Statement of Clare Lynette Hargreaves

Name:	Clare Lynette Hargreaves
Address:	Level 12, 60 Collins Street, Melbourne
Occupation	Manager, Social Policy, Municipal Association of Victoria
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1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety.
2. This statement is true and correct to the best of my knowledge and belief.
3. I make this statement on behalf of the Municipal Association of Victoria (MAV) and am authorised to do so.

Professional background

4. I am currently employed as a Manager of Social Policy at the MAV. I have worked at this organisation since 1994. In this role I have contributed to national and state-wide policy and service system development, negotiated intergovernmental agreements and provided advocacy and support and on behalf of Victorian local governments to both the Victorian and Commonwealth governments.
5. Previously, I have held community services management positions in both rural and metropolitan Victorian councils. I have also held management and social work positions in community and hospital based psychiatric services.
6. In these roles I have had experience in managing aged care services, service development and providing case work services to older people.
7. I hold a Bachelor of Arts, Diploma of Social Studies and have completed senior management courses in local government.

Municipal Association of Victoria's Position Statement

8. The Municipal Association of Victoria welcomes the opportunity to present this submission to the Royal Commission on Aged Care, Quality and Safety.
9. This statement is informed by evidence collected from both Victorian councils, the Australian Local Government Association and the MAV's interstate equivalent organisations where appropriate.

10. The MAV is the legislated peak body representing Victoria's 79 councils and is a signatory to the Trilateral Statement of Intent (the Statement) (February 2017) between the Commonwealth, State of Victoria and Victorian local government (represented by the MAV). The purpose of the Statement is to recognise the role of local government in Victoria as planner, developer, funder and deliverer of services for older and younger people and to retain the benefits of the Victorian HACC system. (This Statement was signed off at Ministerial level).

11. On behalf of local government this submission advocates for a commitment by the Commonwealth to the ongoing recurrent funding for expansion of the Commonwealth Home Support Program (CHSP), preferably implemented through a National Partnership Agreement and Bilateral Agreements with each jurisdiction.

12. Below we provide a summary of the MAV's key recommendations before responding specifically to the topics put forth by the Royal Commission.

Recommendations

a. Capitalise on the historical investment and commitment of local government by providing certainty and ongoing recurrent funding for CHSP.

b. Retain block funding to support population based service planning and delivery, which ensures appropriate access for all older people and capacity for demand management.

c. Retain and expand the CHSP and reinstate annual growth funding for CHSP, and discontinue Level 1 Home Care Packages and roll the funding allocation into CHSP.

d. Negotiate a formal role with local government in planning, co-design and stewardship on behalf of their communities / citizens (public sector stewardship).

e. Continue current intergovernmental Commonwealth / State / local approach to planning and co-design of community care.

f. Establish a formal National Partnership Agreement on community aged care supported by Bilateral Agreements with each jurisdiction to achieve continuity of care and access and equity for older people nationally. (Bilateral Agreements have the capacity to recognise the different starting points of each jurisdiction and build on the strengths of the existing system).

g. Continue Commonwealth and State/Territories investment in local government to support councils to act as effective public sector stewards at the local level.

Key features to retain and develop in the new system

13. ***System***

a. Continue intergovernmental Commonwealth / State / local approach to planning and co-design of community care.

b. Establish National Partnership Agreement on community aged care supported by Bilateral Agreements with each jurisdiction - building on the strengths of each system.

c. Negotiate a formal role with councils in planning, co-design and stewardship on behalf of their communities/citizens (public sector stewardship).

d. Embrace the subsidiarity principle – that a central authority (C/W) should have a subsidiary function and perform only those tasks which cannot be performed at the local level.

e. Design primary care type services to be devolved, place based and bottom up, with easily accessible advice to local people.

f. Plan supply and demand on a demographic basis with local input and advice from State and local government.

g. Strengthen wellness and reablement approaches in program guidelines.

h. Commit to ongoing Commonwealth funding to the Victorian government to deliver the Regional Assessment Service

14. The largest segment of the older population is being served by community care, assisting in keeping those people out of costly acute and residential care. The transactional costs alone of moving to an individualised funding model would be prohibitive. Commonwealth funding for residential care totalled $12.2B for 181,000 clients nationally in 2017-2018 and Commonwealth funding for the Home Support Program totalled $2.8B for 780,000 clients nationally in 2017-2018.

15. For up to 70 years, Victorian councils have been effectively managing demand for services on behalf of the Commonwealth - allocating formal and informal community services appropriately according to residents' needs, and are clearly understood by the community to be the first entry point into the system.

16. ***Service Design***

a. Plan services on a demographic and geographic basis with place based responsibility for meeting the needs of the older population of that community (in contrast to providing individualized services to selected individuals, with no responsibility for others who miss out).

b. Continue block funding on a price / volume basis to support this population based approach, enabling differing and variable needs of residents to be met within a funding envelope for the municipality, and workforces allocated accordingly.

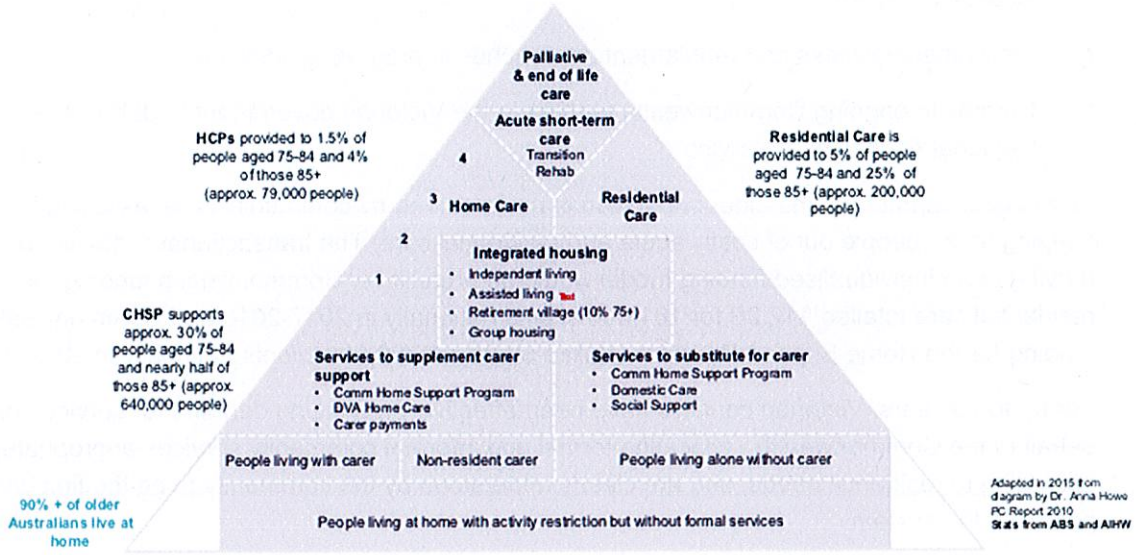
c. Re-establish the role of councils as the first point of contact. If local government is not the main player in some jurisdictions, community health / not for profit agencies for example may be contracted.

d. Create a new funding stream for planning and service coordination. Local government can play a key role in providing information to residents and undertake local area planning with the State and Commonwealth to ensure an appropriate range of services are available to meet diverse needs.

17. Local solutions for residents both formal and informal are activated by local councils/agencies – as they take responsibility for the population (in comparison to role of an agency with a set allocation of packages).

18. Access to entry level / foundational services should be easy for residents, enabling connection with assessment and advice regarding formal and informal community services, allowing for more judicious allocation for more expensive services.

19. *Diagram 1: Aged Care Typology and Utilisation*



Conclusion

20. Nationally local government has a legislative commitment to promote the health and wellbeing of all its residents including older people (in Victoria through the *Local Government Act 1989* and the *Public Health* and *Wellbeing Act 2008*).

