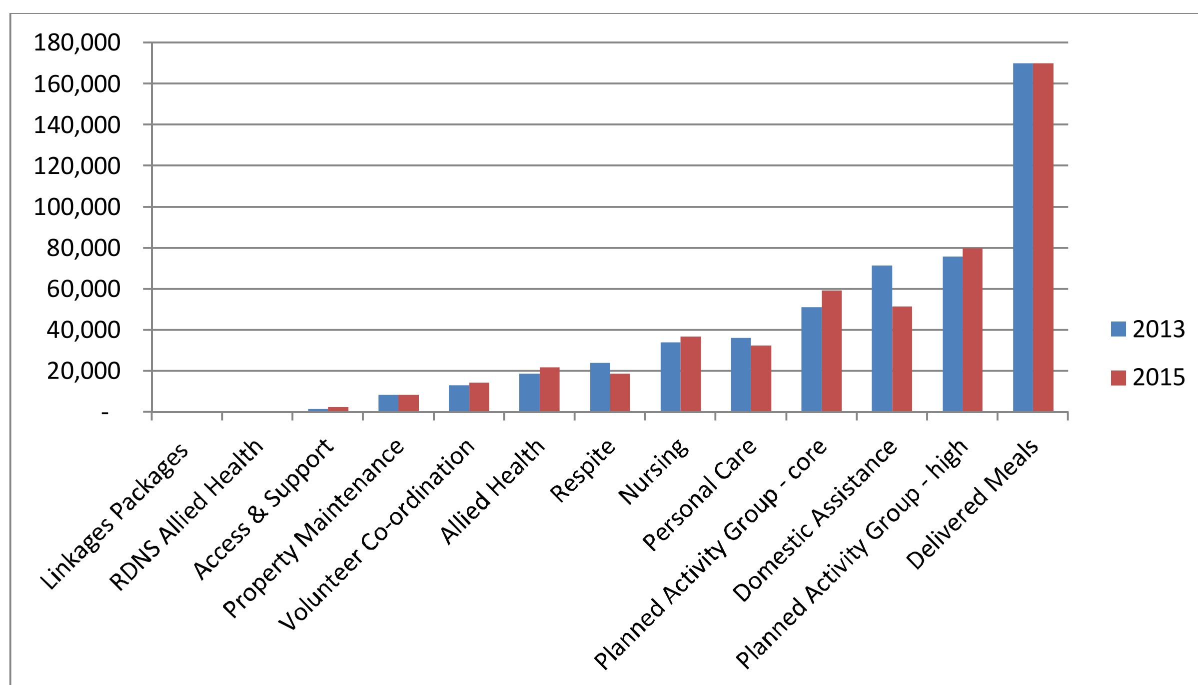


Table 4: State HACC funding (outputs) by service, 2012-13 to 2014-15

SERVICE	2013	2014	2015	CHANGE N	CHANGE %
Access and support	1,514	2,409	2,409	895	59.1
Allied Health	18,864	21,055	21,739	2,875	15.2
Delivered Meals	169,919	169,919	169,919	-	-
Domestic Assistance	71,511	72,179	51,488	-20,023	-28.0
Linkages packages	119	118	118	-1	-0.4
Nursing	34,018	34,356	36,870	2,852	8.4
Personal Care	36,057	37,955	32,311	-3,746	-10.4
Planned Activity Group - core	51,154	57,622	59,392	8,239	16.1
Planned Activity Group - high	75,888	79,631	80,025	4,138	5.5
Property Maintenance	8,555	8,555	8,555	-	-
Respite	24,055	24,555	18,834	-5,221	-21.7
Volunteer Co-ordination	12,953	14,261	14,202	1,248	9.6
RDNS Allied Health	327	327	302	-25	-7.7

SERVICES DELIVERED (ALL CLIENTS)

During the calendar year 2014, a total of 7,670 clients were provided with a HACC service, most of whom (n = 5,888, 77%) were aged 65 years or over.

The proportion of the population aged 70+ years provided with a service in 2014 was 33.6%.

The most accessed services (i.e., used by the greatest number of clients) during 2014 were Assessment and Domestic Assistance.

Table 5: Number of clients by service 2014

SERVICE	NUMBER OF CLIENTS
Assessment	3,065
Domestic Assistance	2,972
Allied Health	2,426
Property Maintenance	1,529
Nursing Care	1,450
Personal Care	967
Planned Activity Group	880
Delivered Meals	675
Respite	387
Volunteer Social Support	369
Case Management	183
Client Care Coordination	124
Counselling/support, information and advocacy	15

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 were Planned Activity Groups and Domestic Assistance.

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

SERVICE	NUMBER OF HOURS/MEALS
Planned Activity Group	124,521
Domestic Assistance	95,071
Personal Care	48,361
Nursing Care	34,904
Respite	29,666
Volunteer Social Support	25,102
Allied Health	21,960
Assessment	10,931
Property Maintenance	7,601
Case Management	5,597
Client Care Coordination	2,836
Counselling/support, information and advocacy	26
Delivered Meals	69,545

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 Darebin are divided between core and high provision.

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

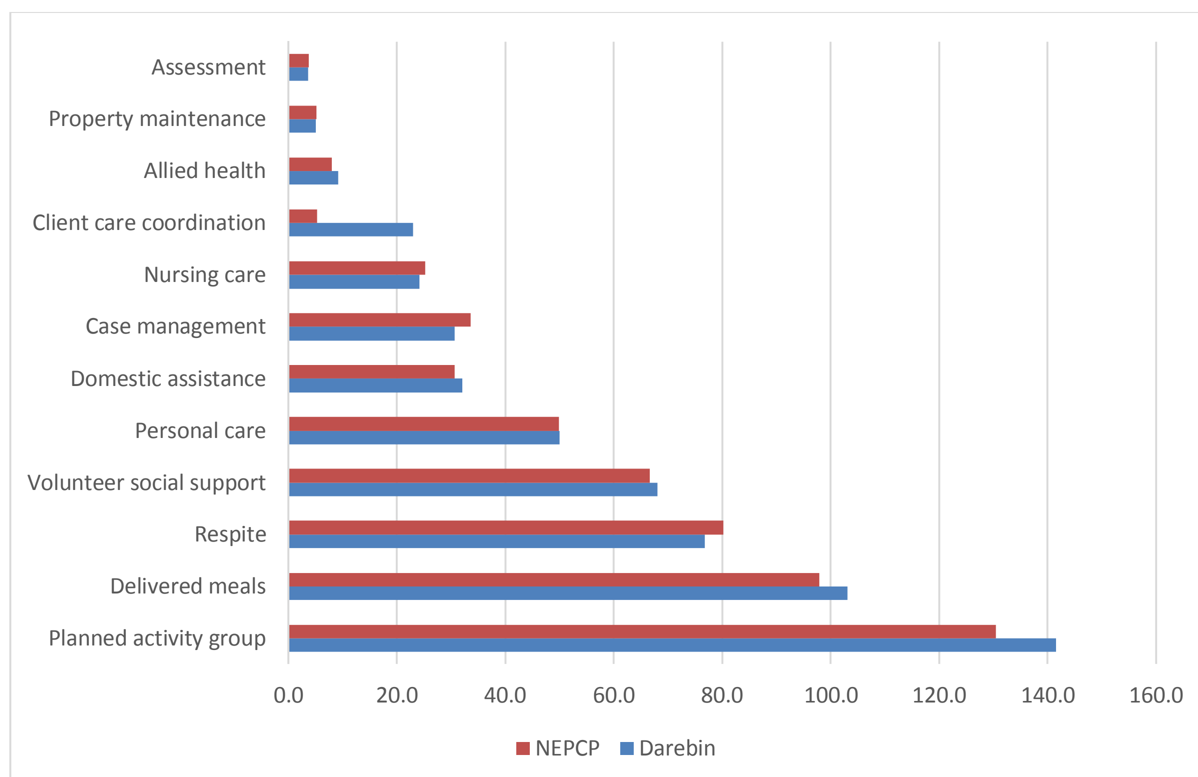
SERVICE	NUMBER OF HOURS	% OF TOTAL
Planned Activity Group – core	49,930	39.8
Planned Activity Group – high	75,421	60.2
Total	125,351	100.0

The following table shows the average number of hours/meals delivered to clients within the 12 months for 2014. Planned Activity Groups provided the most hours per client. Table 6b (and Figure 2) also compare average provision per client within the year for Nillumbik with figures for the whole NEPCP.

Table 6b: Average number of hours/meals delivered by service, Darebin and NEPCP, 2014

SERVICE	AVERAGE HOURS PER CLIENT, DAREBIN	AVERAGE HOURS PER CLIENT, NEPCP
Planned Activity Group	141.5	130.4
Delivered Meals	103.0	97.8
Respite	76.7	80.2
Volunteer Social Support	60.0	66.6
Personal Care	50.0	49.8
Domestic Assistance	32.0	33.5
Case Management	30.6	30.6
Nursing Care	24.1	25.2
Client Care Coordination	22.9	8.0
Allied Health	9.1	3.7
Property Maintenance	5.0	5.1
Assessment	3.6	5.3

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



Average hours per client provision of client Care Coordination were noticeably higher in Darebin than across the PCP (four times the average provision within the year), and somewhat higher for

Planned Activity Group hours and delivered meals. On the other hand, average provision of respite, Case Management, and Nursing Care was lower.

The difference between Darebin and the other municipalities in the NEPCP has been quite consistent over time, with average provision ranging from 20 (in 2012) to 34 (in 2011) hours per client for Darebin, compared with averages of 2-3 hours for Nillumbik, and 4-15 hours for Banyule. Total hours provided are similar in Darebin and Banyule, but the number of clients in Darebin is much lower than the number in Banyule (123 clients in 2014 in Darebin, compared with 561 clients in Banyule). Clearly, staff working in agencies in Darebin have consistently provide quite a different level of Care Coordination from staff in other locations, or perhaps record Care Coordination quite differently in the HACC MDS.

Occupational Therapy was the most frequent Allied Health service provided, followed by Physiotherapy and Podiatry. The majority of Allied Health services were coded as delivered at a centre rather than at clients' homes (79%).[7] However, some services—Dietetics 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	1,693	7,553	9,246
Physiotherapy	746	5,558	6,304
Podiatry	912	3,592	4,504
Dietetics	635	516	1,151
Speech therapy	55	131	186
Counselling	268	74	342
Audiology	0	3	3
Total specified	4,309	17,427	21,736
Not specified	263	12	275
Total	4,572	17,439	22,011

[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:

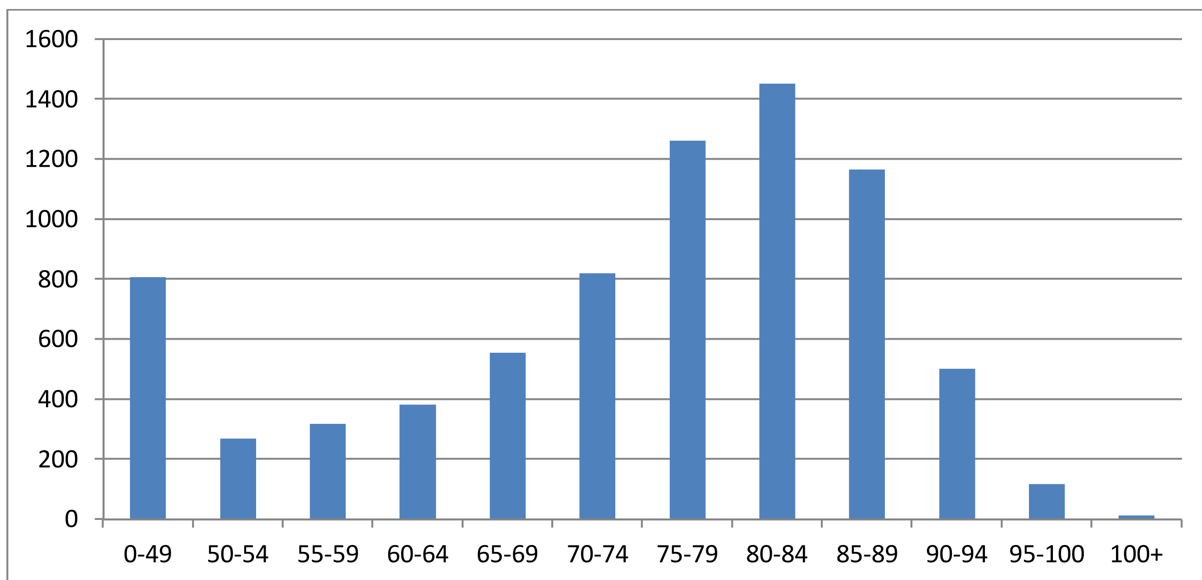
- Age
- Language diversity
- Indigenous status
- Living arrangements
- Carer availability
- Income source
- Usual accommodation

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 (81.8%) 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 7.8 per 1000 in the 0–49 age group to nearly one-half (459.7 per 1000) in the age group 80 years and over.

