Victorian Healthcare Association

SUBMISSION

Victorian HACC Program Position Paper
Triennial Plan & Expenditure Priorities
2012-15

16 December 2011

1. Introduction

By 2021, Victoria's population will grow to more than six million - almost a 20 per cent increase since 2008. Of these people, 1.1 million or 17.5 per cent, will be aged over 65 - a 50 per cent increase since 2008. An ageing population has ramifications on the delivery and design of home and community care (HACC) services, as older Victorians constitute the bulk of HACC clients (about 70 per cent[1]). These changing demographics create an opportunity to reshape the HACC system by building on existing frameworks and service capacity that have been successful to date.

The VHA appreciates the opportunity to comment on the recent release of the *Victorian HACC Program Position Paper: Triennial Plan & Expenditure Priorities 2012-15*. The directions proposed for the investments in Victorian HACC services, which align strongly with the Victorian Health Priorities Framework 2012-22 (VHPF 2022), have been welcomed by the VHA as a positive step towards a more effective service system into the future.

The VHA welcomes the goal of the Department of Health (DH) to *achieve greater transparency and continuity in the assessment and referral processes, the resources and services available and outcomes expected for Victorian consumers and their families*.

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The Victorian Healthcare Association

The VHA is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

2. The VHA's Response

2.1 Patient Centred Care

The VHA observes that the current mix of services provided to older Victorians is reasonable, although problems exist with timely access to appropriate services and an absence of service coordination. The priority of patient-centred care aims to alleviate these problems by reorientating the HACC service participating units to recognise their interdependence and interact as a structured, functioning unit towards increasing individual and community resilience and responding to community needs.

Older people strongly value their independence. They want to live in their own homes and neighbourhoods, stay connected to their families and friends, have their everyday needs met and remain part of their community as they age. This is enabled with good health and aligns with a priority of the VHPF 2022 in *developing a system that is responsive to people's needs.*

In the past, HACC services centred on providing assistance to individuals with tasks they could no longer perform alone. The shift towards 'wellness' or 'active ageing', as outlined in the Victorian HACC Active Service Model, emphasises proactive and preventative

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interventions that have the potential to reduce dependency levels of older Victorians, or slow their decline, despite the presence of a disability resulting from a chronic illness. This notion emphasises the roles of healthy lifestyles and daily routines, degree of social inclusion, amount of exercise and sense of autonomy and control in enabling older people to maintain their health and independence as long as possible[2]. At the same time, these actions have the potential to save expenditure through decreased demand for high-cost, high-intensity services such as intensive community care, unplanned hospital admissions, or premature residential aged care. This is evidenced by the AIHW report, which investigated pathways in aged care, identifying that the use of community care delays entry into permanent residential care[3].

The Active Service Model still presents as a viable blueprint for shaping the direction of HACC services towards achieving patient centred care into the next triennium. However, this can only be achieved through a collaborative and respectful partnership between the provider and user. Service providers need to respect the input that service users can make towards their own health from their goals, values, knowledge and past experiences. On the other hand, service users need to respect the professional expertise, values, information and knowledge of service providers. The VHA recognises that there are strategies that require investment in order to enhance this partnership. This includes:

a. ICT and information sharing

Supportive infrastructure must be available in striving towards patient-centred care. The VHA recognises the role of information and communication technology (ICT) in making HACC services more efficient and effective in supporting the independence and health of older Victorians. The use of e-health and communication technology is a reform priority listed in the VHPF 2022 and embodies the systematic change necessary to build a health system that is productive and sustainable.

ICT initiatives are required to enhance the interoperability between health and local government IT systems, which enables better sharing of assessment information such as client care plans, with client consent. This may assist in managing assessment demand by ensuring information about the client is accessible to others to avoid duplication and enable them to seamlessly navigate through the service provider world. Information sharing initiatives can facilitate the growth of strong multidisciplinary teams that are able to effectively manage the gamut of complex health needs of clients.

Increasing web-based information sharing strategies, such as forums, enable service providers to share valuable knowledge including good models of practice, innovation, lessons learnt and mistakes made, which can contribute to a more efficient and effective HACC program.

b. Clinical indicators and benchmarking

There is a significant amount of data within the health system that is collected but not used in a meaningful way, particularly in relation to HACC service provision. For example, many healthcare agencies are using internal resources to collect and provide data but the data is not analysed or disseminated in a way that improves their services. The VHA believes health services should not be required to submit data unless they receive meaningful benchmarking information in return. This 'information in/information out' approach will ensure the measures and their implementation contribute to the improvement of health services and outcomes for the Victorian community.

Health service administrators rely on data analysis and comparisons of inputs, operational procedures and outcomes to operate their services more efficiently. Currently, health

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services that provide HACC services have little opportunity to benchmark against their peers, unlike the KPI's that are set via elective surgery and emergency access monitoring, or WIES data in the acute sector. Benchmarking can thus be a powerful tool in identifying the capacity to reach productivity and be a flag in identifying community services needing help to improve. This can be achieved via the appropriate implementation of indicators.