21. Home and community care services have historically been delivered through a successful trilateral partnership between the three spheres of government. Local government has and continues to be committed to playing an active role.

22. We are therefore looking to the Commonwealth to acknowledge and continue this joint partnership to maximise the policy, planning, service delivery and financial investment being contributed by the three spheres of government on behalf of the Australian community.

A) What role does local government currently play in the delivery and oversight of the aged care system in Victoria (and, to the extent you have knowledge of this, in other States and Territories of the Commonwealth)? In your answer, please include comment on the extent of changes in recent years, and any risks that you consider may follow from future changes contemplated by the Australian Government.

23. Since its inception in 1985, local government has been, and continues to be, the primary provider of the Home and Community Care (HACC) Program, now the Commonwealth Home Support Program (CHSP). It is also the primary provider of Regional Assessment Services, providing a state-wide system with one major provider of home-based services in each local government area (LGA).

24. Given councils' history and extensive experience they have developed absolute expertise in the funding, demand management and delivery of services for their communities in a planned, coordinated and integrated manner. In 2017-2018 the contribution to the CHSP by Victorian local government was estimated at $150-$200M, thereby ensuring a complex and highly integrated service system which:

- Provided an easily identifiable access point into CHSP and related services, whether funded or not.
- Undertook a holistic assessment of client needs via a strong and multi-tiered assessment framework.
- Planned, coordinated and delivered the full suite of quality and integrated services to diverse groups of people (excluding nursing and allied health).
- Embed wellness and reablement to maintain functional independence.
- Delivered an extensive array of social support, health and well-being programs.
- Employed a large and highly skilled workforce – close to 7,000 people in 2017-2018.
- Collaborated with primary care and acute care providers, expectations central to Primary Care Partnerships and Primary Health Networks.
- Advocated on behalf of vulnerable Victorians.

25. Councils provide most service types within the CHSP. The services vary dependent on the needs of the community and the funding provided. The close connection councils have with their communities informs and supports the provision of services that best meet the needs of residents.

26. The majority of councils deliver services for which they are not funded for. For example, councils in Victoria are not funded to deliver transport, however transport is essential to support the health, wellbeing and independence of residents through shopping, accessing primary/community health services and social support. Despite this funding anomaly, councils have chosen to fully fund this service.

27. In small rural communities often council and the health services are the only organisations with the scale, capacity and local connections to manage community care and related programs across the municipality.

28. In a number of rural areas, joint approaches between the local organisations, or between councils across a sub–region have developed to overcome issues of sufficient scale and expertise.

29. While some councils have elected to relinquish their roles in delivering CHSP services they all continue to provide funding to the other local organisations, mainly rural health services, who have taken on this role. Most of this divesting occurred at the time of council amalgamations and compulsory competitive tendering in the mid1990s.

30. Currently five councils subcontract some or all their home care services, and a few other councils use some sub-contractors for minor parts of their services, to achieve specialisation or better meet diverse needs. Purchasing meals from external providers and contracting home maintenance services are also relatively common practices.

Nature and extent of changes

31. The key changes arising from the reforms include:

- **Funding**: potential replacement of output-based funding with a mixed funding approach to individualised funding and the mooted discontinuation of block funding as of 30 June 2020.
- **Scope of services funded**: only basic home support services are funded - Care Coordination is no longer funded as a separate service type in CHSP.
- **Service provision**: potentially contestability and a shift to a market-based system may dissuade councils from continuing their roles in funding and delivering services.
- **Assessment, referral pathway and case management**: creation of My Aged Care as a single-entry point; the introduction of Regional Assessment Services independent from service provision. (The ability to self-refer and receive immediate support at the local level is a key feature of the Victorian system).
- **Eligibility criteria**: the target group does not include people aged less than 65 years or less than 50 years for Aboriginal people – creating a 'hard' cut off point that had not previously existed.
- **Consumer directed care**: introduction of individualised budgets attached to the consumer and client choice in selecting a service provider.

Risks arising from changes

32. In a report by the MAV to the Victorian Office of the Commonwealth Department of Health in 2016[1], the following benefits of local government involvement in aged care were identified at being at risk to varying degrees depending on the path chosen by the Commonwealth. The

[1] Municipal Association of Victoria (2016) *Background Paper: History of Local Government in HACC Services*

nature and extent of these changes may be profound and pose considerable risks to clients, carers, communities, workforces, the Victorian service system and councils.

32.1. The additional long-standing financial contribution by councils has provided all Victorian communities with a robust, uniform and accessible local community care system.

32.2. Victorian communities have supported their councils having a service provision role in a wide range of locally planned and co-ordinated human services, including early years and aged care, and using their independent resource base (i.e. rates, land, buildings) and civic leadership role to this end.

32.3. Councils have a long history and accumulated experience in delivering community care services and have developed expertise in ageing.

32.4. The exchange of skills and knowledge from the service provision role (HACC staff) informs and improves councils' wider service delivery functions and community planning capacity in relation to older people.

32.5. HACC and the other community services provide a direct connection between council and large numbers of local older people, people of all ages living with disability and their family carers. It is a very personal and tangible relationship with the local council.

32.6. Another added value of councils' role in HACC is the dialogue with citizens through the HACC service relationship which informs other needs and solutions in the municipality e.g.: pedestrian and footpath issues, community safety concerns, transport routes etc.

32.7. HACC has provided a lot of people with access to local support services as they age or lose function, and thus see council as a point of contact for information and advice re other needs.

32.8. As a sphere of government, councils are best placed to support local and regional collaborative partnerships in policy and program development and can support and plan for more horizontally integrated service networks.

32.9. Council and the public health services can provide a base for localised services, which improve access, workforce opportunities, economic development and inter-agency communication, particularly in rural communities, which otherwise may be serviced by outreach from regional centres.

32.10. Through HACC, councils have been able to provide local family friendly job opportunities, with skill development, training, fair wages and conditions for a predominantly middle-aged female workforce, including those with English as a second language, who often have the least employment options in a local community.

32.11. Having both provision and planning roles provides councils with a sound base for policy making and advocacy, which is enhanced by:

- ability to respond to local variations in need as they occur, including demographic change.

- ability to integrate the full range of local conditions, resources and needs in economic, social, physical and natural dimensional planning.
- geographical proximity allows local councillors to be directly aware of the local consequences of policies and exercise their mandate and experience to provide policy advice and advocacy for the local community with other levels of government.
- a direct connection with local neighbourhoods and individuals, families and a wide range of service providers and service users, in combination with an organisational infrastructure which can provide capital, material, human and/or financial resources.[2]

Response from the Local Government Association of New South Wales

33. More than 100 councils across NSW have delivered aged and disability services within their communities with the assistance of State and Commonwealth Government funding for many decades.

34. There are currently 78 councils (from a total of 128 councils) delivering direct aged care services across NSW plus another 30 councils delivering non-output services providing sector support services to the industry in their local government area.

35. Sector Support services focus on capacity building, information dissemination, training and professional development, coordination of regional networks and interagency aged care forums, Aboriginal network support and development.

36. Sector Support roles can also provide one-on-one support to older people from marginalised communities accessing aged care services, including supported referrals to My Aged Care. These roles, such as ageing and disability positions in councils, can help build inclusive communities and support older people to access services appropriate to their needs.

37. NSW Councils continue to balance the competing demands of the aged care reform roll out, amalgamations and restructures and continuity of service provision amidst an uncertain funding future. Already, a significant number of staff, expertise and sector knowledge has been lost in NSW councils and the industry at large

38. Without sufficient collaboration, support and funding, Councils' capacity to enhance services and re-invent ageing infrastructure to meet the needs of frail older people will be significantly reduced. This will greatly impact on Councils' ability to work in partnership with both State and Commonwealth governments as they endeavour to implement strategies at a local level.

39. Risks are associated with the uncertain funding future regarding some programs including the CHSP. A key risk is that providers, including local councils, withdraw services leaving vulnerable people without essential services for support and social connection. It also results in a significant loss of expertise, knowledge and resources from the sector.