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

AGE GROUP	N RESIDENTS 2014	% RESIDENTS 2014	N HACC CLIENTS 2014	% HACC CLIENTS 2014	RATIO (HACC CLIENTS PER 1000 RESIDENTS)
0–49	103,350	71	807	10.5	7.8
50–59	15,855	11	587	7.7	37.0
60–69	11,036	8	939	12.2	85.1
70–79	8,814	6	2,083	27.2	236.3
80+	7,067	5	3,249	42.4	459.7
Unknown			5	0.1	
Total	146,122	100	7,670	100.0	52.5

In the future, the HACC service target group will be divided into two, with those aged 65 year 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)

AGE GROUP	N RESIDENTS 2014	% RESIDENTS 2014	N HACC CLIENTS 2014	% HACC CLIENTS 2014	RATIO (HACC CLIENTS PER 1000 RESIDENTS)
0–64	125,018	85.6	1,777	23.2	14.2
65+	21,104	14.4	5,888	76.8	279.0
Unknown			5	0.1	
Total	146,122	100	7,670	100.0	52.5

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 the large number of carers who are relatively young and may access a service in their own right). In contrast, Domestic Assistance, Personal Care 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

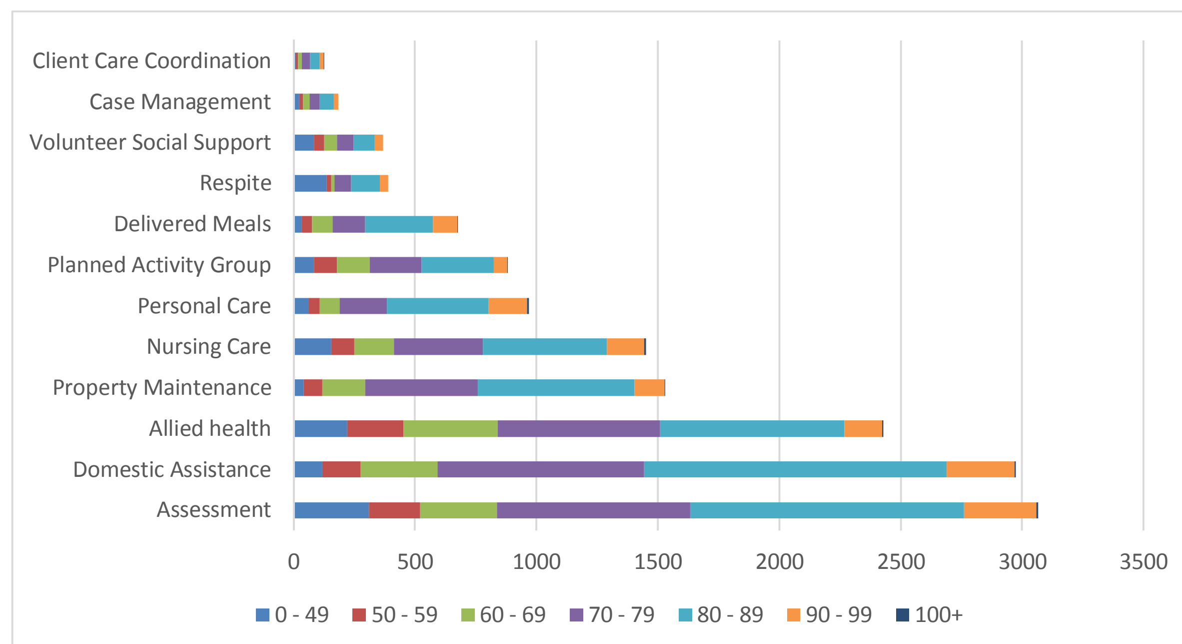


Table 10: Number of clients

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
Assessment	310	209	316	797	1126	299	7	3,064	89.9	72.7
Domestic Assistance	116	159	317	851	1245	278	6	2,972	96.1	80.1
Allied Health	219	233	386	670	759	156	3	2,426	91.0	65.5
Property Maintenance	40	76	177	463	646	124	3	1,529	97.4	80.8
Nursing Care	154	94	163	368	509	154	7	1,449	89.4	71.6
Personal Care	61	44	83	196	417	160	6	967	93.7	80.6
Planned Activity Group	83	94	134	215	296	56	1	879	90.6	64.6
Delivered Meals	33	41	86	133	280	100	2	675	95.1	76.3
Respite	134	19	15	68	117	34	0	387	65.4	56.6
Volunteer Social Support	83	41	53	70	86	34	0	367	77.4	51.8
Case Management	23	15	25	44	58	18	0	183	87.4	65.6
Client Care Coordination	6	12	15	33	41	16	1	124	95.2	73.4

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, Volunteer Social Support, and Case Management hours than other age groups.

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

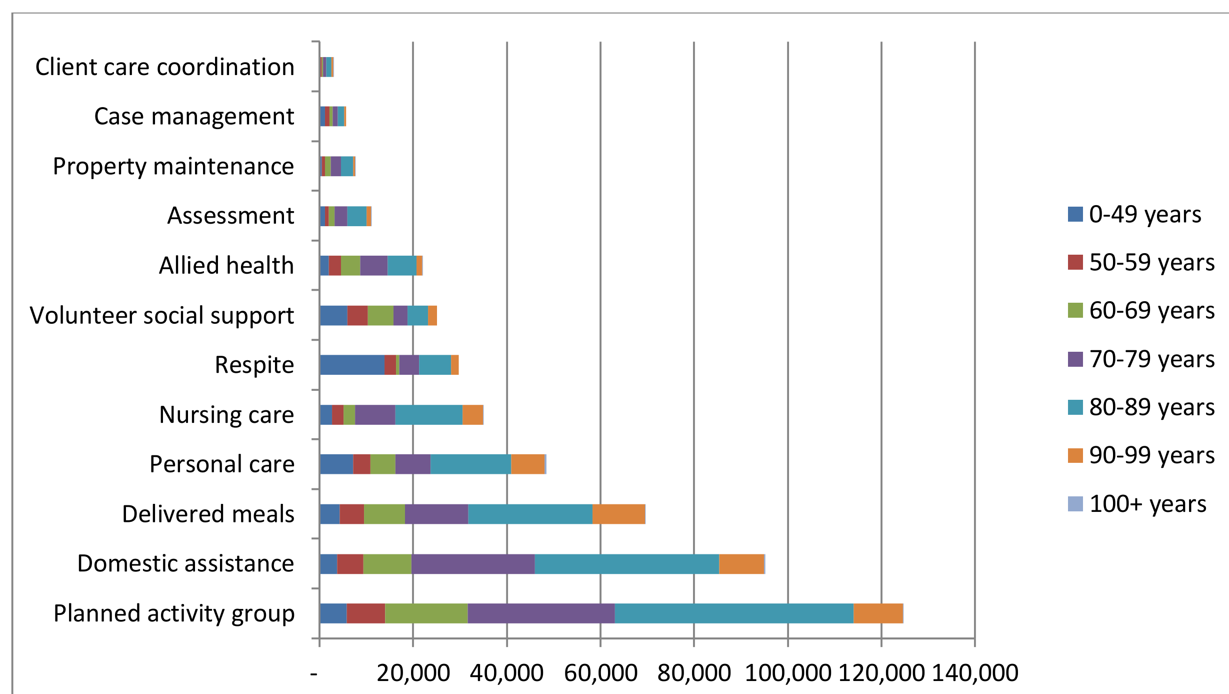


Table 11: Number of outputs (hours/meals)

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	5,732	8,259	17,625	31,423	51,020	10,411	32	124,501	95.4	74.6
Domestic Assistance	3,659	5,593	10,315	26,321	39,358	9,622	203	95,071	96.2	79.4
Delivered Meals	4,196	5,269	8,720	13,602	26,397	11,243	118	69,545	94.0	73.9
Personal Care	7,134	3,686	5,387	7,405	17,230	7,187	331	48,360	85.2	66.5
Nursing Care	2,568	2,560	2,422	8,554	14,447	4,286	65	34,902	92.6	78.4
Respite	13,785	2,541	692	4,122	6,860	1,666	-	29,666	53.5	42.6
Volunteer Social Support	5,865	4,368	5,499	3,057	4,389	1,892	-	25,070	76.6	37.2
Allied Health	1,925	2,588	4,150	5,795	6,251	1,235	16	21,960	91.2	60.6
Assessment	1,103	784	1,326	2,655	4,089	948	23	10,927	89.9	70.6
Property Maintenance	433	691	1,249	2,205	2,507	510	6	7,601	94.3	68.8
Case Management	1,173	839	742	1,045	1,369	429	-	5,597	79.0	50.8
Client Care Coordination	19	363	319	698	1,016	420	1	2,836	99.3	75.3

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	894	1,104	1,664	2,251	2,746	586	9,246	90.3	60.4
Physiotherapy	506	763	1,185	2,066	1,541	244	6,305	92.0	61.1
Podiatry	295	363	960	1,079	1,477	329	4,504	93.4	64.1
Speech therapy	69	5	22	52	35	3	186	62.7	48.0
Dietetics	147	249	234	226	251	43	1,151	87.2	45.3

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, Property Maintenance, Personal 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	8.8	11.1	10.8	8.6	8.2	7.9	5.3	9.1
Assessment	3.6	3.7	4.2	3.3	3.6	3.2	3.3	3.6
Domestic Assistance	31.5	35.2	32.5	30.9	31.6	34.6	33.8	32.0
Property Maintenance	10.8	9.1	7.1	4.8	3.9	4.1	2.0	5.0
Nursing Care	16.7	27.2	14.9	23.2	28.4	27.8	9.3	24.1
Planned Activity Group	69.1	87.9	131.5	146.2	172.4	185.9	32.0	141.6
Personal Care	117.0	83.8	64.9	37.8	41.3	44.9	55.2	50.0
Respite	102.9	133.7	46.1	60.6	58.6	49.0	0.0	76.7
Volunteer Social Support	70.7	106.5	103.7	43.7	51.0	55.7	0.0	68.3
Client Care Coordination	3.2	30.3	21.3	21.2	24.8	26.3	1.0	22.9
Delivered Meals	127.2	128.5	101.4	102.3	94.3	112.4	59.0	103.0
Case Management	51.0	55.9	29.7	23.8	23.6	23.8	0.0	30.6

CULTURAL AND LINGUISTIC DIVERSITY

Country of birth

Australia was the recorded country of birth for just less than half of clients in the Darebin area, while nearly one-half 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	3,406	44.4
Main English Speaking Countries	227	3.0
Non-English Speaking Countries	3,736	48.7
Missing Data	301	3.9
Total	7,670	100

*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 (21.6%), followed by Greece (11.6%).

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

COUNTRY OF BIRTH	NO. OF CLIENTS	% OF ALL CLIENTS
Italy	1,657	21.6
Greece	889	11.6
Former Yugoslav Republic of Macedonia	163	2.1
Lebanon	137	1.8
China	133	1.7
England	110	1.4
Egypt	70	0.9
Malta	65	0.8
Vietnam	61	0.8
Croatia	58	0.8

Language

About 40% 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	4,358	56.8
Non-English Language Preferred	2,955	38.5
Missing	357	4.7
Total	7,670	100

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

Table 17: Top 10 preferred non-English languages

TOP 10 NON-ENGLISH LANGUAGES	NO. OF CLIENTS	% OF ALL CLIENTS
Italian	1,274	16.6
Greek	742	9.7
Macedonian	139	1.8
Arabic	114	1.5
Mandarin	77	1.0
Cantonese	59	0.8
Vietnamese	56	0.7
Croatian	33	0.4
Spanish	27	0.4
Bosnian	27	0.4

Need for an interpreter was explored by preferred language for the 10 most common languages. Over 40% of Croatian speakers needed an interpreter. Even higher proportions were recorded for the other languages; 97% of Mandarin-speakers required an interpreter.

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

PREFERRED LANGUAGE	INTERPRETER NEEDED	INTERPRETER NOT NEEDED	MISSING DATA	TOTAL	% NEEDED INTERPRETER
Italian	660	572	42	1,274	54
Greek	509	218	15	742	70
Macedonian	88	49	2	139	64
Arabic	68	43	3	114	61
Mandarin	74	2	1	77	97
Cantonese	52	6	1	59	90
Vietnamese	48	6	2	56	89
Croatian	13	18	2	33	42
Spanish	13	11	3	27	54
Bosnian	11	9	7	27	55

% of all clients includes ‘missing’

Relative access to HACC services can be ascertained by comparing service use with the number of clients in the community who use that language (or were born in that country). This table indicates an issue with the accuracy of recording language for some language groups—more HACC clients aged over 70 years were recorded as speaking Bosnian than were apparently living in Darebin at the time.

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

LANGUAGE SPOKEN AT HOME	NO. OF POPULATION AGED 70+	% OF POPULATION AGED 70+[8]	NO. OF CLIENTS AGED 70+	% OF CLIENTS AGED 70+	CLIENTS AGED 70+ PER 1000 POPULATION 70+
English Preferred Language			2,587	48.5	
Non-English Language Preferred			2,511	47.1	
Missing			234	4.4	
Italian	4,267	27.8	1,172	22	275
Greek	2,294	14.9	649	12.2	283
Macedonian	508	3.3	120	2.3	236
Arabic	222	1.4	69	1.0	311
Mandarin	121	0.8	66	1.2	545
Cantonese	114	0.7	48	0.9	421
Vietnamese	114	0.7	39	0.7	342
Croatian	115	0.7	26	0.5	226
Spanish	89	0.6	22	0.4	247
Bosnian	8	0.1	19	0.4	2,375
Total	15,346		5,332	100	347

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

Some service types have a higher proportion than others of clients whose preferred language is not English. Service types with particularly high proportions of clients whose preferred language is other than English include Planned Activity Groups, Personal Care and Respite. 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	437	408	35	880	48.3
Personal Care	498	402	67	967	44.7
Domestic Assistance	1,666	1,219	87	2,972	42.3
Property Maintenance	886	589	54	1,529	39.9
Allied Health	1,419	877	130	2,426	38.2
Case Management (Linkages)	107	69	7	183	39.2
Volunteer Social Support	202	139	28	369	40.8
Assessment	1,687	1,246	132	3,065	42.5
Client Care Coordination	78	38	8	124	32.8
Nursing Care	779	429	242	1,450	35.5
Respite	205	166	16	387	44.7
Delivered Meals	499	147	29	675	22.8

When the three largest language groups were analysed separately, it was clear the representation of Macedonian clients as a proportion of all clients was highest in Planned Activity Groups (although higher numbers used Domestic Assistance and Assessment). Italian and Greek clients were more evenly spread through the services. Over one in five clients of Domestic Assistance spoke Italian by preference, and a further one in ten spoke Greek.

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

	Italian clients		Greek clients		Macedonian clients	
	N	%	N	%	N	%
Planned Activity Group	104	11.8	75	8.5	32	3.6
Personal Care	196	20.3	93	9.6	15	1.6
Domestic Assistance	650	21.9	289	9.7	40	1.3
Property Maintenance	280	18.3	148	9.7	16	1.0
Allied Health	355	14.6	198	8.2	25	1.0
Case Management (Linkages)	23	12.6	13	7.1	2	1.1
Volunteer Social Support	32	8.7	31	8.4	4	1.1
Assessment	530	17.3	320	10.4	56	1.8
Client Care Coordination	13	10.5	4	3.2	2	1.6
Nursing Care	146	10.1	93	6.4	20	1.4
Respite	60	15.5	42	10.9	5	1.3
Delivered Meals	36	5.3	51	7.6	10	1.5
Number of clients in the language group	1,172		649		120	

Some services types provided a higher proportion than others of service hours to people whose preferred language was not English. 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	56,467	63,731	4,324	124,521	53.0
Personal Care	25,477	20,040	2,843	48,361	44.0
Respite	16,683	11,931	1,051	29,665	41.7
Domestic Assistance	54,077	38,194	2,800	95,071	41.4
Assessment	6,103	4,303	524	10,931	41.4
Allied Health	13,375	7,538	1,047	21,960	36.0
Case Management	3,472	1,889	236	5,597	35.2
Property Maintenance	4,929	2,379	293	7,601	32.6
Nursing Care	20,522	8,663	5,719	34,904	29.7
Client Care Coordination	1,894	776	166	2,836	29.1
Volunteer Social Support	17,061	6,908	1,133	25,102	28.8
Delivered Meals	55,402	11,539	2,604	69,545	17.2

When the three most common language groups were examined, a similar picture emerged, with relatively high proportions of Planned Activity Group hours going to Italian-, Greek-, and Macedonian-speaking clients. Italian-speakers were also relatively high users of Personal Care, and Greek-speakers were relatively high uses of Respite.

