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Options for the future of Veterans' Home Care (VHC)

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Options for the future of Veterans' Home Care (VHC)

Volume One: Final Report

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Table of Contents

Volume One

EXECUTIVE SUMMARY I

The profile of veterans and war widows receiving VHC in 2006 ---------- ii

The changing demographic profile of veterans and war widows ---------- iii

The views of VHC service providers ---------- iii

The views of veterans and war widows ---------- iv

Findings from a national consultation with key stakeholders ---------- v

The evidence in the international literature ---------- vi

Options for the future ---------- vi

Comparative assessment of the options for the future of Veterans' Home Care ---------- ix

1 INTRODUCTION AND BACKGROUND 1

2 METHODOLOGY 5

2.1 Overview of review inputs ---------- 5

2.2 Quantitative analysis of demographic and utilisation data ---------- 6

2.3 Review of existing program documentation and previous reviews ---------- 6

2.4 International literature review ---------- 6

2.5 Consultation with veterans and their carers ---------- 7

2.6 Consultation with other key stakeholders ---------- 9

3 RESULTS 12

3.1 Key findings from the international literature ---------- 12

3.2 The profile of veterans and war widows receiving VHC in 2006 ---------- 17

3.3 The profile of veterans in receipt of HACC services in 2005/06 ---------- 26

3.4 The projected future demand for VHC services 2007-2016 ---------- 28

3.5 The views of VHC service providers ---------- 32

3.6 The views of veterans and war widows ---------- 36

3.7 Findings from a national consultation with key stakeholders ---------- 39

4 DISCUSSION OF THE RESULTS 51

4.1 The results in their historic context ---------- 52

4.2 The results in their contemporary service context ---------- 53

5 OPTIONS FOR THE FUTURE OF VHC 57

5.1 Option 1 – End the VHC program and transfer clients to HACC ---------- 59

5.2 Option 2 - Maintain the VHC model as is ---------- 60

5.3 Option 3 - Maintain the VHC model but with some fine tuning ---------- 62

5.4 Option 4 – Redevelop VHC as an environmental support program ---------- 66

5.5 Option 5 – Expand scope of VHC to include other basic services ---------- 69

5.6 Option 6 - Maintain scope of VHC but increase service intensity ---------- 71

5.7 Option 7 – Expand both scope and intensity ---------- 73

5.8 Option 8 – Redesign VHC to become a community care coordination and brokerage service ------- 75

5.9 Option 9 – Redesign VHC and absorb it into a total health and community case management and brokerage service ---------- 78

5.10 Comparative assessment of the options for the future of Veterans' Home Care ---------- 82

REFERENCES 84

Volume Two

APPENDIX 1 92

Comparison of VHC and other Australian Government funded programs ---------- 92

APPENDIX 2 96

Results from an international review of the literature, including existing program documentation and previous reviews ---------- 96

Changes in the demographic and policy context 96

Best practice interventions in home care 99

Review of the practice literature on service models and policy 123

Conclusions on strategies for the prevention and avoidance of hospitalisation 135

Best practice service models in community care 137

Review of issues in current practice and policy development in home care 140

Summary of literature review findings 149

APPENDIX 3 162

Methods and assumptions in projections ---------- 162

APPENDIX 4 183

Results of the veteran and war widow survey ---------- 183

APPENDIX 5 202

Results of the VHC service provider survey ---------- 202

List of tables

Volume One

Table 1 Strategies used to facilitate communication ... 10
Table 2 VHC population compared to the DVA population, 2006 ... 18
Table 3 VHC population compared to the DVA population – age and sex, 2006 ... 18
Table 4 VHC population compared to the DVA population – location, 2006 ... 19
Table 5 VHC population compared to the DVA population – non-VHC health service usage, 2006 ... 19
Table 6 Number of assessments per client in 2006 ... 20
Table 7 VHC service usage in 2006 ... 21
Table 8 Approved hours by service type and State, 2006 ... 22
Table 9 Approved hours by service type and rurality, 2006 ... 23
Table 10 VHC service usage by gender, 2001 and 2006 ... 24
Table 11 HACC services used by DVA pensioners ... 26
Table 12 Units of HACC services used by DVA pensioners ... 27
Table 13 Number of HACC service types used by DVA pensioners ... 28
Table 14 Functional profile: all veterans ... 37
Table 15 Proportion of veterans receiving each service ... 37