[2] Municipal Association of Victoria (2016) op cit. pg.5

40. The principle of competitive neutrality is also a growing risk for councils in an open market environment (e.g. councils may need to justify why they are operating in a market-driven context, competing with local aged care businesses).

41. The uncertainty around a proposed integrated care at home program is also a risk to service continuity and an assurance that services provided continue to meet community needs.

42. A LGNSW survey to councils in 2018 indicated "most councils are still undecided as to whether they will continue to deliver aged and/or disability services and that the clarification of future government funding is a key factor in council service planning processes". LGNSW continues to advocate for a commitment to ongoing, recurrent funding for aged care and home support services.

Case Study: Assessment Services in Victoria

43. In Victoria, the State government is the single Regional Assessment Service (RAS) for the state. 68 of the 79 councils in Victoria are RAS outlets. The remaining 11 outlets are community health providers. The outlets are grouped into the 9 Aged Care Planning Regions (ACPR) with 7-14 outlets per region. This model supports locally delivered assessment.

44. There are distinct advantages to delivering assessment at a local level, primarily being aware of community supports and services available (both funded and non-funded) and having general community awareness.

45. Being affiliated with councils, means that Assessment teams are able to interact with other areas of council and support the development of programs and service which may be missing in the community. As the single RAS, the Victorian State Government is able to influence the consistent delivery of Home Support Assessment to the advantage to clients who will receive an assessment comparable to counterparts in other ACPR.

46. Assessment in other Australian states and Territories is delivered by multiple RASs per state (NSW 5, Qld 6, SA 4, NT 2, ACT 2, Tas 2, WA 4). Each ACPR has 2-3 RASs per region, with the exception of some regions of WA and NT where there is a single provider. Most are non-government agencies. Some agencies cover multiple states.

47. Assessment in Victoria is block funded, this is in contrast to other jurisdictions, where a unit cost is applied. A block funded assessment model is to the advantage of clients. Assessors are supported with time to undertake a holistic assessment of the client in the first instance, minimising the need for follow up reviews and assessments. The Assessor can discuss a range of supports with the client inclusive of both funded and non-funded services. Unit funding supports poor assessment practice by incentivizing a high volume of assessment. This may mean that clients are assessed multiple times rather than exploring a person's full set of needs at the initial assessment. There is an advantage to the agency in reassessing a client rather than reviewing a support plan, a function available to assessors within the My Aged Care portal.

48. Assessments, where necessary, in Victoria are supported by face to face interpreters. Funding for this service has been provided by the Victorian Department of Health and Human Services (DHHS). A face to face interpreter is preferable to a video or over the phone interpreting service. In all languages, body language and facial expressions make up a significant portion of

communication. When interpreters are physically in the room they can do a much better job of reading body language and facial expressions. People communicate as much or more with our body than we do with our words. In person, the interpreter can pick up on things like when the speaker is confused or has a question or needs further explanation. Speakers frequently point to certain body parts or items in their vicinity but fail to clarify what it is that they are speaking about. The lack of visual cues increases the chance of misinterpretation, especially when terminology used has multiple meanings. Without the ability to observe, an interpreter would have to interrupt the proceeding to seek clarification much more often than during face-to-face interaction. In some languages, non-verbal communication is even more significant than others. Facial expressions and gestures can convey additional meanings that may not be picked up on over-the-phone and may lead to misinterpretations. In other states and territories, phone interpreters are the norm. No Commonwealth funding is provided to support assessment with face to face interpreters.

49. Victorian councils maintain a register of vulnerable persons who may require supports in times of emergency (i.e. fire, flood, etc.). Without the involvement of councils in aged services, the Vulnerable Persons Register is likely to cease. Without the register, reaching vulnerable clients in a timely manner may be impossible and put people's lives at risk.

B) What role does local government currently play in Victoria and, to the extent you have knowledge of this, in other States and Territories of the Commonwealth, in service co-ordination of aged care services?

Municipal Association of Victoria

49.1. *The role played by Victorian councils is also outlined in responses to topics A and F.*

Australian Local Government Association

50. In its submission to the 2019-2020 Federal Budget[3], the Australian Local Government Association stated:

50.1. *Over the past two decades the roles and responsibilities of local governments have grown significantly but their revenue base has not. Local Government's remit has increased as a result of the need to address market failure (particularly in rural and regional areas where it is frequently not financially viable for the private sector to provide essential goods and services such as aged care or childcare). In addition, there are examples of poor service delivery on behalf of the Commonwealth and state governments (for example support for medical and allied health services and early childhood education) and increasing community demand for services.*

50.2. *Cost shifting by the Commonwealth and state governments is one of the most significant problems faced by local governments in Australia. Along with rate capping (in the states where this occurs), cost shifting undermines the financial sustainability of the local government sector by forcing councils to assume*

[3] Australian Local Government Association (2019) Draft Submission to the 2019-2020 Federal Budget

responsibility for more infrastructure and services, without sufficient corresponding revenue.

50.3. *The financial sustainability of local governments and their ability to provide essential services and infrastructure in their communities is further impacted by the relative decline in core federal funding to local government in the form of Financial Assistance Grants (FAGs).*

50.4. *The Commonwealth Home Support Programme (CHSP) provides a basic level of aged care services to support continued independence for people aged 65 and over living at home and delaying entry to more expensive residential care. The CHSP funding currently ceases from 30 June 2020.*

50.5. *Many local governments across the country currently deliver successful and important services to the elderly in their communities under CHSP. This includes providing a holistic approach to services, fostering social connections and inclusion and providing an even greater impetus for local governments to actively support their older people across all the domains of active ageing.*

50.6. *For example, in Victoria, seventy-two councils currently deliver CHSP and approximately 210,000 Victorians use these services along with allied health and home nursing services. Councils' contribution is now up to $200 million annually and they provide services in key areas of home and community care including domestic support, meals, transport, personal care, social support (including planned activity groups) and home maintenance. In NSW 90 councils deliver similar services under the CHSP program and in South Australia approximately 50 Councils are involved.*

50.7. ***Why is this important to the Commonwealth?***

50.8. *The 2015 Intergenerational Report stated that the number of Australians aged 65 and over is projected to more than double by 2054–55, with 1 in 1,000 people projected to be aged over 100. In 1975, this was 1 in 10,000. Expenditure on aged care services is projected to nearly double as a share of the economy by 2055, as a result of the increase in the number of people aged over 70. There is significant public involvement in the sector, with $17.8 billion of Commonwealth expenditure allocated to supporting aged care services in 2016-17.*

50.9. *Keeping people out of expensive residential care and more connected to the community will ultimately be more cost effective for the Commonwealth. The CHSP is far from being an 'entry-level' service, it is a key component for keeping the vast majority of people requiring support in their homes for their whole lives.*

50.10. *Councils deliver cost effective and efficient services with block funding as they contribute significant in-kind funding which stretches the Federal funding even further. In addition, the Productivity Commission Review into the National Disability Agreement stated that some services were not suited to individualised funding, and should continue to be block funded. Due to the similarity of service delivery this is also likely to be relevant to aged care services.*

50.11. *Councils also add value to services through volunteer networks and significant infrastructure, such as kiosks, libraries and community centres. Councils combine expertise in social support and community wellbeing services. With the use of volunteers, councils offer essential services such as transport at a significantly reduced rate making it affordable and accessible for older people.*

50.12. ***What is our proposed solution?***

50.13. *The CHSP programme continue beyond 1 July 2020 for a further three years at a minimum, to ensure continuity of care, recognising that frequent changes to community sector funding arrangements do not deliver certainty to those dependent on community care.*

50.13.1. *Commit to continued block funding for the three-year period beyond 2020 to:*

50.13.2. *Provide continuity of direct service delivery of core CHSP services*

50.13.3. *Provide information, advice and community support*

50.13.4. *Ensure reasonable and necessary support options where markets are thin*

50.13.5. *Sustain and build service capacity during development of My Aged Care system; and*

50.13.6. *Enable informed choice and expand knowledge of community options.*

Response from the Local Government Association of South Australia

51. Local government's role in providing a sense of community is clearly a major focus for South Australian councils, who note their role extends further than the direct provision of aged care services. Many councils have strategies that link aged care to community wellbeing and social inclusion, such as community development plans and active ageing strategies.