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

	Italian clients		Greek clients		Macedonian clients	
	N hours	% of all hours	N hours	% of all hours	N hours	% of all hours
Domestic Assistance	20,848	21.9	8,345	8.8	1,365	1.4
Volunteer Social Support	1,135	4.5	1,901	7.6	135	0.5
Personal Care	9,200	19.0	3,691	7.6	649	1.3
Nursing Care	3,176	0.4	1,850	0.4	286	0.4
Allied Health	2,566	11.7	1,535	7.0	171	0.8
Planned Activity Group	24,269	19.5	16,449	13.2	4,068	3.3
Delivered Meals	3,706	5.3	2,812	4.0	726	1.0
Respite	4,073	13.7	3,383	11.4	211	0.7
Assessment	1,636	15.0	1,143	10.5	155	1.4
Case Management	561	10.0	381	6.8	62	1.1
Client Care Coordination	256	9.0	83	2.9	62	2.2
Property Maintenance	1,115	14.7	553	7.3	58	0.8

The average number of hours per client 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 highest for Planned Activity Groups, as expected. However, in Darebin, clients who preferred a language other than English were generally provided with lower average levels of service than those who spoke English by preference.

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

	ENGLISH	NON-ENGLISH LANGUAGE	DIFFERENCE	% DIFFERENCE
Planned Activity Group	129	156	27.0	20.9
Personal Care	51	50	-1.3	-2.6
Domestic Assistance	32	31	-1.1	-3.5
Assessment	4	3	-0.2	-4.5
Allied Health	9	9	-0.8	-8.8
Respite	81	72	-9.5	-11.7
Case Management	32	27	-5.1	-15.6
Client Care Coordination	24	20	-3.8	-15.9
Nursing Care	26	20	-6.2	-23.3
Property Maintenance	6	4	-1.5	-27.3
Delivered Meals	111	79	-32.5	-29.3
Volunteer Social Support	84	50	-34.8	-41.2

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 similar amounts to the average per client of most services, but high use of Planned Activity Groups and low use of Volunteer Social Support, Respite, and Case Management.
- Greek speakers had similar amounts to the average client of several services, but high use of Planned Activity Groups and Respite, and low use of Volunteer Social Support, Personal Care, Nursing Care, and (especially) Delivered Meals.
- Macedonian speakers had low average use per client of most services, but high average use of Client Care Coordination.

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

	ITALIAN	GREEK	MACEDONIAN	ALL CLIENTS USING SERVICE
Domestic Assistance	32.1	28.9	34.1	32.0
Volunteer Social Support	35.5	61.3	33.6	68.0
Personal Care	46.9	39.7	43.3	50.0
Nursing Care	21.8	19.9	14.3	24.1
Allied Health	7.2	7.8	6.8	9.1
Planned Activity Group	233.4	219.3	127.1	141.5
Delivered Meals	102.9	55.1	72.6	103.0
Respite	67.9	80.6	42.2	76.7
Assessment	3.1	3.6	2.8	3.6
Case Management	24.4	29.3	31.0	30.6
Client Care Coordination	19.7	20.8	31.0	22.9
Property Maintenance	4.0	3.7	3.6	5.0

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, 150 clients (2.0%) identified as Aboriginal or Torres Strait Islander (Indigenous).

The number of people in the city of Darebin aged over 50 years who identify as Indigenous is 188.

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

Table 26: Number of clients identified as Indigenous by service

	NO	YES	NOT SPECIFIED	TOTAL	% CLIENTS INDIGENOUS
Client Care Coordination	101	21	2	124	16.9
Planned Activity Group	762	56	62	880	6.4
Property Maintenance	1,450	56	23	1,529	3.7
Allied Health	2,168	79	179	2,426	3.3
Volunteer Social Support	290	8	71	369	2.2
Nursing Care	1,195	30	225	1,450	2.1
Domestic Assistance	2,888	60	24	2,972	2.0
Assessment	2,919	52	94	3,065	1.7
Delivered Meals	655	9	11	675	1.3
Case Management	179	2	2	183	1.1
Personal Care	924	5	38	967	0.5
Respite	383	1	3	387	0.3

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	2,307	493	36	2,836	17.4
Property Maintenance	6,226	1,285	90	7,601	16.9
Allied Health	18,740	2,059	1,161	21,960	9.4
Assessment	10,256	400	275	10,931	3.7
Delivered Meals	67,106	1,950	489	69,545	2.8
Planned Activity Group	113,030	3,231	8,260	124,521	2.6
Volunteer Social Support	21,727	561	2,814	25,102	2.2
Case Management	5,366	117	114	5,597	2.1
Domestic Assistance c	93,149	1,680	242	95,071	1.8
Nursing Care	31,106	592	3,206	34,904	1.7
Personal Care	47,713	207	440	48,361	0.4
Respite	29,630	17	19	29,666	0.1

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 on average within the year than non-Indigenous clients of Property Maintenance, Allied Health, Assessment, Delivered Meals, and Case Management, and similar hours of Client Care Coordination, but lower hours of other services, and much less 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

	NO	YES	DIFFERENCE	% DIFFERENCE
Property Maintenance	4.3	23.0	18.7	435.0
Allied Health	8.6	26.1	17.4	201.6
Assessment	3.5	7.7	4.2	118.9
Delivered Meals	102.5	216.7	114.2	111.5
Case Management	30.0	58.5	28.5	95.1
Client Care Coordination	22.8	23.5	0.6	2.8
Volunteer Social Support	74.9	70.1	-4.9	-6.5
Domestic Assistance	32.3	28.0	-4.3	-13.2
Personal Care	51.6	41.4	-10.2	-19.8
Nursing Care	26.0	19.7	-6.3	-24.2
Planned Activity Group	148.3	57.7	-90.6	-61.1
Respite	77.4	17.0	-60.4	-78.0

OTHER CLIENT CHARACTERISTICS

Carer availability

Overall, the proportion of clients who had an informal carer was 33.4%.

The proportion of clients who had a carer was highest for Respite and Case Management, and lowest for Volunteer Social Support and Domestic Assistance. 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 Personal Care, 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 relatively small number of people said to be receiving respite but to have no carer (n = 42) 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 WHO HAVE A CARER
Respite	340	42	5	387	87.9
Case Management	122	61	0	183	66.7
Client Care Coordination	82	33	9	124	66.1
Personal Care	568	361	38	967	58.7
Nursing Care	772	616	62	1,450	53.2
Assessment	1,366	1,673	26	3,065	44.6
Planned Activity Group	366	440	74	880	41.6
Delivered Meals	245	428	2	675	36.3
Property Maintenance	531	969	29	1,529	34.7
Allied Health	830	1,354	242	2,426	34.2
Volunteer Social Support	124	175	70	369	33.6
Domestic Assistance	939	2,002	31	2,972	31.6

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

Table 30: Number of hours

	HAS A CARER	HAS NO CARER	NOT STATED	TOTAL	% OF HOURS TO CLIENTS WITH A CARER
Respite	27,258	1,872	535	29,666	91.9
Personal Care	34,391	13,790	180	48,361	71.1
Nursing Care	22,608	11,264	1,032	34,904	64.8
Client Care Coordination	1,800	930	106	2,836	63.5
Case Management	3,289	2,308	-	5,597	58.8
Planned Activity Group	65,779	52,325	6,417	124,521	52.8
Assessment	5,201	5,607	123	10,931	47.6
Allied Health	9,480	10,892	1,587	21,960	43.2
Delivered Meals	22,645	46,743	157	69,545	32.6
Domestic Assistance	30,513	63,964	594	95,071	32.1
Property Maintenance	2,264	4,577	760	7,601	29.8
Volunteer Social Support	7,390	12,045	5,668	25,102	29.4

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 most services—especially true of Respite. However, clients received fewer hours of service if they had a carer for Property Maintenance, Volunteer Social Support, Delivered Meals, Client Care Coordination, and Case Management.

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

	HAS A CARER	HAS NO CARER	DIFFERENCE	% DIFFERENCE
Respite	80.2	44.6	35.6	79.9
Nursing Care	29.3	18.3	11.0	60.2
Personal Care	60.6	38.2	22.4	58.5
Planned Activity Group	179.7	118.9	60.8	51.1
Allied Health	11.4	8.0	3.4	42.0
Assessment	3.8	3.4	0.5	13.6
Domestic Assistance	32.5	32.0	0.6	1.7
Property Maintenance	4.3	4.7	-0.5	-9.7
Volunteer Social Support	59.6	68.8	-9.2	-13.4
Delivered Meals	92.4	109.2	-16.8	-15.4
Client Care Coordination	22.0	28.2	-6.2	-22.1
Case Management	27.0	37.8	-10.9	-28.8

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

Living arrangements

One-half of Darebin's HACC clients (53.2%) 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 (7.2%).

Table 32: Number of clients

LIVING ARRANGEMENT	NO. OF CLIENTS	% OF CLIENTS
Lives Alone	3,116	40.6
Lives with Family	3,612	47.1
Lives with Others	390	5.1
Not stated	552	7.2
Total	7,670	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 Darebin received a service.

Table 33: Living arrangements of HACC clients 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	4,154	27.07	2,454	46.0	591

Living arrangements of clients varied by service type. Over half of the clients of Delivered Meals, Domestic Assistance, 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
Delivered Meals	445	211	19	0	675	65.9
Domestic Assistance	1,854	1,051	44	23	2,972	62.4
Property Maintenance	867	628	14	20	1,529	56.7
Personal Care	461	435	19	52	967	47.7
Case Management	85	97	-	1	183	46.4
Assessment	1,401	1,456	80	128	3,065	45.7
Nursing Care	587	542	91	230	1,450	40.5
Client Care Coordination	48	65	2	9	124	38.7
Allied Health	914	1,212	189	111	2,426	37.7
Volunteer Social Support	130	163	40	36	369	35.2
Planned Activity Group	276	478	75	51	880	31.4
Respite	71	312	4	-	387	18.3

When number of hours is examined rather than number of clients, the picture is similar. Overall, total numbers of hours of Domestic Assistance and Property Maintenance provided and numbers of Delivered Meals 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 CLIENTS LIVE ALONE
Delivered Meals	48,989	18,481	2,075	-	69,545	70.4
Domestic Assistance	61,558	32,132	1,022	359	95,071	64.7
Nursing Care	20,026	11,469	2,258	1,151	34,904	57.4
Client Care Coordination	1,466	1,255	9	106	2,836	51.7
Case Management	2,716	2,801	-	80	5,597	48.5
Property Maintenance	3,673	3,297	124	507	7,601	48.3
Assessment	5,256	5,031	228	417	10,931	48.1
Personal Care	21,025	26,256	874	205	48,361	43.5
Allied Health	9,428	10,422	1,376	733	21,960	42.9
Planned Activity Group	48,844	61,179	11,458	3,040	124,521	39.2
Volunteer Social Support	6,495	9,555	6,408	2,645	25,102	25.9
Respite	3,465	26,073	127	-	29,666	11.7

When average number of hours per client (within the year) was examined, the biggest different that living alone made to the allocated hours of service within a year was to clients receiving Nursing Care, who were given almost twice as many hours as those who lived with family or others. For some services, fewer hours of service on average were allocated to clients who lived alone: Personal Care, Property Maintenance, Volunteer Social Support, and Respite.

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

	LIVES ALONE	LIVES WITH FAMILY OR OTHER (OR MISSING)	DIFFERENCE	% DIFFERENCE
Nursing Care	34.1	17.2	16.9	97.9
Client Care Coordination	30.5	18.0	12.5	69.4
Planned Activity Group	177.0	125.3	51.7	41.2
Allied Health	10.3	8.3	2.0	24.5
Delivered Meals	110.1	89.4	20.7	23.2
Domestic Assistance	33.2	30.0	3.2	10.8
Assessment	3.8	3.4	0.3	10.0
Case Management	32.0	29.4	2.6	8.7
Personal Care	45.6	54.0	-8.4	-15.6
Property Maintenance	4.2	5.9	-1.7	-28.6
Volunteer Social Support	50.0	77.9	-27.9	-35.8
Respite	48.8	82.9	-34.1	-41.1

Accommodation

The majority of clients lived in a private residence that they owned or were purchasing (67.3%). The level of missing data on Accommodation setting was relatively high, at 10.6%.

Table 37: Usual accommodation setting

ACCOMMODATION	NO. OF CLIENTS	% OF CLIENTS
Private residence – owned/purchasing	5,164	67.3
Private residence – private rental	509	6.6
Private residence – public rental	691	9.0
Independent living unit within a retirement village	86	1.1
Boarding house/private hotel	23	0.3
Short term crisis, emergency or transitional accommodation facility	11	0.1
Supported accommodation or supported living facility	187	2.4
Institutional setting	17	0.2
Public place/temporary shelter	8	0.1
Private residence rented from Aboriginal Community	4	0.1
Alcohol and drug treatment residence	3	0.0
Other	152	2.0
Not stated/inadequately described	815	10.6
Total	7,670	100.0

Income source

Most clients were on the Age pension (62%). Level of missing data on Income source was relatively high, at 10%.

Table 38: Clients' main income source

INCOME SOURCE	NO OF CLIENTS	% OF CLIENTS
Aged Pension	4,769	62.2
Veterans' Affairs Pension	163	2.1
Disability Support Pension	1,159	15.1
Carer Payment (Pension)	110	1.4
Unemployment related benefits	37	0.5
Other government pension or benefit	226	2.9
No government pension or benefit	430	5.6
Not stated/inadequately described	776	10.1
Total	7,670	100.0

Client referral source

The most common source of referrals to HACC was the person themselves (29%), followed by a family member, friend, or significant other (19%).

Table 39: Client referral source

SOURCE OF REFERRAL	NO. OF CLIENTS	% OF CLIENTS
Self	2,208	28.8
Family, significant other, friend	1,426	18.6
Hospital	1,316	17.2
GP/medical practitioner – community based	495	6.5
Aged Care Assessment Service	386	5.0
Community nursing or health service	359	4.7
Other community	351	4.6
Palliative care facility/hospice	81	1.1
Extended care/rehabilitation facility	44	0.6
Other medical/health service	43	0.6
Psychiatric/mental health service or facility	27	0.4
Disability support service	26	0.3
Accommodation provider	22	0.3
Aboriginal health service	15	0.2
Residential aged care facility	3	0.0
Law enforcement agency	1	0.0
Not stated/inadequately described	524	6.8
Total	7,670	100

Referral pathways differed across HACC service types. The five 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.)

- Allied Health had the highest rate of self-referral (44%), followed by Property Maintenance (39%)
- Family, significant others, and friends were a relatively common referral source for Planned Activity Groups and Respite.
- Referrals from GPs were relatively uncommon, but most associated with referrals to Nursing Care and Allied Health.
- Hospitals were a significant referral source for Domestic Assistance, Personal Care, Nursing Care and Assessment.
- ACAS was a significant source of referrals for Care Coordination and Nursing Care.