Indicators provide a means to assess and benchmark not only the effectiveness and appropriateness of clinical care but other dimensions of quality that are relevant to primary and community healthcare including safety, accessibility, acceptability and coordination of care. Areas for improvement can be identified through the monitoring of relevant safety and quality indicators. It is important, however, that these indicators are integrated within existing organisational planning and evaluative frameworks and not seen as a stand-alone activity. As HACC providers provide an array of services, the VHA acknowledges that all HACC providers do not adopt every indicator but select a 'local bundle' of indicators from a Victorian statewide set that suits their needs.

The VHA has long advocated that local needs are best addressed by local decisions that lead to local solutions. To achieve this, data must be available at the local level to demonstrate need and structure of service provision, rather than the current regional approach. This data must be available to agencies/providers so they can plan for correct placement of services. The same data must be available to decision-makers to educate their policy and funding decisions.

2.2 Aligning Resources with Population Profiles

Victoria is fortunate to have a highly-integrated and well-funded HACC service delivery system. Significant funding is provided to these services by state and local governments. However, funding flexibility is an important value in meeting client needs that should be reflected in the way care is packaged and provided. The aged population cannot be viewed as one homogenous group. To state it simply, one size does not fit all. The VHA thus welcomes the priority of aligning resources with population profiles and diversity planning.

The VHA believes investment in community-based interventions such as HACC that shape the health and wellbeing of Victorians, is vital. Issues like drought, social isolation, access to services, transport, employment and population change, and the supply of health practitioners cannot be overlooked. The VHA welcomes the DH proposal to continue the current equity strategy in per capita funding (PCF) to local government areas (LGA). It is recognition of the unique needs of many communities in regional and rural Victoria and the necessity to appropriately fund services to clients who are already suffering inequality due to where they choose to reside. However, it is important that this process is transparent.

The VHA also applauds the DH priority to ensure resource allocation is aligned with the changing demographics of target populations with a change to the HACC funding model to be implemented from 2012-13. The shift to the Need for Assistance (NFA) approach to determine HACC populations for PCF, which is based on more robust data and is continuously updated with the release of population projections, is welcomed by the VHA. It is important, however, that a process is available for LGAs to have the opportunity to demonstrate any undue impact of the transition to the new funding model.

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2.3 Workforce

Any attempt at reshaping the current HACC model must be matched by an appropriate, well-distributed and sustainable workforce.

HACC provider organisations vary considerably in terms of size and services offered in order to meet differing client needs and dependency levels. For this reason the staffing mix required must come from a range of different disciplines and backgrounds including allied health staff, home and personal carers and volunteers (including input from informal carers).

The VHA supports the three priorities outlined in the position paper that encourage upskilling and training to support the HACC workforce. However, innovation in workforce models is also needed, including the scope of staff practice, their skills, roles and sharing between HACC agencies, which should be a focus to achieve efficiency and patient-centred care outcomes.

The current approach to workforce requires patient care to be given according to professional discipline, regardless of the competency of other healthcare workers. This often results in healthcare services being restricted in their workforce solutions. For example, an experienced patient care worker trained in the activities of daily living and with some drug competencies, could provide routine home nursing in consultation with a registered nurse. Work demarcation needs to be addressed in order to move away from professional 'silos' towards a workforce based on capability and competency.

More inter-professional and multidisciplinary models of care should be investigated. A core of workforce redesign is creating new categories of healthcare workers that complement trained health professionals and relieve them of the routine and time-consuming elements of their profession.

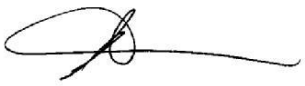
The establishment of Health Workforce Australia by the Council of Australian Governments presents an opportunity to develop policy and deliver innovative programs in rejuvenating the health workforce so that they are more responsive to HACC clients and the services provided.

3. Conclusion

Whilst Australia's ageing population presents many challenges ahead, the three priorities outlined by DH provide a positive platform to enhance the HACC program and to continue to meet the needs of its clients, and enable them to remain independent and active within their community.

The VHA welcomes the opportunity to provide information to DH regarding the HACC program plan for the next triennium and looks forward to working in collaboration towards the attainment of these three priorities.

Please contact me on (03) 9094 7777 to clarify any information in this submission.



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[1] Australian Institute for Primary Care. 2008. The Active Service Model: A conceptual and empirical review of recent Australian and International literature (1996-2007).
[2] Australian Institute for Primary Care. 2008. The Active Service Model: A conceptual and empirical review of recent Australian and International literature (1996-2007),
[3] Australian Institute of Health and Welfare (AIHW). 2011. Pathways in aged care: do people follow recommendations?

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