51.1. There is considerable anecdotal evidence that many older people and those who support them find navigating the My Aged Care system to be a challenge. South Australian councils are reporting that older residents still contact Council by phone or in person seeking help and support, essentially because councils have a very long history of providing home care services. South Australian councils recognise that they are often the first point of contact for older members of the community, who have a strong sense of trust for council services. This often results in councils supporting the more vulnerable members of society and providing advice, advocacy and referral to other services.

51.2. Much has been written about the unique perspective that local government brings to the provision of services and programs for ageing citizens. Local government has a view of older people as citizens of their local community, not consumers or clients of a service. In particular, local government centre-based programs, which focus on social connection, have complemented Home and Community Care (HACC) services through reconnecting, re-abling and fostering community connections, networks and friendships between local people. Councils are seen as having a community development role, which seeks to build the community's social capital and wellbeing through inclusive programs that increase community participation, social connectedness and skills/capacities.

Response from the Local Government Association of New South Wales

52. Local Government plays a significant role in building the inclusiveness of the local community, by coordinating and supporting local area activities. And as a regulator, Local Government makes a positive impact on the inclusiveness of the community through development controls, public domain management policies and community strategic planning.

53. In summary, local government:

53.1. Identifies, provides or facilitates the provision of facilities and services which meet the needs of older residents to maximise quality of life and wellbeing.

53.2. Assists older residents to remain in their local community by facilitating appropriate infrastructure and facilities, adequate support services and housing options.

53.3. Recognises the importance of including older people in council's planning and other activities relating to infrastructure.

53.4. Provides or facilitates the provision within the local community of services and programs relevant for all older people, regardless of their health status, gender, marital status, sexuality, language, culture, race, religion, disability or status.

53.5. Meets the gaps in service provision when there are no other providers, particularly in rural and remote areas. It also supports other providers by accommodating services in council buildings and providing local facilities for services and support activities.

53.6. Acts as local 'community hubs' and as such has extensive knowledge of local community services and provides significant information and referral services as part of their community development programs. For example, access to home care services is enhanced in rural and remote areas of NSW through council facilitation of required referral processes for consumers.

53.7. Has a growing role in market stewardship to ensure aged care service provision is effective at meeting the needs of all local citizens. This is essentially driven by the move to a more open market environment for both aged and disability services.

C) How do local and State Government currently fill the Commonwealth funding gap in Victoria and, to the extent you have knowledge of this, in other States and Territories of the Commonwealth?

54. The strength of the previous HACC program run jointly by the three spheres of government - which has been operating successfully for the older population and a number of people with disabilities in Victoria since post World War 2 - is based on providing small amounts of appropriate preventive service to enable people to stay in their own homes.

55. Since 2008, there has been even greater emphasis on an 'active service model' to restore the older person's capacity and physical wellbeing to manage their own life as much as possible. Western Australia and Victoria have led this approach. In fiscal/economic terms for government – this is understood to have led to reduced numbers of hospital emergency presentations; a reduced dependence on in-home services such as domestic assistance and personal care; and / or the need to utilise more costly residential aged care / packages.

56. A key feature also is that the resident is professionally assessed in their home in a comprehensive manner at the outset and linked in to a range of formal and informal supports in the local community.

57. The large majority of people receiving these services are now 85 years and over. Councils play a significant role in both oversight on behalf of the geographic area and also appropriately allocating ('rationing') services to those most in need and working through a range of support options to all residents contacting or being referred to the council.

58. The principle of 'subsidiarity' - the idea that a central authority should have a subsidiary function, performing only those tasks which cannot be performed effectively at a more immediate or local level, very aptly encapsulates the rationale for these services being delivered at the local level.

59. HACC services have been highly visible and accessible to the community. Residents can readily contact council for assistance with understanding and navigating the system who can coordinate navigation of the system with them.

60. As there are a large number of people involved receiving very small amounts of service per annum, the block-funding model is most appropriate. (The transactional costs alone of trying to deliver these services as 'individual packages' would be both prohibitive for governments and also reduce the funding pool available / reduce the number of individuals able to be supported / linked in to appropriate services).

61. The program has been a joint effort to the Commonwealth, State and local government for many decades, with each sphere playing an appropriate role and both the Victorian State and the 79 councils being willing to provide additional revenue to meet the needs of their residents. Councils in Victoria commenced the service post war and for many years contributed funding for 20% of the total HACC service delivery in Victoria.

62. Councils continue to contribute in the order of $150-$200 M per annum. For councils to continue their efforts and allocate rate dollars to these services - formal recognition of their sphere of government role is required by the Commonwealth.

D) What are the positives and negatives surrounding the current model for delivery of home care and home support to older Australians?

63. **Positives**

63.1. The foundational program previously HACC now CHSP has supported people to remain living independently in their own homes for decades, thereby preventing premature admission into residential care.

63.2. HACC / CHSP has been a significant and cost effective model of primary care support (ref Diagram 1 P. 2).

63.3. Provision of a single client record visible to key stakeholders.

63.4. The adoption of the Wellness and Reablement model by the Commonwealth.

63.5. Local government is a trusted service provider, perceived by the community to be understanding and supportive of their needs.

64. **Negatives**

64.1. Level 1 and arguably Level 2 Home Care Packages are nearly identical to the level of service provided via CHSP but are more costly to deliver. The fee structure for HCPs dissuades clients from moving to CHSP.

64.2. Within the model of Home Care Packages there is a potential for providers to over service to expend the budget.

64.3. Clients with a low level of need are unnecessarily accessing Home Care Packages contributing to the long wait for Assessment and allocation of packages for people with greater support needs.

64.4. The model of Wellness and Reablement is a core component of the CHSP but is not encouraged or supported in Home Care Packages.

64.5. The Home Care Package program lacks guidelines. Providers purchase a wide variety of goods and services that may or may not be related to the care and independence of the client.

64.6. Vulnerable clients are left without supports due to the difficulty in accessing services through My Aged Care.

64.7. There is limited opportunity to manage demand for services when delivery is spread across numerous providers with no local oversight.

64.8. Refer response to Question H.

E) How might the system be improved moving forward?

65. In response to the significant concerns Victorian councils have raised with the MAV regarding the potential service system failure in aged and community care, we propose to find a solution with the Commonwealth that maintains the high quality and considerable strengths of the system we have in Victoria, which has evolved over many decades through public sector stewardship and a tripartite partnership between the Commonwealth, State and local government (Refer Executive Summary, P.1.)

66. The corollary of the reforms to date has resulted in councils making decisions regarding funding and service delivery with potentially negative consequences for both the community and the Commonwealth agenda.

67. To ensure service coverage for older people and current standards are maintained, we would propose the following:

Bilateral Agreement/s

68. While the MAV acknowledges the desire of the Commonwealth to achieve national objectives through the aged care reforms, there are many examples where National Partnerships have successfully been enacted through Bilateral Agreements with each jurisdiction to achieve similar nationwide outcomes. For example, under the National Partnership on Universal Access to Early Childhood Education (to achieve 15 hours of kindergarten) Bilateral Agreements recognised the different starting point of each jurisdiction and successfully built on their existing system. The MAV seeks to work with the Commonwealth and the State to explore opportunities to maintain the strengths of the Victorian system through the continuation of a Bilateral Agreement that quarantines the strengths of the Victorian Community Care system, and which ensures continuity of care and is premised on the principle of subsidiarity.