Table 40: Referral source (% of clients)

	SELF	FAMILY, SIGNIFICANT OTHER, FRIEND	HOSPITAL	GP/MEDICAL PRACTITIONER	AGED CARE ASSESSMENT SERVICE
Domestic Assistance	31.9	20.0	21.1	7.1	4.2
Volunteer Social Support	27.4	26.0	3.8	3.0	2.4
Personal Care	20.2	19.6	25.6	5.6	6.8
Nursing Care	16.4	15.2	22.6	9.7	13.4
Allied Health	44.3	11.0	9.7	8.5	4.6
Planned Activity Group	24.5	36.1	4.3	3.4	8.5
Delivered Meals	33.2	23.6	18.5	4.7	5.9
Respite	14.0	37.0	16.5	5.4	8.3
Assessment	25.3	20.9	20.7	6.6	7.5
Case Management	9.5	7.6	6.5	2.7	8.4
Client Care Coordination	19.4	26.6	12.9	4.0	15.3
Property Maintenance	39.2	17.3	17.7	4.9	4.1

Cessation of HACC services

During 2014, a valid reason for cessation was recorded for 1,417 clients. A further 2,551 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	486	6.3
Client no longer needs assistance from agency – improved status	201	2.6
Client's needs have not changed but agency cannot or will no longer provide assistance	44	0.6
Care recipient moved to residential aged care	106	1.4
Care recipient moved to other institutional setting	112	1.5
Care recipient moved to other community-based service	28	0.4
Care recipient moved out of area	20	0.3
Care recipient terminated service	76	1.0
Client died	128	1.7
Other reason	216	2.8
Not stated/inadequately described	6253	81.5
Total	7670	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 then 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 Darebin in 2014 (based on population projections)
- The service level for each service in 2014
- The service-to-population ratio for each service (hours or meals per 1,000 residents)

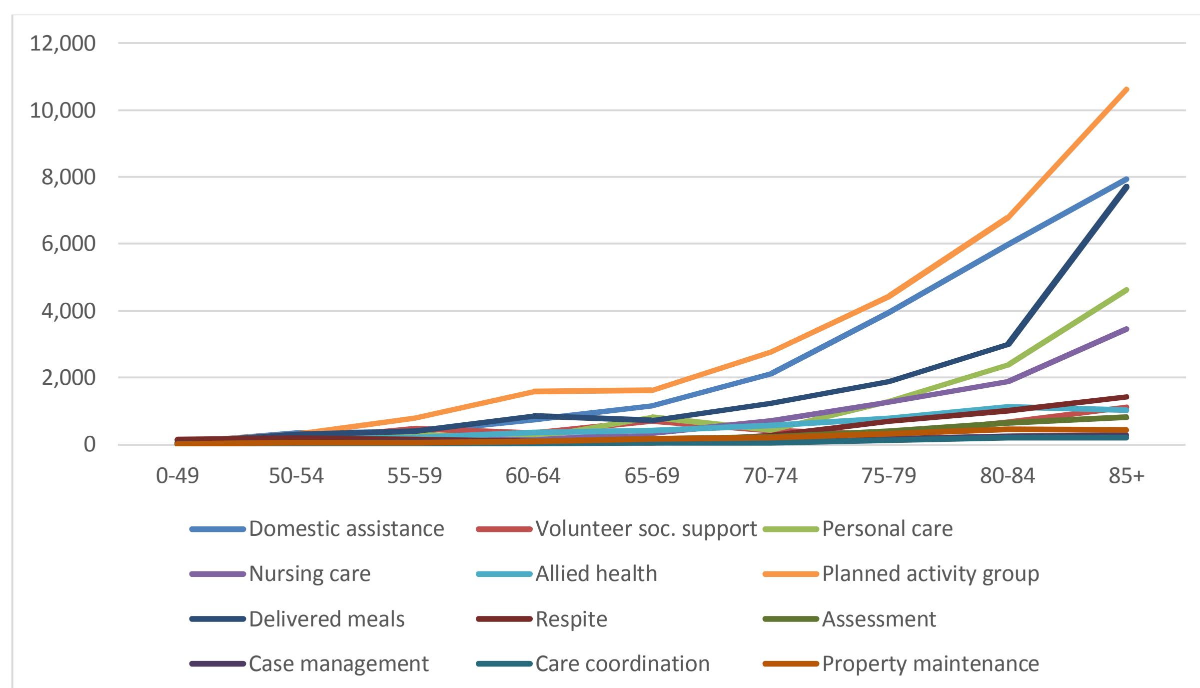
The service-to-population ratio increases significant with age. The rate of increase in the service-to-population by age for a given service is impacted by both the increase in the number of clients and the increase in individual service levels with age.

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	103,350	8,567	7,288	5,813	5,223	4,596	4,218	3,553	3,514
N clients per age group	781	245	293	331	494	788	1,029	1,256	1,662
Age-specific provision (hours or meals)									
Domestic Assistance	3,659	2,907	2,686	4,255	6,060	9,673	16,648	21,301	27,882
Volunteer soc. support	5,865	999	3,369	1,918	3,580	1,846	1,212	2,326	3,955
Personal Care	7,134	1,696	1,990	1,154	4,233	1,965	5,441	8,477	16,271
Nursing Care	2,568	1,328	1,232	678	1,744	3,179	5,375	6,688	12,110
Allied Health	1,925	1,114	1,474	2,046	2,104	2,541	3,254	3,936	3,567
Planned Activity Group	5,732	2,479	5,780	9,148	8,477	12,686	18,737	24,120	37,343
Delivered Meals	4,196	2,416	2,853	4,950	3,770	5,661	7,941	10,668	27,090
Respite	13,785	1,575	966	453	239	1,190	2,932	3,544	4,982
Assessment	1,103	417	367	520	806	1,015	1,640	2,248	2,812
Case Management	1,173	260	579	275	467	371	674	850	949
Care Coordination	19	147	216	108	211	169	529	716	721
Property Maintenance	433	354	337	428	821	880	1,325	1,552	1,471
Service hours or meals to population ratio									
Domestic Assistance	35.4	339.3	368.6	732.0	1,160.3	2,104.7	3,946.9	5,995.2	7,934.5
Volunteer soc. support	56.8	116.6	462.3	330.0	685.5	401.6	287.2	654.7	1,125.4
Personal Care	69.0	198.0	273.0	198.6	810.4	427.5	1,289.9	2,385.7	4,630.5
Nursing Care	24.8	155.0	169.1	116.6	333.9	691.7	1,274.2	1,882.2	3,446.2
Allied Health	18.6	130.1	202.2	352.0	402.8	552.8	771.4	1,107.7	1,015.0
Planned Activity Group	55.5	289.3	793.1	1,573.7	1,623.1	2,760.3	4,442.1	6,788.6	10,626.9
Delivered Meals	40.6	282.0	391.5	851.5	721.8	1,231.7	1,882.6	3,002.5	7,709.2
Respite	133.4	183.8	132.5	77.9	45.8	258.9	695.0	997.5	1,417.8
Assessment	10.7	48.7	50.3	89.4	154.3	220.8	388.8	632.6	800.2
Case Management	11.3	30.3	79.4	47.3	89.4	80.7	159.8	239.1	269.9
Care Coordination	0.2	17.2	29.6	18.6	40.4	36.8	125.4	201.6	205.1
Property Maintenance	4.2	41.3	46.2	73.6	157.2	191.5	314.1	436.8	418.6

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. This means that the relationship between the intensity of service provision and age group is strongest for this service type.

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)

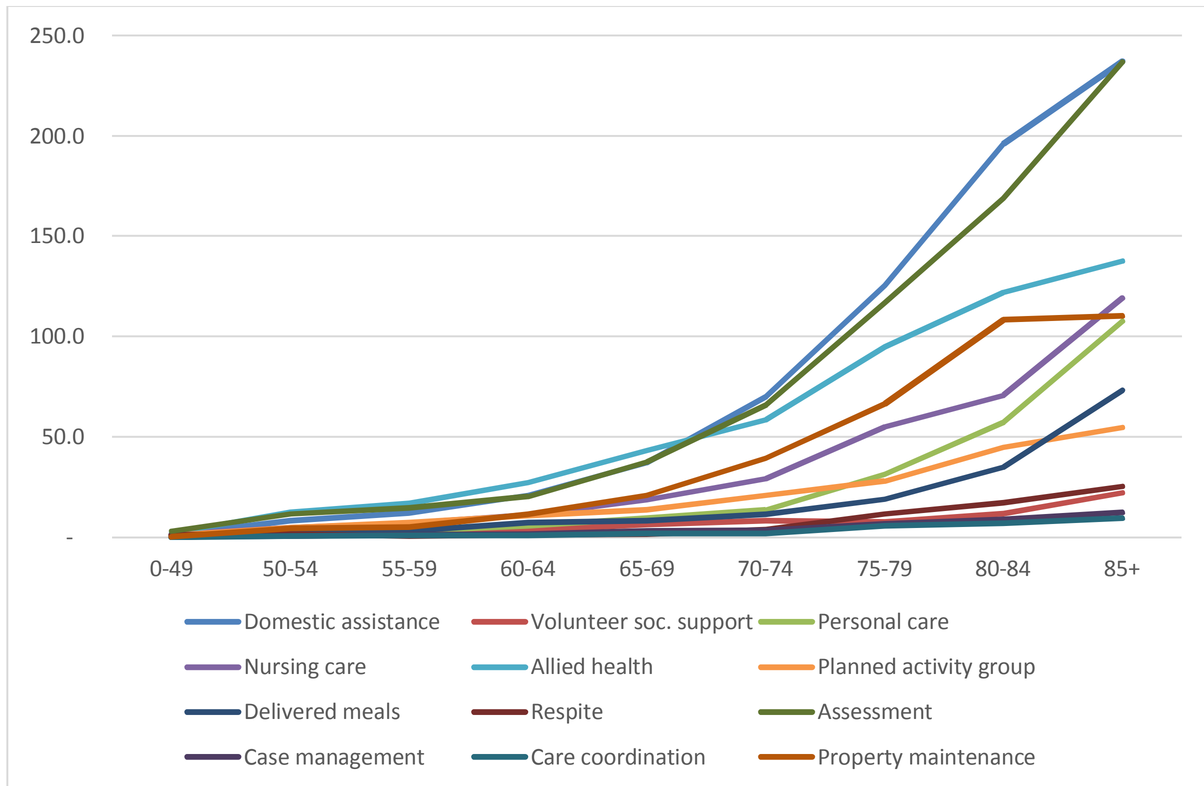
As expected, the client-to-population ratio increases with age for all HACC services. However, the rate of increase is much steeper for some service types than others (see figure below). The trend is particularly strong for Assessment, where provision per year per 1000 people aged 85 and over rises to 237 (see figure 7 below).

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

	0–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85+
Population 2014	103,350	8,567	7,288	5,813	5,223	4,596	4,218	3,553	3,514
N clients per age group	781	245	293	331	494	788	1,029	1,256	1,662
Age-specific provision (hours or meals)									
Domestic Assistance	116	70	89	122	195	322	529	696	833
Volunteer soc. support	83	15	26	20	33	38	32	42	78
Personal Care	61	21	23	33	50	63	133	204	379
Nursing Care	154	42	52	65	98	135	233	251	419
Allied Health	219	110	123	159	227	269	401	434	484
Planned Activity Group	83	40	54	62	72	97	118	160	193
Delivered Meals	33	17	24	43	43	53	80	125	257
Respite	134	14	5	7	8	18	50	61	90
Assessment	310	102	107	119	197	303	494	600	832
Case Management	23	6	9	9	16	16	28	32	44
Care Coordination	6	6	6	6	9	9	24	25	33
Property Maintenance	40	39	37	67	110	182	281	385	388
Client-to-population ratio									
Domestic Assistance	1.1	8.2	12.2	21.0	37.3	70.1	125.4	195.9	237.1
Volunteer soc. support	0.8	1.8	3.6	3.4	6.3	8.3	7.6	11.8	22.2
Personal Care	0.6	2.5	3.2	5.7	9.6	13.7	31.5	57.4	107.9
Nursing Care	1.5	4.9	7.1	11.2	18.8	29.4	55.2	70.6	119.2
Allied Health	2.1	12.8	16.9	27.4	43.5	58.5	95.1	122.2	137.7
Planned Activity Group	0.8	4.7	7.4	10.7	13.8	21.1	28.0	45.0	54.9
Delivered Meals	0.3	2.0	3.3	7.4	8.2	11.5	19.0	35.2	73.1
Respite	1.3	1.6	0.7	1.2	1.5	3.9	11.9	17.2	25.6
Assessment	3.0	11.9	14.7	20.5	37.7	65.9	117.1	168.9	236.8
Case Management	0.2	0.7	1.2	1.5	3.1	3.5	6.6	9.0	12.5
Care Coordination	0.1	0.7	0.8	1.0	1.7	2.0	5.7	7.0	9.4
Property Maintenance	0.4	4.6	5.1	11.5	21.1	39.6	66.6	108.4	110.4

The intensity of service provision to the population in Darebin rose steadily in older age groups. Service intensity increased most dramatically with age for Domestic Assistance and 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 strong growth in demand for all services to 2019 and 2024, particularly for Respite, Volunteer Social Support, Allied Health and Case Management.