Volume Two

Table 16 Comparison of HACC and VHC Services ... 92
Table 17 VHC versus HACC Services ... 94
Table 18 Other DVA services available to Veterans eligible for VHC ... 95
Table 19 Description and evidence rating for the references relevant to home visiting ... 100
Table 20 Description and evidence rating for the references relevant to home modification ... 103
Table 21 Description and evidence rating for the references relevant to respite care ... 106
Table 22 Description and evidence rating for the references relevant to other DVA services including nursing and allied health ... 109
Table 23 Description and evidence rating for the references relevant to care packages ... 112
Table 24 Description and evidence rating for papers on overall trends in the literature ... 115
Table 25 Specific departmental (veterans) web-sites examined ... 118
Table 26 Other web-sites examined ... 120
Table 27 Description and evidence rating for practice literature on prevention and hospital avoidance ... 130
Table 28 Best practice service models found in the literature review ... 139
Table 29 DVA and VHC Literature: program reviews, guidelines and other documents ... 151
Table 30 Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs ... 157
Table 31 Potential survey response ... 183
Table 32 Actual survey response ... 183
Table 33 Survey response by gender ... 185
Table 34 People caring for veterans ... 187
Table 35 Functional profile: all veterans ... 191
Table 36 Proportion of veterans receiving each service ... 193
Table 37 Proportion of veterans receiving ‘other services’ ... 194
Table 38 Domestic assistance, travelling, shopping – current need ... 197

Table 39 Home modifications ... 199
Table 40 Aids and equipment ... 199
Table 41 Number of clients receiving VHC services from Respondents ... 202
Table 42 Percentage of clients currently receiving services in each VHC service stream ... 203
Table 43 Proportion of VHC and other clients estimated to live alone or with someone ... 203
Table 44 Proportion of veterans estimated to live with another person by occupant category and program ... 203
Table 45 Health and ability of VHC clients compared to general community care clients ... 204
Table 46 Proportion of VHC clients receiving other services ... 204
Table 47 Proportion of VHC clients who receive additional or alternative services by service stream ... 205
Table 48 Other services identified by providers and how often they were identified ... 205
Table 49 Proportion of providers who feel the current program will meet veterans' needs ... 207
Table 50 Proportion of respondents who feel change is needed in the assessment process of the VHC Program ... 207
Table 51 Summary of suggested improvements to the assessment process ... 207
Table 52 Proportion of providers who feel change is needed in range of services VHC provides ... 208
Table 53 Summary of suggested improvements to the range of services ... 208
Table 54 Proportion of providers who feel change is needed in quantity of services ... 209
Table 55 Summary of suggested improvements in quantity of services ... 209
Table 56 Proportion of providers indicating the need for change in care coordination ... 209
Table 57 Summary of suggested changes to care coordination ... 210
Table 58 Summary of other changes suggested and issues raised ... 210
Table 59 Summary of changes suggested in the next two years ... 212
Table 60 Other comments made by service providers ... 213

List of figures

Volume One

Figure 1 Projected total number of hours of VHC across all four service types ... iii
Figure 2 VHC in context ... 2
Figure 3 The review framework - 'Inputs and Outcomes' ... 5
Figure 4 Sampling framework ... 8
Figure 5 Type of assessment (initial or repeat) each year, 2001–2006 ... 20
Figure 6 Method of assessment (in-home or over-the-phone) each year, 2001–2006 ... 20
Figure 7 Method of assessment each year by type of assessment, 2001–2006 ... 21
Figure 8 Number of service types used, 2001-2006 ... 21
Figure 9 Approved hours by service type and functional score, those receiving services and responding to the postal survey ... 24
Figure 10 Functional screen total score – comparison of clients receiving VHC services and clients receiving NSW Home Care Services ... 25
Figure 11 Functional screen individual item scores – comparison of clients receiving VHC services and clients receiving NSW Home Care Services ... 25
Figure 12 Projected DVA treatment population ... 28
Figure 13 Projected age profile of the DVA treatment population ... 29
Figure 14 Projected total number of hours of VHC domestic assistance ... 30
Figure 15 Projected total number of hours of in home respite ... 30
Figure 16 Projected total number of hours of personal care ... 31
Figure 17 Projected total number of hours of home & garden maintenance ... 31