Commonwealth Home Support Program

69. The lack of clarity regarding policy and funding changes is highly disruptive and is having significant impact on community care workforces, consumers and councils' budget planning processes. Retaining and expanding the CHSP and reinstating both recurrent and growth funding for CHSP are priorities for local government. It is further recommended that Level 1 Home Care Packages are discontinued and the funding for such be rolled into the CHSP. Frequent changes to community sector funding arrangements do not deliver certainty to older people dependent on community services.

Block funding

70. The mooted discontinuation of block funding and the lack of certainty regarding funding levels is influencing councils' decisions regarding their future roles in service delivery. It is recommended that block funding be retained to support population based service planning and delivery, which ensures appropriate access for all older people and capacity for demand management.

Regional Assessment Service

71. Commit to the ongoing Commonwealth funding of the Victorian government to deliver the Regional Assessment Service.

Stewardship by Government

72. The reform processes, outlined within the *Future reform – an integrated care at home program to support older Australians* discussion paper, are contingent on effective processes of stewardship operating at various levels of government. Yet, as the recent Productivity Commission (2017) review into human services noted, "there are currently a number of limitations in terms of governments' abilities to act as system stewards". This issue is not restricted to Australia. Internationally a number of different systems are grappling with this issue.

73. The MAV is of the view that there is a real and significant need to invest in improving the capacity and capability of government agencies to act as effective stewards if the benefits of mixed market systems are to be realised. There are significant risks in driving greater levels of competition within public services, particularly for those who are most disadvantaged. Without significant investment in improving the stewardship capabilities of governments there is the potential for a number of these reforms to disintegrate a well-established service system in Victoria and potentially have a detrimental impact on some parts of the population. Victoria has a long-standing intergovernmental partnership to plan and deliver a coordinated system of community care to older people – which provides a high quality platform and essential stewardship. It is our view that public sector stewardship must be continued.

New funding stream for planning and service coordination

74. The creation of a new funding stream for planning and service coordination is recommended. Local government can provide a key role in providing information to residents and undertake local area planning with the State and Commonwealth to ensure an appropriate range of services are available to meet diverse needs. This would ensure clients (and their carers) are able to continue to access the service system, and local area planning in collaboration with State and Commonwealth governments could be led to ensure a range of services are available to respond to diverse needs in a planned and coordinated manner.

F) Describe the role of local government in the delivery of aged care historically in Victoria

75. Local government in Victoria has had a longstanding and robust partnership with the Commonwealth and State government in human services delivery for many decades.

76. Local government has responsibility under the *Local Government Act 1989* and subsequent amendments, to provide equitable and appropriate services and facilities for the community. Local government also has responsibility to protect, improve and promote the public health and wellbeing of its residents, under the *Public Health and Wellbeing Act, 2008.*

77. By the 1960s, Victorian local government had systematically developed a role in initiating and providing human services, including aged community care, supported and encouraged by State government subsidies. This situation was atypical for a local government sector*: among Australian States the Victorian municipal system is notable for its commitment to human services development.*[4]

[4] Victorian Government (1983) *Human Services Program Report: Main Report*, 1983, p 1

78. From 1971, Victoria received funding from the Commonwealth under the State Grants (Home Care) Act 1969 and the Delivered Meals Subsidy Act 1970[5]. Respite services for families caring for children with disabilities were introduced in Victoria in the early 1970s.

79. The functions, structure and funding responsibility for aged care was frequently examined throughout the 1970s and early 1980s in Victoria and nationally. Several studies were undertaken by the State, concluding that councils' role in direct service provision had significant benefits:

    79.1. *Local government is now widely regarded at both the State and local level as being the most appropriate level for the development of human services because it is accessible, responsible and accountable, and is seen as the level of government best suited to developing an integrated range of services responsive to the changing needs of local communities.* [6]

80. Councils' contribution to services such as domestic assistance had been, and remained at twenty per cent, up to an agreed wage limit, and the meals subsidy remained low, predicated on the history of its development as a "good neighbour" type service, primarily delivered by volunteers.

81. The Commonwealth Home and Community Care (HACC) Act of 1985 introduced major changes to the funding and administration of aged and disability services with the major reforms:

- consolidating several community care programs, which were previously administered under separate Commonwealth Acts
- defining and standardising the target recipients, and
- extending the range of funded services to include home maintenance, personal care and respite care.

82. With the introduction of the HACC Act, local government was requested to 'maintain effort' by continuing to provide $2.04 million (in 1985 dollars), which represented about 10 per cent of councils' financial contribution at the time. Until 2003-04, this lower than actual but imputed additional council contribution to HACC services, was included in the State's reporting to the Commonwealth, although the practice of councils' contributing financially to the service was not formally included in legislation, or the Commonwealth/State Agreement.

83. With the introduction of Compulsory Competitive Tendering (CCT) by the Victorian Government in 1995, councils reviewed their role in providing community care services, and market tested their services. Five councils withdrew from the role of provider altogether and the delivery of these services was devolved to other local organisations, mainly rural health services, some with and some without additional council contributions.

84. In 1996, the Victorian Government introduced an output purchasing model for some of the HACC services. Councils adjusted their budgets to the purchased targets at the time, although many continued to fund both additional hours of service to better meet local need, as well as the gap

[5] Municipal Association of Victoria (1994) AV, op cit, p 11.

[6] Victorian Government (1983) op cit, p 6.

between subsidy and cost of the other HACC activities, such as meals, which remained subsidised, not fully funded or purchased services.

85. Because councils were used to contributing about 20 per cent of the costs under the old formulas, many continued to contribute at around that level.

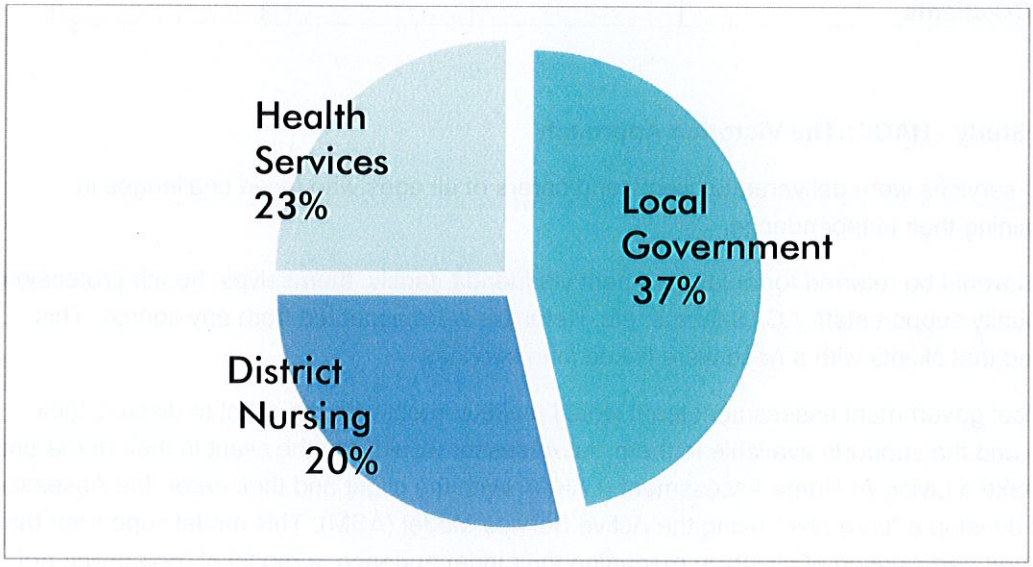
The distribution of funding in Victoria

86. Up until 2016 Victorian councils received approximately 37 per cent of the annual State HACC budget and 72 out of the 79 councils provided the more commonly used or core HACC services, including assessment and domestic assistance, personal care, respite care, property maintenance, delivered meals, and social support services. (Refer Figure 1)

87. Eighty per cent of HACC funding for services went to 2 or 3 organisations (including councils) in any local government area (LGA). Every community had at least several other small local or regional organisations providing mainly social support services, including services to culturally and linguistically diverse (CALD) and Aboriginal communities.