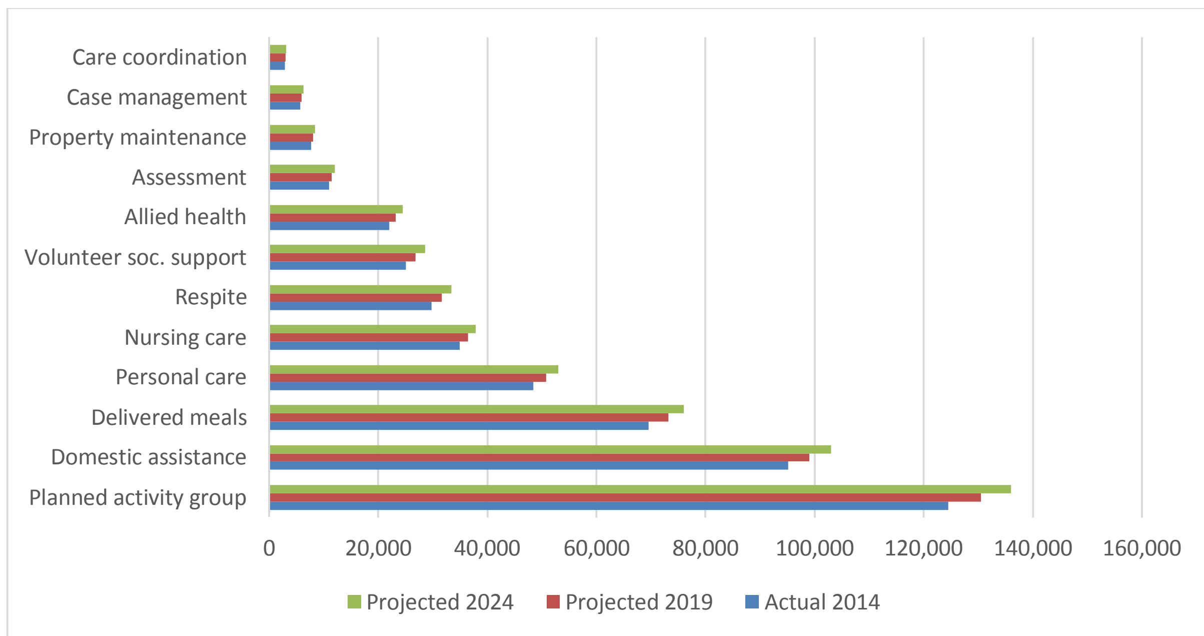
Table 44: Service level (hours or meals) by service, 2014, Projected 2019, and projected 2024

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
Planned Activity Group	124,501	130,439	135,984	5,937	4.8	11,483	9.2
Domestic Assistance	95,071	98,980	102,986	3,909	4.1	7,915	8.3
Delivered Meals	69,545	73,183	75,966	3,638	5.2	6,421	9.2
Personal Care	48,361	50,779	52,973	2,418	5.0	4,612	9.5
Nursing Care	34,902	36,411	37,775	1,510	4.3	2,874	8.2
Respite	29,666	31,653	33,309	1,987	6.7	3,643	12.3
Volunteer soc. support	25,070	26,836	28,561	1,765	7.0	3,491	13.9
Allied Health	21,960	23,145	24,417	1,185	5.4	2,457	11.2
Assessment	10,927	11,438	11,955	512	4.7	1,028	9.4
Property Maintenance	7,601	7,943	8,352	342	4.5	751	9.9
Case Management	5,597	5,926	6,257	329	5.9	660	11.8
Care Coordination	2,836	2,948	3,076	112	3.9	240	8.5

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

The following graph illustrates these increases in service demand by service type.

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

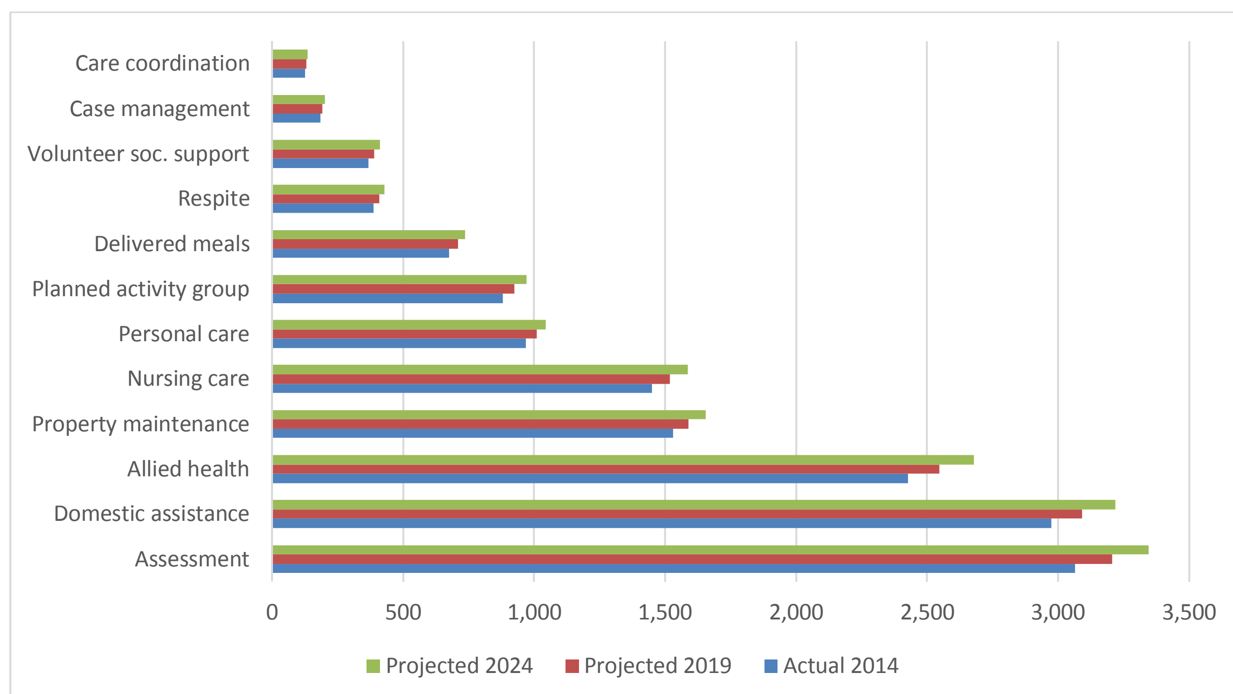


The number of clients is also likely to increase. The following table and graph illustrate projected increases in client numbers. Increases in numbers of clients are particularly strong for Property Maintenance and Domestic Assistance.

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 %
Assessment	3,064	3,204	3,344	140	4.6	280	9.1
Domestic Assistance	2,972	3,091	3,217	119	4.0	245	8.2
Allied Health	2,426	2,546	2,678	120	4.9	252	10.4
Property Maintenance	1,529	1,588	1,654	59	3.8	125	8.2
Nursing Care	1,449	1,518	1,585	69	4.8	136	9.4
Personal Care	967	1,009	1,044	42	4.3	77	7.9
Planned Activity Group	879	925	971	46	5.2	92	10.5
Delivered Meals	675	708	735	33	4.9	60	8.8
Respite	387	409	428	22	5.7	41	10.6
Volunteer soc. support	367	390	411	23	6.2	44	12.0
Case Management	183	192	202	9	5.0	19	10.1
Care Coordination	124	129	135	5	4.3	11	9.0

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, firstly 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 next examines those assumptions by looking at whether change over the previous 4 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

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	3,659	4,015	4,295	356	9.7	636	17.4
50–54	2,907	3,145	3,375	238	8.2	468	16.1
55–59	2,686	2,932	3,152	246	9.2	466	17.3
60–64	4,255	4,931	5,334	676	15.9	1,079	25.4
65–69	6,060	6,357	7,238	297	4.9	1,178	19.4
70–74	9,673	10,208	10,694	535	5.5	1,021	10.6
75–79	16,648	16,585	17,627	-63	-0.4	979	5.9
80–84	21,301	21,433	21,883	132	0.6	582	2.7
85+	27,882	29,374	29,390	1,492	5.4	1,508	5.4
0–64	13,507	15,024	16,156	1,517	11.2	2,649	19.6
65+	81,564	83,956	86,830	2,392	2.9	5,266	6.5
Total	95,071	98,980	102,986	3,909		7,915	

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

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	116	127	136	11	9.7	20	17.4
50–54	70	76	81	6	8.2	11	16.1
55–59	89	97	104	8	9.2	15	17.3
60–64	122	141	153	19	15.9	31	25.4
65–69	195	205	233	10	4.9	38	19.4
70–74	322	340	356	18	5.5	34	10.6
75–79	529	527	560	-2	-0.4	31	5.9
80–84	696	700	715	4	0.6	19	2.7
85+	833	878	878	45	5.4	45	5.4
0–64	397	442	475	45	11.2	78	19.6
65+	2,575	2,649	2,742	74	2.9	167	6.5
Total	2,972	3,091	3,217	119		245	

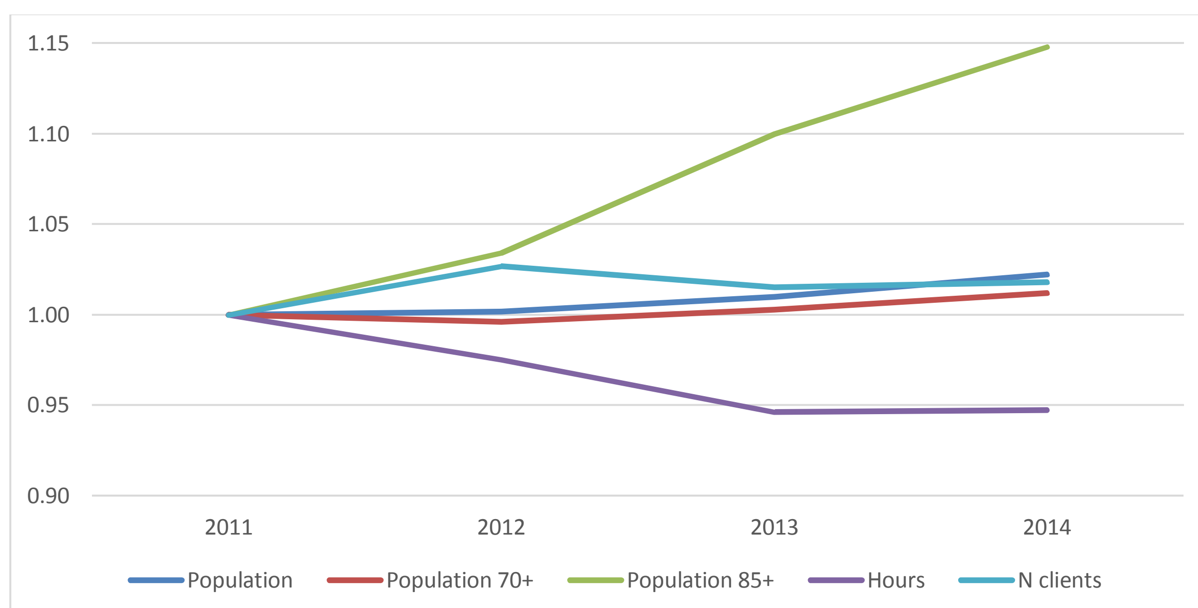
The figures in this section of the report use growth curves to illustrate change from a pre-determined point – in this case, 2011. The numbers in the graph are ratios of the number for each year in comparison to the number in 2011. The purpose of constructing these figures is to test the assumption that change 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 Darebin population, the population aged 70 and over and the population aged 85 and over. The population growth curves show that the size of the population aged 85 years and over has grown much faster than their the population aged 70 years and over or the general population

The demand curves are for hours and numbers of clients.

Total hours of Domestic Assistance provided decreased from 2011, but the number of clients grew slightly. Changes in the number of Domestic Assistance clients was broadly similar to increase in the size of the population, but changes in hours of Domestic Assistance provided were not related to changes in the population. Growth in the population may drive change in the numbers of Domestic Assistance clients, but is not related to the total number of hours of Domestic Assistance provided.

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	100,373	97,866	94,979	95,071
N clients	2,920	2,998	2,964	2,972

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 based on recent changes in provision of Domestic Assistance result in lower estimates of growth in clients and decreased hours, in contrast with increases 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	98,980	102,986	86,890	79,412	92,935	91,199
Clients	3,091	3,217	3,063	3,156	3,077	3,186
% increase in hours	4.1	8.3	-8.6	-16.5	-2.2	-4.1
% increase in clients	4.0	8.2	3.0	6.2	3.5	7.2

VOLUNTEER SOCIAL SUPPORT

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

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	5,865	6,437	6,885	571	9.7	1,020	17.4
50–54	999	1,081	1,160	82	8.2	161	16.1
55–59	3,369	3,678	3,954	308	9.2	584	17.3
60–64	1,918	2,223	2,405	305	15.9	486	25.4
65–69	3,580	3,756	4,276	175	4.9	696	19.4
70–74	1,846	1,948	2,040	102	5.5	195	10.6
75–79	1,212	1,207	1,283	-5	-0.4	71	5.9
80–84	2,326	2,340	2,390	14	0.6	64	2.7
85+	3,955	4,166	4,169	212	5.4	214	5.4
0–64	12,152	13,418	14,403	1,267	10.4	2,251	18.5
65+	12,918	13,417	14,157	499	3.9	1,239	9.6
Total	25,070	26,836	28,561	1,765		3,491	

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

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	6	7	7	1	9.7	1	17.4
50–54	6	6	7	0	8.2	1	16.1
55–59	6	7	7	1	9.2	1	17.3
60–64	6	7	8	1	15.9	2	25.4
65–69	9	9	11	0	4.9	2	19.4
70–74	9	9	10	0	5.5	1	10.6
75–79	24	24	25	-0	-0.4	1	5.9
80–84	25	25	26	0	0.6	1	2.7
85+	33	35	35	2	5.4	2	5.4
0–64	24	27	29	3	10.7	5	19.0
65+	100	103	107	3	2.8	7	6.6
Total	124	129	135	5		11	

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

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

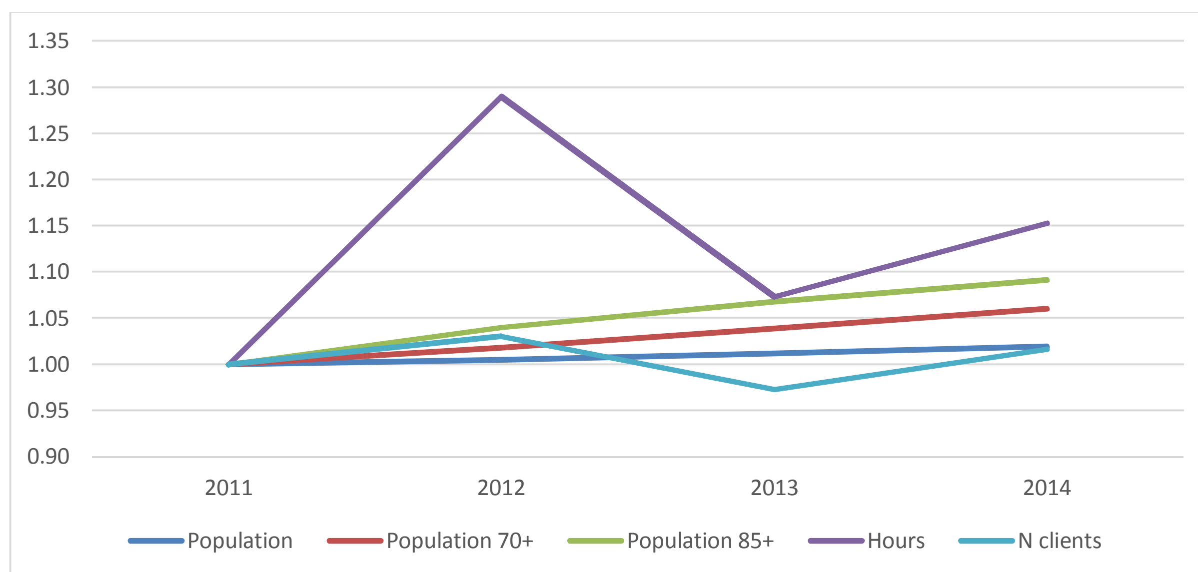


Table 49b: Hours and number of clients, Volunteer Social Support, 2011–2014

	2011	2012	2013	2014
Hours	21,777	28,095	23,375	25,102
N clients	363	374	353	369

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 and clients than those based on population growth only.