Figure 18 Projected total number of hours of emergency respite ... 32
Figure 19 Health status of veterans and their carers ... 36
Figure 20 Veterans' assessment of their needs in the next 1-2 years ... 39
Figure 21 Assessment of Option 1 ... 59
Figure 22 Assessment of Option 2 ... 60
Figure 23 Assessment of Option 3 ... 63
Figure 24 Assessment of Option 4 ... 68
Figure 25 Assessment of Option 5 ... 69
Figure 26 Assessment of Option 6 ... 72
Figure 27 Assessment of Option 7 ... 74
Figure 28 Assessment of Option 8 ... 76
Figure 29 Assessment of Option 9 ... 79
Figure 30 The concept of graduated levels of care coordination ... 80

Volume Two

Figure 31 Actual and projected number of DVA gold or white card holders by age at December ... 162
Figure 32 Actual and projected proportion of male DVA gold or white card holders who are assessed for VHC services by age at December ... 163
Figure 33 Actual and projected proportion of female DVA gold or white card holders who are assessed for VHC services by age at December ... 164
Figure 34 Actual and projected proportion of males assessed for VHC who receive domestic assistance by age at December ... 165
Figure 35 Actual and projected proportion of females assessed for VHC who receive domestic assistance by age at December ... 166
Figure 36 Actual and projected proportion of males assessed for VHC who receive in home respite by age at December ... 166
Figure 37 Actual and projected proportion of females assessed for VHC who receive in home respite by age at December ... 167
Figure 38 Actual and projected proportion of males assessed for VHC who receive personal care by age at December ... 167
Figure 39 Actual and projected proportion of females assessed for VHC who receive personal care by age at December ... 168
Figure 40 Actual and projected proportion of males assessed for VHC who receive home & garden maintenance by age at December ... 168
Figure 41 Actual and projected proportion of females assessed for VHC who receive home & garden maintenance by age at December ... 169
Figure 42 Actual and projected proportion of males assessed for VHC who receive emergency respite by age at December ... 169
Figure 43 Actual and projected proportion of females assessed for VHC who receive emergency respite by age at December ... 170
Figure 44 Actual and projected average annual occasions of domestic assistance for males who receive any domestic assistance in that year by age at December ... 171
Figure 45 Actual and projected average annual occasions of domestic assistance for females who receive any domestic assistance in that year by age at December ... 172
Figure 46 Actual and projected average annual occasions of in home respite for males who receive any in home respite in that year by age at December ... 172
Figure 47 Actual and projected average annual occasions of in home respite for females who receive any in home respite in that year by age at December ... 173
Figure 48 Actual and projected average annual occasions of personal care for males who receive any personal care in that year by age at December ... 173