88. This relatively uniform and visible local provision platform across the state contributed to accessibility and integration of HACC with other services.

89. *Figure 1: HACC funding distribution in Victoria*



90. Table 1 below indicates that councils in Victoria serviced 44% of all HACC in 2015-2016 which is in excess of the government funding allocation due to the contribution of local government.

Table 1: Clients who received a HACC/CHSP service from Victorian local government in 2015-16 (most recent data)

HACC MDS 2015-16	Under 65	65 and above	Total
Clients who received a service from local government	**20,502**	**114,412**	**134,914**
%	15%	85%	100%
All clients	**76,691**	**228,728**	**305,419**
%	25%	75%	100%
Proportion of local government clients over all HACC clients	**27%**	**50%**	**44%**

Case Study - HACC: The Victorian Approach

91. HACC services were delivered to clients and carers of all ages who faced challenges in maintaining their independence.

92. Clients would be referred for an assessment via friends, family, themselves, health professionals, community support staff, ACAS teams, etc. Referrals were accepted from any source. This ensured that clients with a need were linked in to services.

93. The local government assessment team would make contact with the client to discuss their needs and the supports available to them. An Assessor would visit the client in their home and undertake a Living At Home Assessment (LAHA). With the client and their carer, the Assessor would develop a "care plan" using the Active Service Model (ASM). This model supported the continued participation of clients in managing their independence, a model of "doing with not doing for."

94. The HACC Assessment team were responsible to develop the task lists and service delivery plans. The client would be approved for the appropriate HACC services and referrals would be made for these services (Delivered Meals, Home Maintenance and Modifications, Community Transport, Planned Activity Groups, Respite Care, Shopping Assistance, Domestic Assistance and Personal Care). Services were generally provided by the council. The client may also be referred to other programs and services in the community (funded and non-funded). This may have included ethno-specific groups, exercise programs, allied health services, nursing services, social groups like senior citizens clubs, U3A or Men's Shed or meal programs.

95. Referrals for HACC services were all assessed by the HACC Assessment teams, this was inclusive of ACAS referrals.

96. Service delivery staff would make contact with the client to make arrangements to provide the service/s. Councils varied in their staffing arrangements, some used internal care workers employed by the council while others employed agencies to deliver their services. In the latter arrangement, the council generally retained all client management responsibilities while the external agency only managed rostering of services as well as their delivery.

97. Some services, generally Delivered Meals, were provided to clients prior to assessment when there was an urgent need to do so. The need of the client was assessed over the phone in the first instance and followed up shortly after (within two weeks) with an in-home assessment.

98. The way in which these services were delivered was unique to each council. Funds were used to offer services where there was a need within the community. For example, Property Maintenance services varied considerably across councils. Where there was a high bush fire risk, councils may have invested more in yard maintenance, where inner city councils may have had a greater focus making the inside of the home safe.

99. Services were all block funded and this allowed some flexibility in the nature and frequency of services provided to clients.

100. Local government has also played a central role in demand management. They were able to manage the delivery of services according to the needs of the community and the funding available ensuring that funds were spread equitably across the municipality and reducing or eliminating any waitlist. As they had an excellent perspective of the gaps in service, they were able to advocate for additional funding in the region where required.

101. Historically, councils have also delivered Home Care Packages. Many have withdrawn from delivering this service, but those who remain report a high demand for their service. One council reported they have made the decision to expand their service from 10 packages to 150 due to a high demand. They cite the community perceive the council to be trusted and ethical and provide needed assistance to navigate the system. Clients regularly report they are confused about the new system.

G) What was the reasoning behind the eventual transitioning of the Victorian Home and Community Care program to the Commonwealth Home Support Program?

102. The MAV understands the reform of the aged and disability service system was in direct response to a suite of findings from national reports and reference documents, including the Productivity Commission's *Caring for Older Australians*, the National Aged Care Alliance's *Blueprints for Aged Care Reform*, and in 2015 the *Aged Care Roadmap* developed by the Aged Care Sector Committee.[7]

103. At the 31st meeting of the Council of Australian Governments (COAG) held on 19 August 2011 a series of decisions and commitments related to the broader health system and more specifically

[7] Municipal Association of Victoria (2018) *Community Care Matters – Considerations for Councils*

to aged and disability care were made and detailed in the COAG *National Health Reform Agreement* resulting in the creation of a national aged care system and national disability services system.

104. The Agreement clarifies roles and responsibilities of governments regarding basic community care services previously delivered through the HACC program (now CHSP). Local government was not mentioned as a co-funder or partner under the new arrangements.

105. At the request of the Victorian and Western Australian governments, the changes to roles and responsibilities for basic community care, aged care and disability services and the reconciliation arrangements did not initially apply to Victoria and Western Australia. In these States, basic community care services continued to be delivered under HACC as a joint Commonwealth-State funded program until 2016. The Commonwealth and these States maintained bilateral agreements for that purpose.

106. In 2016 the Commonwealth Home Support Program (CHSP) was launched and the Commonwealth assumed full funding, policy and operational responsibility for community care for people aged 65 years and over in Victoria.

107. The Victorian Government continues to fund HACC services for people aged under 65 years (under 50 years for Aboriginal and Torres Strait Islander people), with eligible clients transitioning to the National Disability Insurance Scheme as it rolls out across Victoria.

108. Special transition provisions apply in Victoria until 30 June 2020. This includes continuity of funding levels (and output based 'block funding') and establishing a Victorian Regional Assessment Service (VRAS). The period from July 2019 to July 2020 is through a separate one-year contract which is still to be negotiated.

109. Statements from Schedule F: – Aged Care and Disability - National Health Reform Agreement are extracted below:

109.1. **F5 - The Commonwealth will take full funding, policy, management and delivery responsibility for a consistent and unified aged care system covering basic home care through to residential care.**

109.2. <u>That the Commonwealth will assume:</u>

109.2.1. from 1 July 2011, funding and policy responsibility, and from 1 July 2012, operational responsibility for basic community care services for people aged 65 years and over (50 years and over for Indigenous Australians); and

109.2.2. funding responsibility from 1 July 2011 for specialist disability services delivered by the States in accordance with their responsibilities under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

109.3. <u>That the Commonwealth will be responsible for:</u>

109.3.1. regulating packaged community and residential aged care delivered under Commonwealth aged care programs;

109.3.2. funding packaged community and residential aged care delivered under Commonwealth aged care programs for people aged 65 years and over (50 years and over for Indigenous Australians);

109.3.3. funding and regulating basic community care services for people aged 65 years and over (50 years and over for Indigenous Australians); and

109.3.4. funding specialist disability services delivered by the States in accordance with their responsibilities under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

109.4. That the State will be responsible for:

109.4.1. regulating specialist disability services delivered under the National Disability Agreement

109.4.2. funding and regulating basic community care services for people under the age of 65 years (except Indigenous Australians aged 50 years and over)

109.4.3. funding packaged community and residential aged care delivered under Commonwealth aged care programs for people under the age of 65 years (except Indigenous Australians aged 50 years and over).

109.5. In giving effect to these responsibilities, the States will assume:

109.5.1. funding and program responsibility from 1 July 2011 for basic community care services for people under the age of 65 years (under the age of 50 for Indigenous Australians); and

109.5.2. funding responsibility from 1 July 2011 for packaged community care and residential care delivered through the Commonwealth aged care program to people under the age of 65 years (under the age of 50 years for Indigenous Australians).

109.6. Transition Arrangements:

109.6.1. It is expected that basic level community care services will continue to be delivered through a mix of **local government**, State agency and non-government providers, and that individual providers will continue to be able to deliver both community disability and community aged care services during the implementation period and beyond.