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	26,836	28,561	34,447	47,271	30,641	37,916
Clients	129	135	381	394	255	264
% increase in hours	7.0	13.9	37.4	88.6	22.2	51.2
% increase in clients	4.3	9.0	207.4	217.5	105.8	113.2

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	7,134	7,829	8,375	695	9.7	1,241	17.4
50–54	1,696	1,835	1,969	139	8.2	273	16.1
55–59	1,990	2,172	2,335	182	9.2	345	17.3
60–64	1,154	1,338	1,447	183	15.9	293	25.4
65–69	4,233	4,440	5,055	207	4.9	823	19.4
70–74	1,965	2,073	2,172	109	5.5	207	10.6
75–79	5,441	5,420	5,761	-21	-0.4	320	5.9
80–84	8,477	8,529	8,708	52	0.6	231	2.7
85+	16,271	17,142	17,151	871	5.4	880	5.4
0–64	11,975	13,174	14,126	1,200	10.0	2,151	18.0
65+	36,386	37,604	38,847	1,218	3.3	2,461	6.8
Total	48,361	50,779	52,973	2,418		4,612	

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	61	67	72	6	9.7	11	17.4
50–54	21	23	24	2	8.2	3	16.1
55–59	23	25	27	2	9.2	4	17.3
60–64	33	38	41	5	15.9	8	25.4
65–69	50	52	60	2	4.9	10	19.4
70–74	63	66	70	3	5.5	7	10.6
75–79	133	132	141	-1	-0.4	8	5.9
80-84	204	205	210	1	0.6	6	2.7
85+	379	399	399	20	5.4	20	5.4
0–64	138	153	164	15	10.9	26	19.1
65+	829	856	879	27	3.3	50	6.1
Total	967	1,009	1,044	42		77	

Growth curves for provision of Personal Care in HACC indicate that between 2011 and 2013, while the number of clients and total hours of care provided grew, this growth was not closely related to changes in the population, though change in the number of clients was similar to growth in the population aged 70 years and over. Growth in this age group may predict longer-term change in demand for Personal Care, but is not a particularly reliable indicator on a year-to-year basis.

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

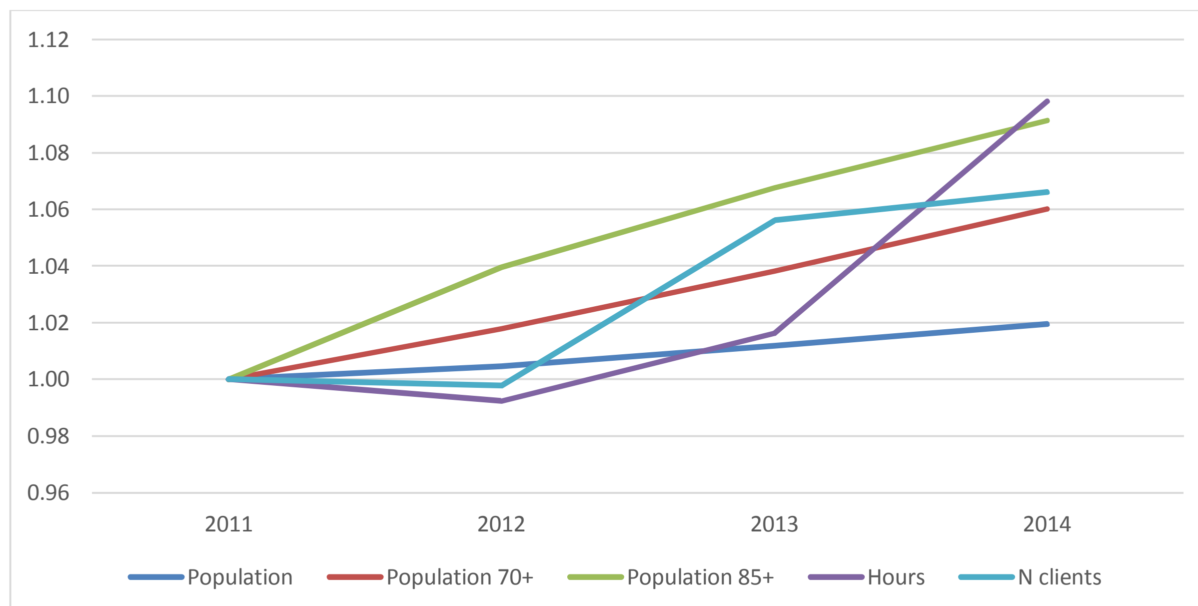


Table 51b: Hours and number of clients, Personal Care, 2011–2014

	2011	2012	2013	2014
Hours	44,039	43,699	44,760	48,361
N clients	907	905	958	967

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 and clients than estimates based on population growth only.

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	50,779	52,973	56,701	66,479	53,740	59,726
Clients	1,009	1,044	1,078	1,201	1,043	1,122
% increase in hours	5.0	9.5	17.2	37.5	11.1	23.5
% increase in clients	4.3	7.9	11.4	24.2	7.9	16.1

NURSING CARE

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

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	2,568	2,818	3,015	250	9.7	447	17.4
50–54	1,328	1,437	1,542	109	8.2	214	16.1
55–59	1,232	1,345	1,446	113	9.2	214	17.3
60–64	678	786	850	108	15.9	172	25.4
65–69	1,744	1,829	2,083	85	4.9	339	19.4
70–74	3,179	3,355	3,514	176	5.5	335	10.6
75–79	5,375	5,354	5,690	-20	-0.4	316	5.9
80–84	6,688	6,729	6,870	41	0.6	183	2.7
85+	12,110	12,758	12,765	648	5.4	655	5.4
0–64	5,807	6,386	6,853	580	10.0	1,046	18.0
65+	29,095	30,025	30,923	930	3.2	1,828	6.3
Total	34,902	36,411	37,775	1,510		2,874	

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

	ACTUAL 2014	PROJECTED 2019	PROJECTED 2024	INCREASE TO 2019 N	INCREASE TO 2019 %	INCREASE TO 2024 N	INCREASE TO 2024 %
0–49	154	169	181	15	9.7	27	17.4
50–54	42	45	49	3	8.2	7	16.1
55–59	52	57	61	5	9.2	9	17.3
60–64	65	75	81	10	15.9	16	25.4
65–69	98	103	117	5	4.9	19	19.4
70–74	135	142	149	7	5.5	14	10.6
75–79	233	232	247	-1	-0.4	14	5.9
80–84	251	253	258	2	0.6	7	2.7
85+	419	441	442	22	5.4	23	5.4
0–64	313	347	372	34	10.7	59	18.9
65+	1,136	1,171	1,212	35	3.1	76	6.7
Total	1,449	1,518	1,585	69		136	

Growth curves for Nursing Care indicate that numbers of hours and clients have declined in Darebin since 2012, 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

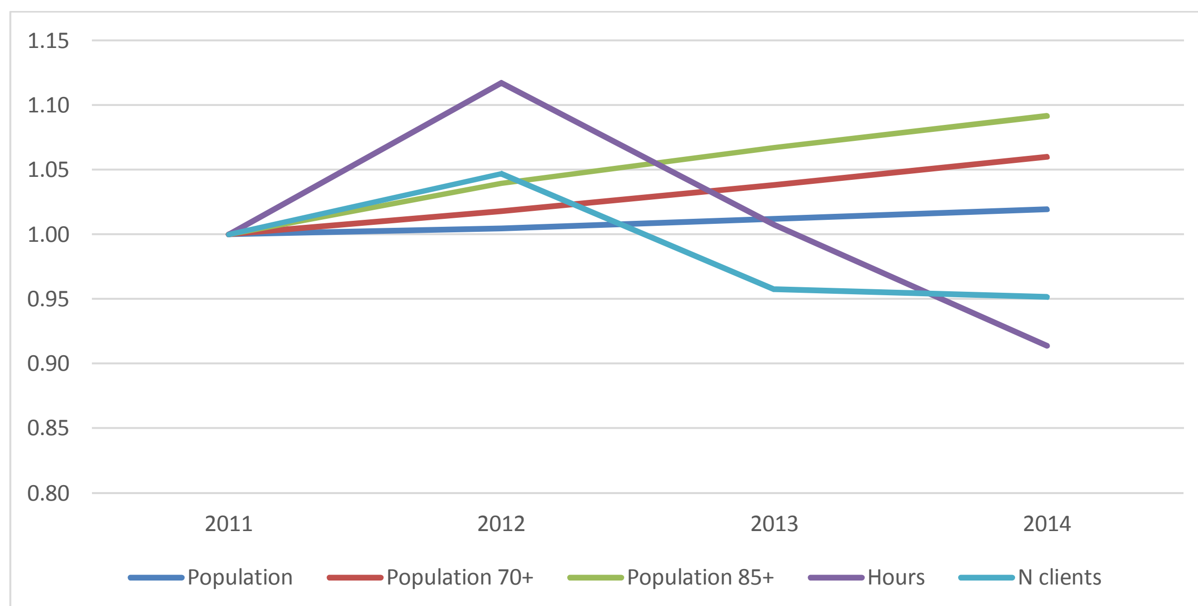


Table 53b: Hours and number of clients, Nursing Care, 2011–2014

	2011	2012	2013	2014
Hours	38,195	42,674	38,480	34,904
N clients	1,524	1,596	1,459	1,450

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	1,925	2,112	2,260	188	9.7	335	17.4
50–54	1,114	1,206	1,294	91	8.2	179	16.1
55–59	1,474	1,608	1,729	135	9.2	256	17.3
60–64	2,046	2,372	2,565	325	15.9	519	25.4
65–69	2,104	2,207	2,513	103	4.9	409	19.4
70–74	2,541	2,681	2,809	140	5.5	268	10.6
75–79	3,254	3,241	3,445	-12	-0.4	191	5.9
80–84	3,936	3,960	4,043	24	0.6	107	2.7
85+	3,567	3,757	3,759	191	5.4	193	5.4
0–64	6,559	7,298	7,848	739	11.3	1,288	19.6
65+	15,401	15,847	16,569	446	2.9	1,169	7.6
Total	21,960	23,145	24,417	1,185		2,457	

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	219	240	257	21	9.7	38	17.4
50–54	110	119	128	9	8.2	18	16.1
55–59	123	134	144	11	9.2	21	17.3
60–64	159	184	199	25	15.9	40	25.4
65–69	227	238	271	11	4.9	44	19.4
70–74	269	284	297	15	5.5	28	10.6
75–79	401	399	425	-2	-0.4	24	5.9
80–84	434	437	446	3	0.6	12	2.7
85+	484	510	510	26	5.4	26	5.4
0–64	611	678	728	67	10.9	117	19.2
65+	1,815	1,868	1,949	53	2.9	134	7.4
Total	2,426	2,546	2,678	120		252	

Changes in demand for Allied Health—in terms of both hours and clients—outstripped changes in the population (with the exception of a dip in hours in 2013). Increases in demand for Allied Health may reflect changes in policy, such as the Active Service Model, that encourage the use of restorative services in HACC. Further changes in population may under-estimate growth in demand for Allied Health in the future, and that provision year-to-year may be difficult to estimate.

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

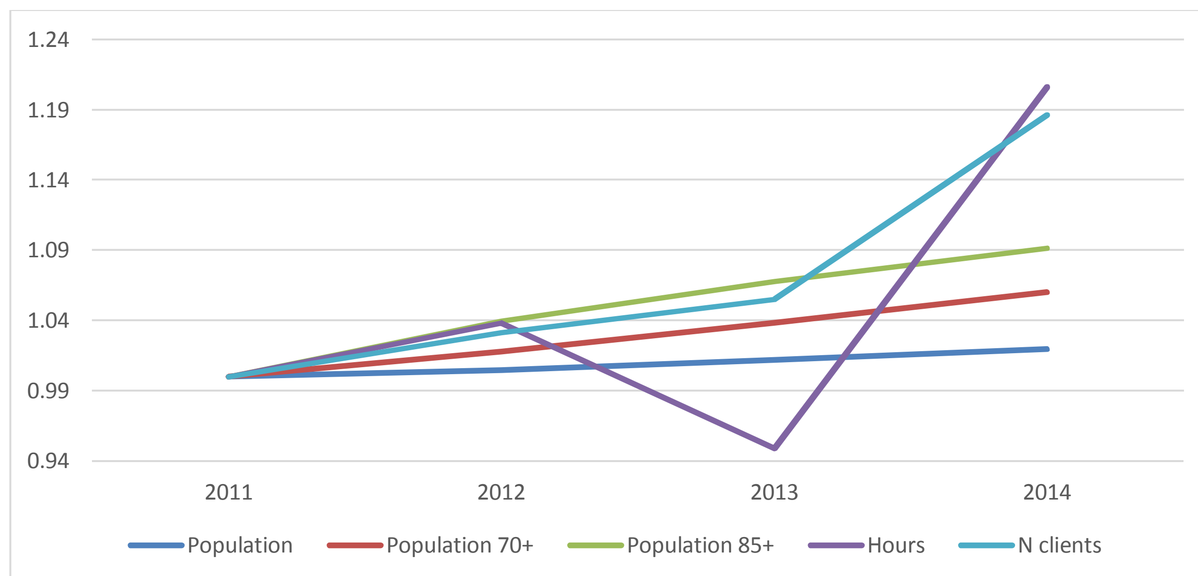


Table 55b: Hours and number of clients, Allied Health, 2011–2014

	2011	2012	2013	2014
Hours	18,209	18,902	17,282	21,960
N clients	2,045	2,109	2,158	2,426

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 alone.