Figure 49 Actual and projected average annual occasions of personal care for females who receive any personal care in that year by age at December ... 174
Figure 50 Actual and projected average annual occasions of home & garden maintenance for males who receive any home & garden maintenance in that year by age at December ... 174
Figure 51 Actual and projected average annual occasions of home & garden maintenance for females who receive any home & garden maintenance in that year by age at December ... 175
Figure 52 Actual and projected average annual occasions of emergency respite for males who receive any emergency respite in that year by age at December ... 175
Figure 53 Actual and projected average annual occasions of emergency respite for females who receive any emergency respite in that year by age at December ... 176
Figure 54 Actual and projected average hours per occasion of domestic assistance for males by age at December ... 177
Figure 55 Actual and projected average hours per occasion of domestic assistance for females by age at December ... 178
Figure 56 Actual and projected average hours per occasion of in home respite for males by age at December ... 178
Figure 57 Actual and projected average hours per occasion of in home respite for females by age at December 179
Figure 58 Actual and projected average hours per occasion of personal care for males by age at December ... 179
Figure 59 Actual and projected average hours per occasion of personal care for females by age at December ... 180
Figure 60 Actual and projected average hours per occasion of home & garden maintenance for males by age at December ... 180
Figure 61 Actual and projected average hours per occasion of home & garden maintenance for females by age at December ... 181
Figure 62 Actual and projected average hours per occasion of emergency respite for males by age at December ... 181
Figure 63 Actual and projected average hours per occasion of emergency respite for females by age at December ... 182
Figure 64 People with whom veterans live ... 186
Figure 65 General health of veterans ... 186
Figure 66 Carers' health ... 188
Figure 67 VHC IADL total score – comparison of surveyed VHC clients & other VHC clients ... 189
Figure 68 Functional screen total score – comparison of those VHC clients surveyed with and without VHC assessment data ... 190
Figure 69 Functional screen total score by survey cohort ... 190
Figure 70 Functional profiles of each cohort in the survey ... 191
Figure 71 Domestic assistance functional profile ... 192
Figure 72 Travelling to places beyond walking distance: functional profile ... 192
Figure 73 Shopping on one's own: functional profile ... 193
Figure 74 Frequency of domestic assistance ... 196
Figure 75 Cost of domestic assistance ($ per visit) ... 196
Figure 76 Cost home and garden services ($ per service) ... 197
Figure 77 Veteran's assessment of their needs in the next 1-2 years ... 198
Figure 78 Ability to pay current fees ... 200
Figure 79 Willingness to pay more for more services ... 201
Figure 80 Willingness to pay more for larger range of services ... 201
Figure 81 Respondents providing services in each VHC stream ... 202
Figure 82 Provider estimate of the proportion of VHC clients with home modifications and aids or equipment ... 206

Executive summary

This is the final report of an independent review for the Department of Veterans' Affairs of the capability of its Veterans' Home Care (VHC) Program and model to continue to meet the needs of veterans[1] in terms of quality of life, independence and health, in particular, maintaining independent functioning within the home environment. It is not a review of the way that VHC currently operates. The purpose is to identify options for the future.

The central strand of inquiry within the review has been to pose and seek answers to the question *'Does the VHC Program (as it is currently constituted) meet the changing needs of the VHC client population, which is ageing, becoming more frail and increasingly demanding both higher level services and additional services not currently available through the program?'* Two examples of this changing demographic are the average age of VHC clients, now 83 and a greater representation of females, in particular war widows.

The outcome of the review is a set of options, set out in Section 5, on possible future changes to the VHC Program. The goal is to ensure that the VHC Program, as part of the broader health and community care system, is capable of delivering specified quality of life, independence and health outcomes that respond to the changing patterns of veteran need.

These options have been informed by an analysis of a wide range of data/information sources (outlined below), extensive and in-depth stakeholder consultations, the findings from previous research and the findings from an evaluation of the outcomes currently achieved by the VHC Program.

The review has involved a series of related steps, which aim to evaluate the way that the program operates currently and to predict the impact of current and future demographic trends on the level and type of resources required to serve the veteran community in the future.

Available databases, a literature review, previous VHC review documents, and program guidelines have been analysed for relevant information. Veteran participants and service and program-level informants have been invited to fill in surveys and/or be interviewed, attend focus groups and respond to key questions and the findings of the review process and draft reports.

The five review inputs have been:

- Demographic data
- Demand and utilisation data
- Reports of previous internal and external VHC Program reviews
- The findings of an international literature review
- Stakeholder engagement and consultation.

Further details on the methods used can be found in Section 2. The results of the review are then set out in Section 3 (beginning on page 12). These results are followed by a discussion of key findings in the context of options for the future (Section 4, page 51). The final section, Section 5 (page 57), sets out options for the future.

Volume 2 of the report contains five appendices. Appendix 1 provides a summary that compares VHC and other Australian Government funded programs. Appendix 2 contains an extensive literature review. It covers the academic, the practice and the policy literature. This includes a summary of existing program documentation and previous reviews. Appendix 3 outlines the

[1] References to 'veterans' in the context of this review should be read to include war widows/widowers unless otherwise stated.

technical methods and the assumptions that have been used in making projections about the future demand for VHC. Appendix 4 provides the results of a national survey of veterans and war widows. Finally, Appendix 5 provides the results of a national survey of VHC service providers.

Key results from these appendices and from Section 3 are briefly summarised below.