H) What concerns are held by Victorian local councils regarding home care and home support?

The future of the Commonwealth Home Support Program

110. The specific details of funding arrangements for the full operation of the CHSP in Victoria (post-transition) have not been disclosed. Agreements with councils expire 30 June 2020.

111. We reiterate our strong view that poorly executed and siloed contestability processes can lead to unintended consequences of:

111.1. Fracturing the 'value-add' that public sector services offer through integration and coordination of responses in a service system which is based on collaboration

111.2. Reducing the sustainability of services and the continuity of service delivery

111.3. Decreasing the sense of community connectedness and social cohesion

111.4. Reduced wages, tenure and conditions for frontline staff who deliver the services

111.5. Discouraging volunteering and philanthropy

111.6. 'Mission drift' from those most in need

111.7. Reducing geographic coverage and accessibility to services

111.8. Limiting services offered[8]

Commonwealth Home Support Programme (CHSP) vs Home Care Packages (HCP)

112. The demand for Home Care Packages in Victoria is currently 14,312, as of 31 March 2018. Unless deemed eligible for Level 2 HCP or higher, these people are at risk as their level of support would be less than that provided in through the CHSP.

My Aged Care

113. Screening process for referrals from My Aged Care are poor, (instances where people with no needs or health care conditions or clients of TAC or Work Cover have been referred)

114. GP knowledge of the service system is poor, a fact which is reflective of a broader problem with the communication between the interfaces of primary health care, acute care and the aged care system.

115. There is insufficient communication between My Aged Care and assessment services, leading to 'over-screening' or multiple unnecessary assessments.

Providers "cherry picking"

116. Due to inconsistency in the 'actual' geographical catchment of some providers, providers may pick up some areas but not all. Assessment staff are then forced to seek out appropriate providers (through 'constantly ringing'), essentially assuming the role of a care navigator. In these

[8] Municipal Association of Victoria (2016) *Productivity Commission Inquiry into Introducing Competition and Informed Consumer Choice into Human Services*

cases, providers have cited 'market failure' and an inability to recruit direct care staff as a reason for not providing services, but this could also be associated with the lack of incentive for non-government providers to provide beyond funded targets (as councils typically do).

117. The dissemination of misinformation from private providers to existing recipients of council services: Councils have reported examples of private providers attending retirement villages and incorrectly informing residents that councils will be leaving services – when no decisions have been made. These providers have also incorrectly suggested to residents that HCPs are 'more flexible than CHSP' and that due to long waitlists they should register for an ACAS assessment as soon as possible.

CHSP "picking up the slack"

118. Some councils have reported that clients are refusing to accept HCPs, this, compounded with the sheer length of time individuals are forced to wait in the national queue means CHSP providers/councils are servicing people with far more complex needs than the program is designed and funded for.

119. Councils have reported that this lack of access to necessary, complex supports has seen some clients who have entered palliative stages of care, still receiving so called 'entry-level' supports

Workforce

120. Increased difficulty with workplace planning is being experienced, due to contract extension delays. This has significant impact on councils' capacity to retain and attract qualified, experienced direct care workers.

121. In rural areas, where council is typically one of the largest employers, many workers are anxious about their future employment.

122. Not only are direct care staff leaving councils in greater numbers than ever before, experienced assessment staff employed in councils are resigning due to uncertainty post June this 2019. Filling these positions with experienced, knowledgeable staff has become nearly impossible, especially for rural and remote councils.

123. Thin markets of professional workers in both CHSP & RAS as the NDIS, respite and employment services are all competing for the same staff.

Impact of local government rate-capping by the State of Victoria and insufficient CHSP targets

124. Budgets are tighter than ever, in some cases resulting in no further contributions from council other than what is already assigned.

125. Councils are forced to work to targets, and where a council's demand is over and above these targets, waitlists ranging from one month to two years have been reported for essential services such as domestic assistance. The longest waitlists are found in rural and remote councils. (CHSP data collected by the MAV).

126. These waitlists are seeing clients 'forced' onto HCPs when their care needs would be easily met by CHSP services had they been available.

127. Under the previous HACC program most councils managed client demand with no or very short term waiting lists.

Uncertainty of contracts, and the potential introduction of marketization of services

a. Implications of the National Competition Policy

b. Lack of certainty post 2020 for both CHSP and RAS

c. Short term contracts are unlikely to appeal to councils – budget timelines do not align with council requirements.

d. 3-5-year contracts are more attractive for councils

e. A perception that ' the Commonwealth isn't ready for the open-market model'

Potential barriers for clients and carers accessing services and/or utilising information include:

f. Limited understanding of transaction process: consumers require an understanding of how the system works including identifying potential providers, the process for exchange, consumer rights and obligations, complaints processes etc.

g. Inadequate information about providers: appropriate choices cannot be made without appropriate decision criteria and access to information to compare providers.

h. Insufficient capacity: consumers may have insufficient funds, be unable to use available information or have difficulty navigating the transaction process.

i. Lack of motivation: limited perceived benefit in comparing or changing providers.

Groups who are at particular risk of experiencing barriers assessing services and/or utilising information include those:

j. with no informal carer or advocate (i.e. no family living nearby)

k. who are geographically isolated (i.e. no internet access, cannot get into town)

l. who are the 'older old' – inclined to be more stoic / less assertive to have needs met

m. with low digital literacy

n. with hearing loss and/or sight impaired

o. with urgent need - resulting in time constraints for research

p. with low literacy or cognitive impairment

q. who are culturally and linguistically diverse

r. who are Aboriginal

s. individuals who are socio-economically disadvantaged.

Potential barriers for clients and carers when comparing service providers on quality and price include:

- Limited information currently on My Aged Care to enable a comparison of service providers on quality and price.
- No information on My Aged Care in relation to timely availability of services (particularly noting that clients frequently need services to commence promptly and mistakenly expect that service delivery will immediately follow registration).
- Disengagement from My Aged Care due to delays or extended time periods to conduct processes (e.g. hold times for telephone calls, multi-stage processes etc.)
- Complexity of pricing structures or lack of transparency in pricing (i.e. hidden fees).
- Reliability on 'glossy brochures' as a source of information about service quality.
- Unscrupulous tactics by predatory providers (e.g. misleading information, uninvited sales approaches).
- Disengaging from considering alternatives due to information overload or complexity (i.e. not in plain English).
- Reliance on familiar brand names reducing the motivation to compare providers.
- Ability of older people to access information via internet or telephone, including geographic variations to internet and mobile phone coverage, variations in digital literacy and hearing and sight disablement.
- Preference of older people and people with a disability to access information in-person.

Appropriate providers

128. Even if consumers are 'empowered' a market will not be effective at driving efficiency and responsiveness if the pool of providers is not large and/or diverse enough to offer true choice.

129. Regional communities are less likely to attract the same number and diversity of service providers as metropolitan Melbourne.

130. Effective local markets need providers that:

130.1. have a local presence so that they can deliver services in the client's home or community: it is irrelevant to a consumer if the national market has hundreds of providers if there is only a single provider (or worse no provider) to their location

130.2. provide the full range of services clients require and are eligible to receive: it is irrelevant to a consumer if there are a number of local providers but none of them provide the particular service type they need

130.3. are appropriate to diverse needs: to be appropriate, services may have to be responsive to the variations between consumers (e.g. demographic, socio-economic, health conditions and personal preferences)

131. The potential risks related to the appropriateness of service providers likely to enter the market include::

131.1. Access and equity

131.1.1. 'cherry-picking' service types, clients or geographic areas that are profitable

131.1.2. service diminution over time due to initially under-estimating full cost or using a 'loss leader' approach to enter the market

131.2. Limited local presence

- less local knowledge
- no tailored local solutions
- difficulty accessing accountability mechanisms

131.3. Limited range of services

- due to lack of experience, capacity or the low unit price
- at risk services include community-based meals, social support groups, volunteer co-ordination, community transport

l) What is the effect of the intergovernmental agreement and the tri-party agreements between the Municipal Association of Victoria (MAV) and other parties?