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	23,145	24,417	31,430	44,984	27,287	34,700
Clients	2,546	2,678	3,240	4,327	2,893	3,502
% increase in hours	5.4	11.2	43.1	104.8	24.3	58.0
% increase in clients	4.9	10.4	33.6	78.4	19.2	44.4

PLANNED ACTIVITY GROUP

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	5,732	6,290	6,728	558	9.7	997	17.4
50–54	2,479	2,682	2,877	203	8.2	399	16.1
55–59	5,780	6,309	6,783	529	9.2	1,002	17.3
60–64	9,148	10,602	11,468	1,454	15.9	2,320	25.4
65–69	8,477	8,893	10,125	416	4.9	1,647	19.4
70–74	12,686	13,387	14,025	701	5.5	1,339	10.6
75–79	18,737	18,665	19,838	-71	-0.4	1,102	5.9
80–84	24,120	24,269	24,778	149	0.6	658	2.7
85+	37,343	39,341	39,362	1,998	5.4	2,019	5.4
0–64	23,138	25,883	27,856	2,745	11.9	4,718	20.4
65+	101,363	104,556	108,128	3,193	3.1	6,765	6.7
Total	124,501	130,439	135,984	5,937		11,483	

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	83	91	97	8	9.7	14	17.4
50–54	40	43	46	3	8.2	6	16.1
55–59	54	59	63	5	9.2	9	17.3
60–64	62	72	78	10	15.9	16	25.4
65–69	72	76	86	4	4.9	14	19.4
70–74	97	102	107	5	5.5	10	10.6
75–79	118	118	125	-0	-0.4	7	5.9
80–84	160	161	164	1	0.6	4	2.7
85+	193	203	203	10	5.4	10	5.4
0–64	239	265	285	26	10.9	46	19.2
65+	640	660	686	20	3.1	46	7.2
Total	879	925	971	46		92	

Growth curves for Planned Activity Group hours broadly parallel growth in the population aged 70 years and over, but the number of clients has fluctuated and was lower in 2014 than in 2011. The projections for demand of Planned Activity Groups in HACC may not be reliable, 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	115,843	117,431	122,091	124,521
N clients	908	890	947	880

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 sharper increases in hours but decreases in client numbers, in contrast with estimated increases in both 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	130,439	135,984	140,494	158,515	135,466	147,250
Clients	925	971	842	805	883	888
% increase in hours	4.8	9.2	12.8	27.3	8.8	18.3
% increase in clients	5.2	10.5	-4.2	-8.4	0.5	1.0

DELIVERED MEALS

Table 58: Service level (number of 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	4,196	4,605	4,926	409	9.7	730	17.4
50–54	2,416	2,614	2,805	198	8.2	389	16.1
55–59	2,853	3,114	3,348	261	9.2	495	17.3
60–64	4,950	5,737	6,205	787	15.9	1,255	25.4
65–69	3,770	3,955	4,503	185	4.9	733	19.4
70–74	5,661	5,974	6,258	313	5.5	597	10.6
75–79	7,941	7,911	8,408	-30	-0.4	467	5.9
80–84	10,668	10,734	10,959	66	0.6	291	2.7
85+	27,090	28,539	28,555	1,449	5.4	1,465	5.4
0–64	14,415	16,070	17,283	1,655	11.5	2,868	19.9
65+	55,130	57,113	58,683	1,983	3.6	3,553	6.4
Total	69,545	73,183	75,966	3,638		6,421	

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	33	36	39	3	9.7	6	17.4
50–54	17	18	20	1	8.2	3	16.1
55–59	24	26	28	2	9.2	4	17.3
60–64	43	50	54	7	15.9	11	25.4
65–69	43	45	51	2	4.9	8	19.4
70–74	53	56	59	3	5.5	6	10.6
75–79	80	80	85	0	-0.4	5	5.9
80–84	125	126	128	1	0.6	3	2.7
85+	257	271	271	14	5.4	14	5.4
0–64	117	131	141	14	11.7	24	20.1
65+	558	577	594	19	3.5	36	6.4
Total	675	708	735	33		60	

Despite steady increases in the target population, the provision of delivered meals dropped sharply between 2011 and 2014, both in terms of clients and numbers of meals. The number of meals delivered in 2014 was only 61% of the number delivered in 2011. 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

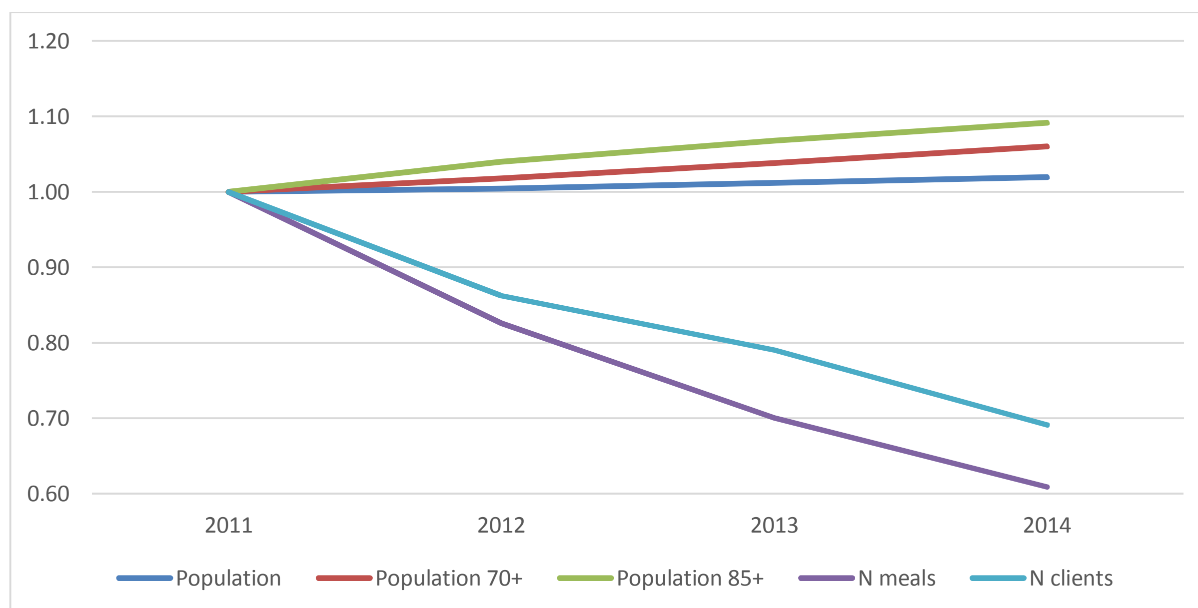


Table 59b: Meals and number of clients, Delivered Meals, 2011–2014

	2011	2012	2013	2014
N Meals	114,104	94,273	79,940	69,545
N clients	976	842	772	675

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 hours and client numbers, rather than increases as predicted by population growth.

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	73,183	75,966	30,504	13,380	51,843	44,673
N clients	708	735	366	198	537	466
% increase in hours	5.2	9.2	-56.1	-80.8	-25.5	-35.8
% increase in clients	4.9	8.8	-45.8	-70.6	-20.5	-30.9

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	13,785	15,128	16,182	1,343	9.7	2,397	17.4
50–54	1,575	1,704	1,828	129	8.2	253	16.1
55–59	966	1,054	1,134	88	9.2	168	17.3
60–64	453	525	568	72	15.9	115	25.4
65–69	239	251	285	12	4.9	46	19.4
70–74	1,190	1,256	1,316	66	5.5	126	10.6
75–79	2,932	2,920	3,104	-11	-0.4	172	5.9
80–84	3,544	3,566	3,641	22	0.6	97	2.7
85+	4,982	5,249	5,251	267	5.4	269	5.4
0–64	16,779	18,411	19,712	1,632	9.7	2,933	17.5
65+	12,887	13,241	13,597	355	2.8	711	5.5
Total	29,666	31,653	33,309	1,987		3,643	

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	134	147	157	13	9.7	23	17.4
50–54	14	15	16	1	8.2	2	16.1
55–59	5	5	6	0	9.2	1	17.3
60–64	7	8	9	1	15.9	2	25.4
65–69	8	8	10	0	4.9	2	19.4
70–74	18	19	20	1	5.5	2	10.6
75–79	50	50	53	-	0.0	3	5.9
80–84	61	61	63	0	0.6	2	2.7
85+	90	95	95	5	5.4	5	5.4
0–64	160	176	188	16	9.9	28	17.6
65+	227	233	240	6	2.8	13	5.7
Total	387	409	428	22		41	

Provision of Respite in Darebin, in terms both of hours and number of clients, has outstripped population growth curves. Increases in population are not likely to be reliable predictors of use of Respite in HACC in Darebin; changes in the population may under-estimate demand.

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

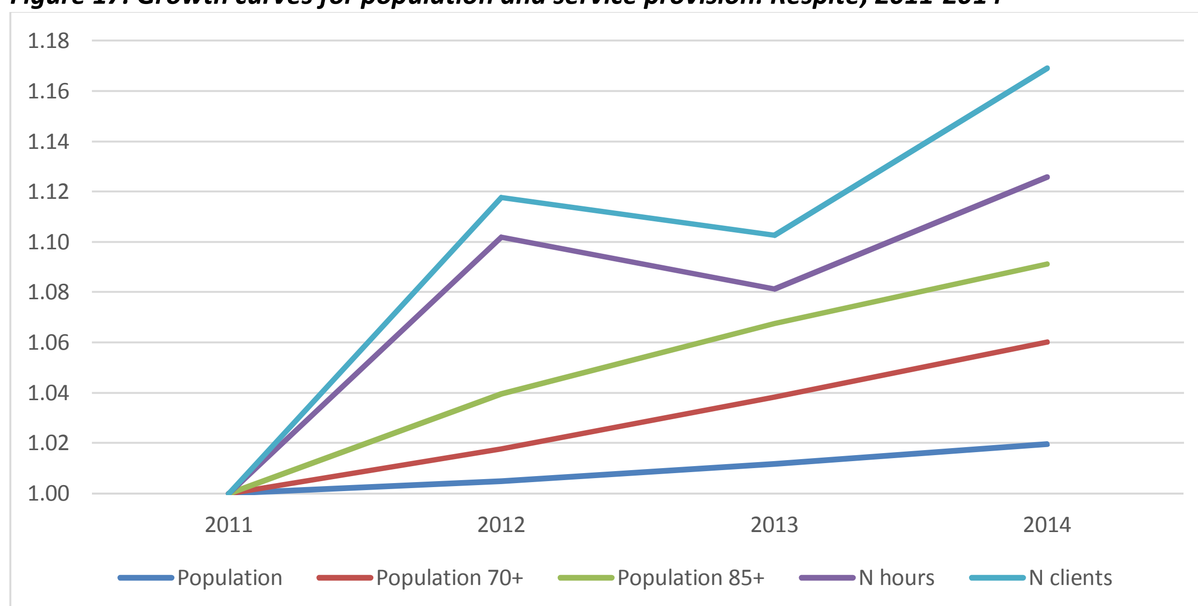


Table 61b: Hours and number of clients, Respite, 2011–2014

	2011	2012	2013	2014
Hours	26,346	29,030	28,493	29,666
N clients	331	370	365	387

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 much sharper increases in both hours and client numbers than those 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	31,653	33,309	36,355	44,554	34,004	38,931
N clients	409	428	505	660	457	544
% increase in hours	6.7	12.3	22.6	50.2	14.6	31.2
% increase in clients	5.7	10.6	30.6	70.6	18.2	40.6

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	1,103	1,211	1,295	107	9.7	192	17.4
50–54	417	451	484	34	8.2	67	16.1
55–59	367	400	430	34	9.2	64	17.3
60–64	520	603	652	83	15.9	132	25.4
65–69	806	845	963	40	4.9	157	19.4
70–74	1,015	1,071	1,122	56	5.5	107	10.6
75–79	1,640	1,634	1,736	-6	-0.4	96	5.9
80–84	2,248	2,262	2,309	14	0.6	61	2.7
85+	2,812	2,962	2,964	150	5.4	152	5.4
0–64	2,407	2,664	2,861	258	10.7	454	18.9
65+	8,520	8,774	9,094	254	3.0	574	6.7
Total	10,927	11,438	11,955	512		1,028	

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	310	340	364	30	9.7	54	17.4
50–54	102	110	118	8	8.2	16	16.1
55–59	107	117	126	10	9.2	19	17.3
60–64	119	138	149	19	15.9	30	25.4
65–69	197	207	235	10	4.9	38	19.4
70–74	303	320	335	17	5.5	32	10.6
75–79	494	492	523	-	0.0	29	5.9
80–84	600	604	616	4	0.6	16	2.7
85+	832	877	877	45	5.4	45	5.4
0–64	638	705	757	67	10.5	119	18.7
65+	2,426	2,499	2,587	73	3.0	161	6.6
Total	3,064	3,204	3,344	140		280	

The provision of HACC Assessment in Darebin has grown from 2011 to 2014, and both the numbers of clients and hours of Assessment have increased more quickly than the population. Number of hours of HACC Assessment has increased by 36% from 2011 to 2014. Further growth in the population may also under-estimate the demand for Assessment services in HACC.

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

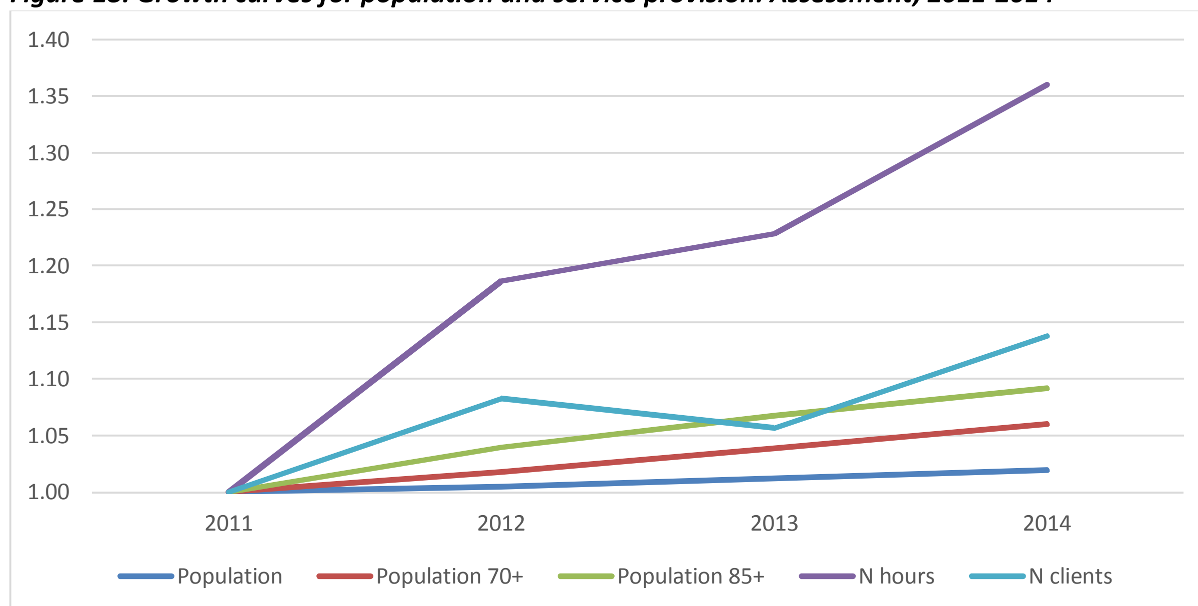


Table 63b: Hours and number of clients, Assessment, 2011–2014

	2011	2012	2013	2014
Hours	8,036	9,537	9,872	10,931
N clients	2,693	2,915	2,846	3,064

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 in 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	11,438	11,955	18,396	30,959	14,917	21,457
N clients	3,204	3,344	3,824	4,771	3,514	4,057
% increase in hours	4.7	9.4	68.4	183.3	36.5	96.4
% increase in clients	4.6	9.1	24.8	55.7	14.7	32.4

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	1,173	1,287	1,377	114	9.7	204	17.4
50–54	260	281	302	21	8.2	42	16.1
55–59	579	632	679	53	9.2	100	17.3
60–64	275	319	345	44	15.9	70	25.4
65–69	467	490	558	23	4.9	91	19.4
70–74	371	392	410	21	5.5	39	10.6
75–79	674	671	714	-3	-0.4	40	5.9
80–84	850	855	873	5	0.6	23	2.7
85+	949	1,000	1,000	51	5.4	51	5.4
0–64	2,287	2,519	2,703	232	9.7	204	17.4
65+	3,310	3,408	3,555	98	8.2	42	16.1
Total	5,597	5,927	6,258	330	5.9	661	11.8

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	23	25	27	2	9.7	4	17.4
50–54	6	6	7	0	8.2	1	16.1
55–59	9	10	11	1	9.2	2	17.3
60–64	9	10	11	1	15.9	2	25.4
65–69	16	17	19	1	4.9	3	19.4
70–74	16	17	18	1	5.5	2	10.6
75–79	28	28	30	-	0.0	2	5.9
80–84	32	32	33	0	0.6	1	2.7
85+	44	46	46	2	5.4	2	5.4
0–64	47	52	56	5	10.6	9	18.7
65+	136	140	146	4	3.0	10	7.1
Total	183	192	202	9	5.0	19	10.1

The number of Case Management clients nearly doubled from 2011 to 2012, and the number of hours also increased substantially (by 30%). However, since then the program has contracted, despite increases in the population. While the program may well continue to grow, changes in the population may not predict change in demand for Case Management of a year-to-year basis.