The profile of veterans and war widows receiving VHC in 2006

In 2006 a total of 80,343 veterans received VHC services.[2] They represented 19% of all DVA clients. Almost all VHC recipients hold Gold cards (98%), compared to only 68% of all DVA clients. One in four DVA Gold card holders receive VHC services, compared to only 3% of white card holders.

As a sub-group, VHC recipients are much older than all DVA clients. Almost all VHC recipients live in major cities or regional areas, as do almost all DVA clients. There is evidence of geographic inequity with DVA clients living in remote and very remote Australia being significantly less likely to receive VHC than their metropolitan and inner regional centre counterparts.

Reflecting their poorer health status, VHC recipients are heavier users of health services than DVA clients generally. Almost all VHC recipients had received medical treatment, pharmacy items and allied health. Two in three DVA clients receiving community nursing are also VHC recipients.

VHC is largely a domestic assistance program, with 84% of VHC recipients receiving domestic assistance. Home and garden maintenance is the next most used service (17%), while personal care is the least used service (3%).

Although the number of assessments is rapidly increasing each year, the number of initial assessments is declining, decreasing from 85% of all assessments in 2001 to just 16% of assessments in 2006. Very few assessments are completed at the veteran's home, declining annually from 13% in 2001 to 0.6% in 2006.

A key finding of this review is that we found no relationship between a veteran's functional ability and the number of hours they are approved for VHC domestic assistance. However, those with the lowest functional abilities are approved for more respite hours, suggesting that the allocation of respite hours is more related to need.

We compared the functional abilities of VHC recipients with applicants for basic services from the NSW Home Care Service. VHC clients are much more functionally able than their Home Care counterparts. However, veterans receiving VHC services have poorer health than people of a comparable age living in the community.

In addition to the services provided by VHC, 56,243 veterans received HACC services in 2005/06. Our estimate is that 80% of this group meet the eligibility criteria for VHC. This group includes some veterans who are receiving both HACC and VHC services concurrently. The HACC services most commonly used by veterans include meals, centre-based day care, transport, domestic assistance and home modifications. This finding has important implications in terms of future demand for VHC.

More detail on veterans and war widows in receipt of VHC can be found in Section 3.3 (page 26). Likewise, Section 3.3 (page 26) provides a profile of the HACC services being provided to veterans.

[2] This figure includes all veterans who were assessed and approved for services during 2006, irrespective of whether they actually received a service in 2006. Among these, 6,277 died during 2006. A further 8,034 were grandfathered-transitional veterans and, on the request of DVA, this group was also excluded from our profile of the 2006 VHC recipients.

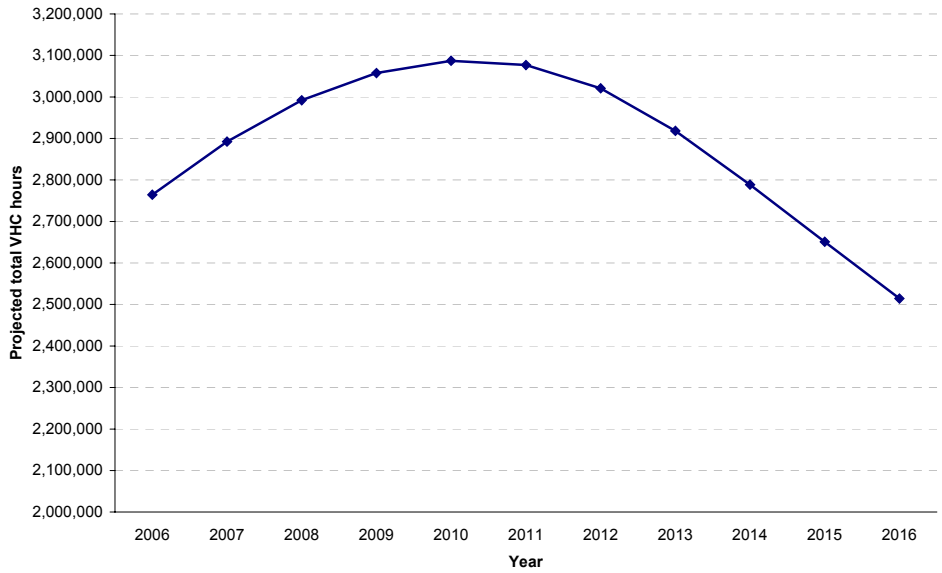
The changing demographic profile of veterans and war widows