132. The MAV has strongly advocated to the Commonwealth on behalf of Victorian citizens (in conjunction with the Victorian State Government) to maintain the strengths of the Victorian system which operates both successfully and cost effectively and is easily accessible and trusted by Victorian residents.

133. Both the Western Australian and Victorian jurisdictions actively sought to retain the HACC program, and not have it rolled into the NDIS / Aged Care reforms of the last eight or so years. Unfortunately, this negotiation was ultimately unsuccessful largely due to the overarching Aged/Disability services fiscal agreement struck by the Commonwealth, which it is understood left Victoria no choice but to participate.

134. The MAV then worked with the State to develop the 'Trilateral Statement of Intent' aimed at retaining the strengths of the Victorian system, which was signed off in 2017 by the Federal and State Ministers and the MAV President.

135. Periodic tripartite meetings with senior officials have been chaired by the MAV to provide a platform to advocate for and address the concerns of councils about the potential disintegration of the system in Victoria and propose mechanisms to retain local government involvement and accessible local services for all those in need.

136. Key features which we recommend should be retained by the Commonwealth include block funding and recognition of the planning role of local government in providing oversight to ensure the provision of a range of appropriate services to residents in the municipality, as well as councils being supported to continue providing directly or contracting services as they deem

appropriate. Governments also have the public sector responsibility of being obligated to service 'hard to reach' clients with multiple difficulties.

137. At the most basic level older residents over 85 face enormous challenges trying to access a national 'call centre' as a starting point, even if they are not on their own and have no cognitive impairment, they may for example have hearing or visual limitations.

138. All residents / families contacting local government receive both advice over the phone and a professional assessment in their home to ensure all aspects of their health, wellbeing and living situation are taken into account.

139. While the Tripartite statement has contributed to most Victorian councils retaining many of these roles to date, we are at a critical juncture in the federal directions being mooted for these well-regarded home-based services. Built on the Victorian experience, the MAV strongly recommends continuation of government and public sector oversight through an extension of the tripartite agreement, and retention of block funding. No private organisation is able to hold public sector planning responsibility or commitment to all residents and oversight for the service system in a geographic area.

140. Similar program models for universal local services have operated successfully under other Commonwealth National Partnerships - which set the overall direction, and then operate through bilateral agreements appropriate to each jurisdiction depending in their starting point and building on their strengths. (Refer the National Partnership on Universal Access to Early Childhood Education).

J) What concerns does the MAV have about the consumer directed care model?

141. The extent to which choice is of primary importance to many consumers of community services is arguable: service quality, timeliness, reliability, stability, continuity and cost are likely to be at least equally relevant. Trust in the provider is also frequently cited by community members in their preference to utilise local government services.

142. While the value of "improving consumer choice" is, at a philosophical level incontestable, the practical achievement of it in an area such as community services is much more complicated. In the provision of community services, for a range of reasons, the concept of choice will inevitably be circumscribed. These include[9]:

142.1. The notion of choice in human services is often a heavily modified one. From the individual consumer's perspective, because of incapacity, or disadvantage it can consist of choice by proxy (involving for example other members of the family), or what has been described as "mediated choice". This is a constraint on choice that has little to do with a lack of service options, or alternatives. However, another dimension of choice failure in community services is the absence of a repertoire of broadly similar services from which to choose. Historically this is the result of funding, cost and resource efficiency factors.

[9] Municipal Association of Victoria (2016) *Productivity Commission Inquiry into Introducing Competition and Informed Consumer Choice into Human Services*

Importantly there is no evidence that this funding brake on consumer choice will change in the short to medium-term.

142.2. The challenges of achieving greater consumer choice in community services, as the UK Experience illustrates, are magnified for disadvantaged groups and for consumers in regional and rural areas. In part this is because the operation of market failure, which undermines the efficacy of competition and market forces in community services generally, is more widespread and difficult to address in these localities and amongst consumers with complex problems. Geographical location and scale, as well as the dimensions and "technology" of the service in question will impact on the attractiveness, or otherwise, of particular community services "markets" to different providers.

142.3. "Informed choice" in the personal and often multi-faceted interventions of community services is difficult to obtain as the field is characterised by high levels of information asymmetry. At an individual agency level, as well as across an aggregated service system, consumers experience significant knowledge deficits. The existence of advocacy and brokerage agencies to neutralise the information disadvantages experienced by community services consumers is reliant upon government funding, which in itself has become increasingly rationed and scarce under constrained budgetary processes.

142.4. In any case, choice should not be the only, or even lead, policy driver in community services: service quality, the scope for the client's participation in decision-making, an integrated and easily negotiable service system, and service models that are locally referenced, that actively address disadvantage and identify changing social needs, as well as build community cohesion and community capacity, are integral to the functioning of an effective community services system.

K) What concerns does the MAV have about Commonwealth oversight of home care and home support?

143. The MAV supports the principle of subsidiarity - the idea that a central authority should have a subsidiary function, performing only those tasks which cannot be performed effectively at a more immediate or local level; this very aptly encapsulates the rationale for these services being delivered at the local level.

144. Adopting this principle the Commonwealth could maintain oversight of CHSP under a National Partnership model, where broad State / Territory objectives are set and the jurisdictions and local government work in partnership to plan and implement these localised services appropriate to each municipality.

145. The community care system is appropriately managed from the "bottom up", not top down.

146. Local government continues to play a significant role in demand management within their municipality

147. Clients continue to be supported though a wellness and reablement approach to promote on-going independence and less reliance on formal supports

148. A "one size fits all" approach does not facilitate a flexible response to diverse needs at a local level.

L) What are the advantages and disadvantages of block funding for aged care services?

149. The HACC program has successfully delivered home based aged care services since 1985 through a model of block funding which has provided small amounts of timely service and support to people to remain living independently at home in their community.

150. Utilising the model of block funding on a price / volume basis to support this population has enabled councils to meet the differing and variable needs of residents, within a funding envelope for the municipality, and allocate workforces accordingly.

151. Victoria's experience is that block funding for community care services has been successful in managing demand as well as providing a response appropriate to all citizens.

152. The mooted discontinuation of block funding and the lack of certainty regarding funding levels is influencing councils' decisions regarding their future roles in service delivery. It is recommended that block funding be retained to support population based service planning and delivery, which ensures appropriate access for all older people and capacity for demand management.

M) Any other information?

153. To varying degrees, Victorian councils fulfil all or the majority of the following functions regarding community care:

153.1. Provider: of funds and delivers services, facilities and programs.

153.2. Planner and coordinator: to ensure an equitable, responsive and accessible service system.

153.3. Partner: funds and facilitates the development of strategic partnerships and alliances that support older people to age well with sustainable, innovative and efficient service delivery models.

153.4. Funder: of other organisations to deliver services and programs through grants and contracts.

153.5. Regulator: has statutory responsibility for monitoring and regulating services and directs activities as required.

153.6. Monitor: undertakes community consultation, research, benchmarking and program evaluation to inform and ensure service quality is responsive to needs.

153.7. Facilitator: of partnerships with community, organisations, peak bodies and governments to enable responsive and collaborative approaches to emerging issues and trends affecting older people; and internal stakeholders to ensure a whole of council approach to the planning and delivery of services.

153.8. Advocate: to the Commonwealth and State governments regarding policy and program reforms to ensure the funding and delivery of a quality service system that is responsive to the increasing demands for services and needs of older residents.

153.9. Steward: Councils roles in stewardship encompass a range of functions in the areas of strategic planning, procurement, monitoring and evaluation. This stewardship role is an important consideration for councils to ensure the 'client benefits' of the current system are retained and available to all older Victorians.

Signed: Clare Hargreaves

Date: 14/3/19

Witness: Ellen Packham

Date: 14/3/19