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

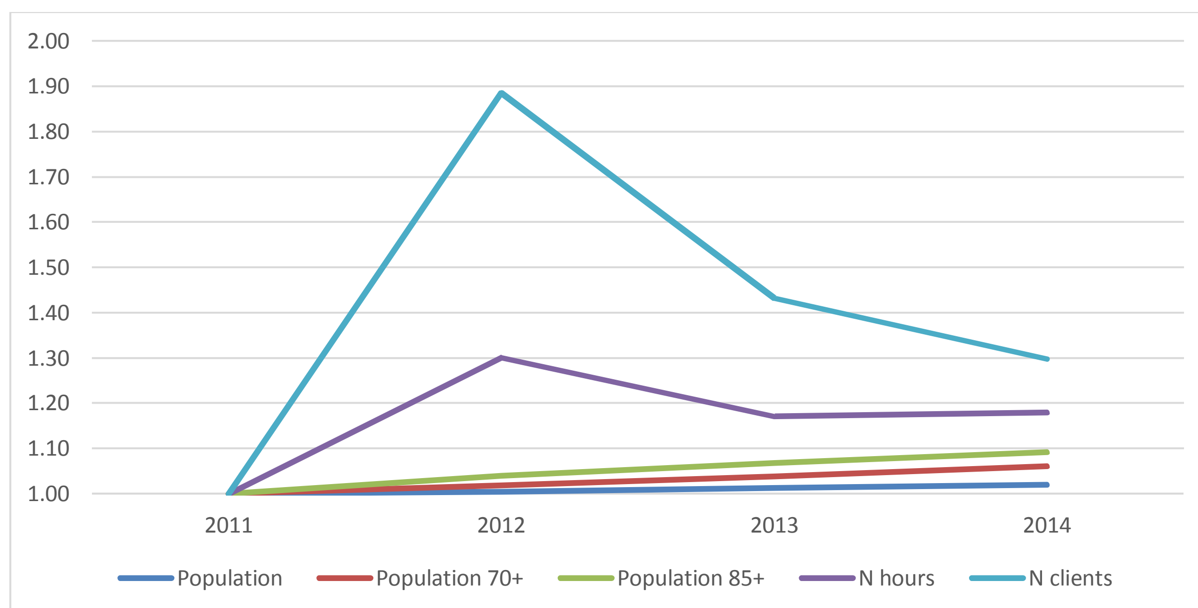


Table 65b: Hours and number of clients, Case Management, 2011–2014

	2011	2012	2013	2014
Hours	4,748	6,174	5,559	5,597
N clients	141	266	202	183

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 steeper increases in clients and hours than projected increases based on population growth only.

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	5,927	6,258	7,822	10,931	6,874	8,594
N clients	192	202	426	990	309	596
% increase in hours	5.9	11.8	39.7	95.3	22.8	53.6
% increase in clients	5.0	10.1	132.6	441.2	68.8	225.7

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	19	21	22	2	9.7	3	17.4
50–54	147	159	171	12	8.2	24	16.1
55–59	216	236	253	20	9.2	37	17.3
60–64	108	125	135	17	15.9	27	25.4
65–69	211	221	252	10	4.9	41	19.4
70–74	169	178	187	9	5.5	18	10.6
75–79	529	527	560	-2	-0.4	31	5.9
80–84	716	721	736	4	0.6	20	2.7
85+	721	759	760	39	5.4	39	5.4
0–64	490	541	582	51	10.4	92	18.7
65+	2,346	2,407	2,495	61	2.6	148	6.3
Total	2,836	2,948	3,076	112		240	

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	6	7	7	1	9.7	1	17.4
50–54	6	6	7	0	8.2	1	16.1
55–59	6	7	7	1	9.2	1	17.3
60–64	6	7	8	1	15.9	2	25.4
65–69	9	9	11	0	4.9	2	19.4
70–74	9	9	10	0	5.5	1	10.6
75–79	24	24	25	-	0.0	1	5.9
80–84	25	25	26	0	0.6	1	2.7
85+	33	35	35	2	5.4	2	5.4
0–64	24	27	29	3	10.7	5	19.0
65+	100	103	107	3	2.8	7	6.6
Total	124	129	135	5		11	

Growth curves for change in Care Coordination from 2011 to 2014 do not follow population growth curves. The number of Care Coordination clients has increased much more than changes in the population might suggest, but the number of hours provided has been quite erratic. 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	2,558	2,042	2,928	2,836
N clients	79	101	128	124

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	2,927	3,054	3,921	5,420	3,424	4,237
N clients	129	135	274	604	201	369
% increase in hours	3.9	8.4	39.2	92.4	21.5	50.4
% increase in clients	4.3	9.0	120.7	387.0	62.5	198.0

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	433	475	508	42	9.7	75	17.4
50–54	354	383	411	29	8.2	57	16.1
55–59	337	368	395	31	9.2	58	17.3
60–64	428	496	537	68	15.9	109	25.4
65–69	821	861	981	40	4.9	160	19.4
70–74	880	929	973	49	5.5	93	10.6
75–79	1,325	1,320	1,403	-5	-0.4	78	5.9
80–84	1,552	1,562	1,594	10	0.6	42	2.7
85+	1,471	1,550	1,551	79	5.4	80	5.4
0–64	1,552	1,722	1,851	170	11.0	299	19.3
65+	6,049	6,221	6,501	172	2.8	452	7.5
Total	7,601	7,943	8,352	342		751	

Table 69: 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	40	44	47	4	9.7	7	17.4
50–54	39	42	45	3	8.2	6	16.1
55–59	37	40	43	3	9.2	6	17.3
60–64	67	78	84	11	15.9	17	25.4
65–69	110	115	131	5	4.9	21	19.4
70–74	182	192	201	10	5.5	19	10.6
75–79	281	280	298	-	0.0	17	5.9
80–84	385	387	396	2	0.6	11	2.7
85+	388	409	409	21	5.4	21	5.4
0–64	183	204	220	21	11.5	37	20.0
65+	1,346	1,384	1,435	38	2.8	89	6.6
Total	1,529	1,588	1,654	59		125	

Growth curves for Property Maintenance in Darebin show decreasing levels of service provision since 2011, despite population increases. Demand projections for this service are unlikely to be reliable.

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

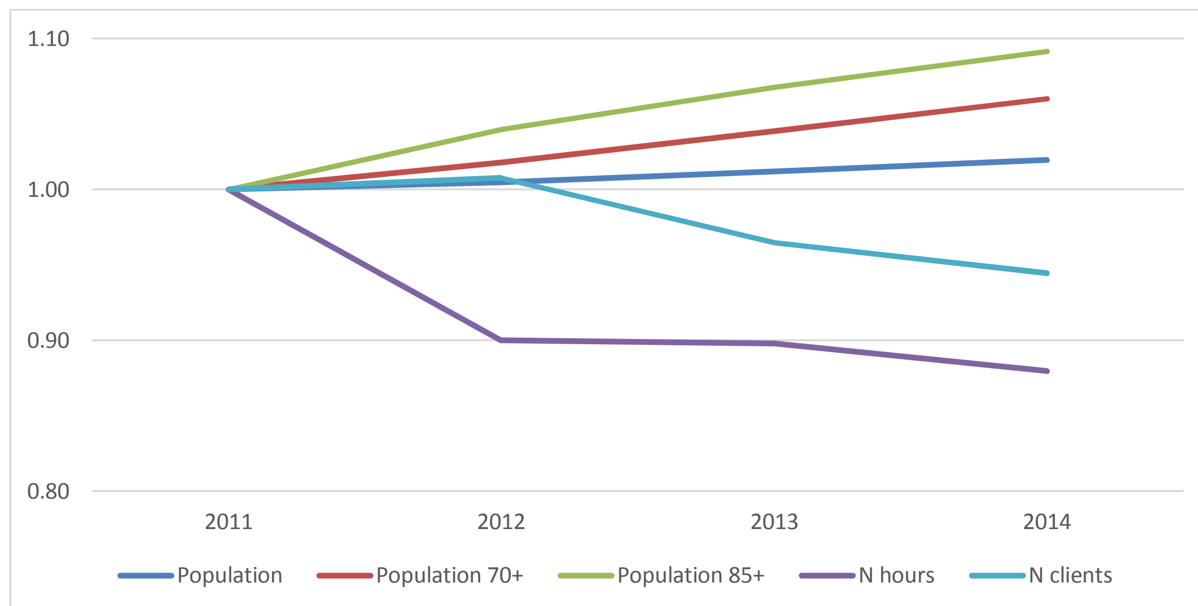


Table 69b: Hours and number of clients, Property Maintenance, 2011–2014

	2011	2012	2013	2014
Hours	8,645	7,779	7,759	7,601
N clients	1,619	1,631	1,562	1,529

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 a decrease in client numbers and hours, 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	7,943	8,352	6,165	5,000	7,054	6,676
N clients	1,588	1,654	1,391	1,266	1,490	1,460
% increase in hours	4.5	9.9	-18.9	-34.2	-7.2	-12.2
% increase in clients	3.8	8.2	-9.0	-17.2	-2.6	-4.5

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.

Client-to-population ratio was highest for Preston, where 30% of clients aged over 60 years were receiving a service, but did not vary a great deal between the other suburbs (range 23% to 25%).

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

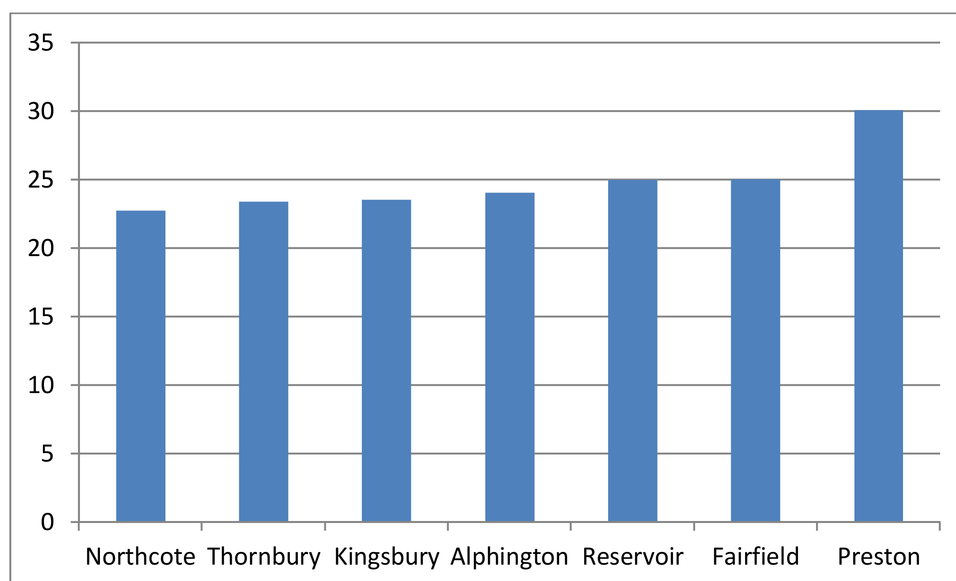


Table 70: Client-to-population ratio, 2014, by suburb

SUBURB	POPULATION AGED 60 AND OVER	N CLIENTS AGED 60 AND OVER	CLIENT-TO-POPULATION RATIO %
Alphington	503	121	24.1
Fairfield	831	208	25.0
Kingsbury	693	163	23.5
Northcote	4,046	920	22.7
Preston	5,567	1,673	30.1
Reservoir	11,352	2,837	25.0
Thornbury	3,040	711	23.4

Discussion and conclusion

The current report focuses on HACC provision now and into the future in Darebin. 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, 7,670 clients were provided with a HACC service in the Darebin area. The proportion of residents using HACC services increased with age, from 8 per 1000 in the 0–49 age group to nearly one-half (460 per 1000) in the age group 80 years and over.

The largest HACC program in Darebin in terms of hours of service is Planned Activity Groups, while the largest in terms of number of clients is Assessment. A substantial proportion (42%) are aged over 80 years, and over three-quarters (77%) are aged over 65 years. About 39% prefer to use a language other than English at home and the most common non-English languages used are Italian, Greek and Macedonian.

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 237.

One-third of clients overall (33%) have a carer, and about one-half (53%) live with family rather than alone or with others. Two-thirds (67%) live in a private house they own or are purchasing. A majority (62%) are on the Age pension.

Client-to-population ratio was highest for Preston, where 30% of clients aged over 60 years were receiving a service, but did not vary a great deal between the other suburbs (range 23% to 25%).

SUMMARY OF HACC AGENCIES AND FUNDING

A total of 39 different agencies were funded to provide HACC services to Darebin residents in 2015, eight of which were funded to provide Allied Health services. Overall, funding for HACC in Darebin grew by 6.7% 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 Respite, Volunteer Social Support, Allied Health and Case Management.

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:

- Volunteer Social Support
- Personal Care
- Allied Health
- Respite
- Assessment
- Case Management
- Care Coordination

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

- Domestic Assistance (hours and 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)
- Property Maintenance

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

- Planned Activity Groups

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 Darebin, 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**[12] 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:

[12] 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[13]

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

[13] 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

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.

<table>
<tr><th>SERVICE</th><th>DESCRIPTION</th></tr>
<tr><td>Respite care</td><td>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.</td></tr>
<tr><td>Client Care Coordination</td><td>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.</td></tr>
<tr><td>Case Management</td><td>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.</td></tr>
<tr><td>Home maintenance</td><td>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.</td></tr>
<tr><td>Counselling/ support, information and advocacy (care recipient)</td><td rowspan="2">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.</td></tr>
<tr><td>Counselling/ support, information and advocacy (carer)</td></tr>
</table>

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[14] describes data elements that are present in the Victorian version of the HACC MDS. The main 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.

[14] 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.