The DVA treatment population is expected to decrease significantly over the next decade and beyond. The 10 year projection is for a 40% decline. At the same time, the average age of the remaining veterans and war widows will increase considerably. A key question for the review is the impact of this changing demographic profile on the demand for VHC. The projected demand for VHC has been calculated taking into account:

- demographic changes in the target population
- the proportion of the target population who are assessed for VHC services
- the proportion of the assessed population who utilise each service type
- the average annual occasions of service amongst those who utilise each service type
- the average number of hours per occasion of service for each service type

A summary of projected demand across the four VHC service types (domestic assistance, personal care, respite and home and garden maintenance) is shown in Figure 1. This projection is based on the hours of VHC claimed rather than the hours that may have been approved. In total, demand is expected to increase between 2006 and 2010 by 11.7%. The peak demand is expected to be in 2010. Between 2010 and 2016, demand is then expected to decrease by 18.5%. It will continue to fall beyond that point.

Figure 1 Projected total number of hours of VHC across all four service types



However, the projections indicate differences in future demand across the four service types. Details on these differences are summarised in Section 3.4. The full technical methodology and the assumptions adopted in these projections are included in Volume 2 (Appendix 3).

The views of VHC service providers

VHC service providers were surveyed and the full results are set out in Appendix 5 in Volume 2. The key finding from this aspect of the review is that, while service providers identified many positive aspects of the current program, a significant majority believes that the VHC program will need to change if it is to meet the needs of veterans into the future.

Approximately 89% of respondents argued that changes are needed in the assessment process with the majority (54%) indicating that major changes are needed. The key change suggested is the need for more in-home or face-to-face assessments. In addition, providers identified the need

for better information flow, in particular the sharing of assessment details and improvements to the current assessment tool.

Providers also favour changes to both the range and quantity of VHC services. But there are mixed views on the scope of change required. About half of all providers (47%) feel that only minor changes are needed in relation to the range of services, with a further 39% believing that major changes are needed. The results are similar for questions about the quantity of services.

The most commonly identified changes are the addition of accompanied or assisted outings such as shopping and bill paying, flexibility in care and the addition of care packages, social support, increased service times and additional services such a gardening, lawn mowing and meal preparation. Smoother transition to higher level care and better recognition of mental health and complex needs are also identified as issues for the future.

A significant majority (81%) of providers see the need for better care coordination in the VHC program. Suggested changes mainly focus on care coordination issues, assessment issues and the role of case management. A related issue is the need for better information sharing between assessors and providers.

The views of veterans and war widows

Veterans and war widows were surveyed and the results are reported in Volume 2 (Appendix 4). Those in receipt of VHC services are grateful for the help provided, with the vast majority (87%) satisfied with services received through the program.

However, based on their increasing age, deteriorating health and that of their partners/carers, many veterans report increasing future need, in particular for domestic assistance (50%), home and garden services (50%), personal care (30%) and transport (35%).

The health profile results in the survey suggest that the VHC program is generally correctly targeted. Veterans currently receiving VHC services have poorer health and less functional abilities than veterans who are not in receipt of VHC. The same applies to carers with the carers of veterans receiving VHC services having substantially worse health than carers of other veterans.

An important finding in considering future demand is that a significant number of veterans not receiving VHC obtain domestic assistance and home and garden services from elsewhere. 44% of those not approved for VHC receive home and garden services from elsewhere compared to 22% of those who had not applied for VHC. Slightly less (38%) of those not approved for VHC are receiving a domestic assistance service compared to 22% who had not applied.

Another important finding is that 16% of VHC recipients receive domestic assistance from providers other than VHC. Just over half of these received domestic assistance from non-profit organisations, with 27% receiving services from private providers and a further 22% from other government sources such as HACC. Likewise, about 60% received home and garden services from providers other than through VHC. About three quarters of these services were from private providers, with 15% from non-profit organisations and a little less than 10% from other government sources.

A sizeable majority of veterans (about two thirds) indicate that they were willing to pay more both for a greater range of services, as well as for more of a particular type of service.

More summary results from the survey can be found in Section 3.6 (page 36).

Findings from a national consultation with key stakeholders

Findings from a national consultation with key stakeholders are reported in Section 3.7, beginning on page 39. All key stakeholder groups - assessment agencies, service providers and the broader community care sector - identify social support, accompanied shopping, transport and routine maintenance services as important inclusions in a future program.

The majority of those consulted commented on the strong links veterans have to DVA, in terms that were often described as 'loyalty' to DVA. However, many agencies have difficulties managing commonly held veteran perceptions that VHC, like other DVA services, should be an 'entitlement'. This is a particular problem for assessment agencies.

The relatively low cost of VHC can create difficulties when transitioning veterans into higher levels of community care. Stakeholders reported many instances of resistance by the veteran moving to CACP or HACC services because of the cost differential, even when the service is warranted by its better capacity to meet the veteran's needs.

There is wide recognition that the program has provided an important alternative service for veterans in need of low level care. There is also wide recognition about the program's capacity to provide the majority of services in a timely manner. Both assessment agencies and service providers commented on the high level of acceptability of the program by the veteran community and this is supported by the veteran survey.

That said, there is surprising concurrence across all stakeholder groups that the program structure is not consistent with the achievement of its aims and objectives, particularly in relation to the achievement of independence and improved health outcomes. To this end, all stakeholders agreed that the scope of the program needs to be expanded to include, at least, accompanied shopping and social support, some routine garden maintenance and transport. This was again supported by the veteran survey.

Likewise, stakeholders agreed that greater flexibility to meet the specific needs of the veteran (rather than fitting the veteran into the program) will enhance the service in the short term and will be essential in meeting the needs of the future. Both assessment agencies and service providers are of the view that the allowance for personal care hours needs to be expanded both for current recipients and for the future viability of the program.

Assessment agencies report a significant increase in the demand for service coordination that can be expected to grow as the veteran group ages or as younger veterans with more complex/multiple conditions become eligible for the program. Perhaps a surprising finding is the degree to which assessment agencies have adapted the *Standard Assessment Instrument.* There is overall support for telephone assessment for some veteran groups, mainly the well-informed and eloquent requiring low level care. However, there is equal agreement that neither the existing assessment instrument nor telephone assessment is adequate for the assessment of those requiring more complex care or for those with cognitive limitations. Both groups will increase as the veteran population ages.

The consultation highlighted some key service improvement issues that could with relatively little effort be implemented in the short term. One is the earliest possible introduction of a more comprehensive assessment instrument. Another is to work with assessment agencies to gain a better measure of the extent and nature of the coordination function and use this as a marker for future service development. Additionally, it is important to open up the process of communication between assessment agencies and service providers and, in addition, with the broader community care sector. Finally, there is a need to address the veteran perception of 'entitlement', particularly in the context of future service expansion and the requirement to work within a capped budget.

The evidence in the international literature

Appendix 2 in Volume 2 summarises the literature and Section 3.1 in Volume 1 sets out key findings. In summary, there is clear evidence in the literature on the relationship between age, health status and the need for home support services – as people age, their needs for community and home support services increase. Given the changing demographic profile of veterans, this has obvious implications for the future of VHC.

On the other hand, there is little evidence in the international literature to support the provision of a narrow range of low level maintenance type services for people with low level needs. Nor is there any evidence in support of remote and locally unconnected assessment processes. Instead, the key lessons from the literature that have implications for future options for the VHC program are:

- There is a need to develop ways to promote the better integration of services, e.g. a range of care coordination strategies that cover a range of needs, refined screening algorithms for use at the level of the regional single entry points and use of information technology for linking between a broader range of services for the purposes of referral.
- Best practice service development strategies involve active programs with set goals (e.g. health promotion and falls prevention, exercise programs) and promote independence, rather than a goal of maintenance care. Respite options linked with outdoor mobility and socialisation and personal care linked to health and nursing interventions (Gitlin et. al. 2006a) represent examples of contemporary best practice.
- An explicit focus on areas such as environmental modification and home safety interventions that links to domestic assistance is logical, as suggested by the randomised controlled trial reported by Nikolaus and Bach (2003). This home based intervention included comprehensive geriatric assessment, assessment of the home for environmental hazards (safety checklist), advice about possible changes, necessary home modifications and education in the use of technical and mobility aids.
- There is a need to develop ways for the program to look beyond DVA services to better target a wider range of interventions for veterans with a spectrum of needs, e.g. interventions that are age related, disease-specific, preventive and more proactive.
- The enhanced use of available assessment, data collection and reporting arrangements would allow assessors, providers and DVA to routinely measure outcomes, e.g. improvements in daily functioning.

Options for the future

The nine options presented in this review have been designed so that they can be considered by DVA as ends in themselves. Alternatively, they might be considered more broadly as a community care development pathway. The longer-term end point would be a more flexible, better integrated and more forward looking 'matrix' of programs, driven by data-based solutions and more capable of responding to veterans' needs over the whole life cycle.

The options range from the maintenance of the status quo through to options that would represent a major realignment of service types and relationships within DVA. Each has different funding implications and would require different lead times.

Each option has been assessed using a standard set of criteria. Not all of these criteria have equal weighting. Some are demonstrably more important than others. The criteria are:

- Consistency with the research evidence on health outcomes
- Consistency with the research evidence on best practice
- Projected needs of veterans

- Consistency with the perspectives of veterans
- Consistency with the perspectives of VHC assessment agencies
- Consistency with the perspectives of VHC service providers
- Consistency with the perspectives of HACC funding authorities (DoHA and states and territories)
- Consistency with the perspectives of broader community care providers
- Consistency with DVA policy and planning frameworks

Each of these criteria is defined in Section 5. The nine options are summarised below. Each is discussed more fully in Section 5.

Option 1 – End the VHC program and transfer clients to HACC

Under Option 1, the VHC program would close and veterans would have their low needs met as others do through the Home and Community Care (HACC) program. This option is the way that services were provided prior to the establishment of VHC.

Option 2 - Maintain the VHC model as is

Option 2 is the maintenance of the status quo. In the short-term, this is a real option for DVA. Because it has contracts with its network of VHC assessment and service provision agencies that have another two years to run, a major change in the way that the program works would not be possible until the end of the current contract period.

Option 3 - Maintain the VHC model but with some fine tuning

Option 3 is essentially the maintenance of the status quo but with improvements in some operational details to make the program more responsive to the needs of veterans and their carers.

The key fine tuning changes in this option relate to:

- Assessment
- Relationships between assessors and service providers
- Choice and flexibility
- Substitutability
- Planned home and garden maintenance
- Communication and coordination with the broader community care sector
- Communication with veterans
- Exit policy and outcome measurement
- Use of data and information

Option 4 – Redevelop VHC as an environmental support program

Under this option, VHC would be re-developed as an environmental support program. Two of the four current service types provided by VHC would continue as part of VHC and two would be transferred elsewhere.

The VHC program would consist of 'environmental-type' services, designed to safely support veterans and war widows in their homes for as long as possible. It would have four service types:

- Domestic assistance
- Safety-related gardening and maintenance
- Home Front
- Rehabilitation Appliances Program (RAP).

Option 5 – Expand scope of VHC to include other basic services

Under this option, VHC would remain as a basic service provider providing comparable levels of service. But the range of services would be expanded to be equivalent to that provided by HACC including, for example, social support, accompanied shopping, assistance to attend appointments, routine garden maintenance and so on.

Option 6 - Maintain scope of VHC but increase service intensity

This option would maintain the current scope of VHC. But the intensity of services provided would be able to be increased as needs increase. There is currently a significant gap in the benchmark service hours provided through VHC and the benchmark hours available for those in receipt of community packages. Under this option, the intensity of VHC services would be increased to fill this current gap.

Option 7 – Expand both scope and intensity

Under this option, VHC would be re-developed as the total community care provider for veterans, up to the point when the veterans requires packaged care. It would continue as an assessment and service provision program.

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Two other options are included that go beyond the parameters set by DVA in our initial brief. Under both options, the program would no longer be limited to low level services and veterans with higher needs would not be referred out of the program. We have included these options because of the strong evidence base behind them in terms their ability to achieve improvements in health outcomes. Further, they solve a paradox that was very apparent throughout the review - veterans are 'special' when they are low need but not when they are high need. This paradox will become increasingly problematic as the veteran population ages.

> "An alternative is to replace targeting - the idea that a client is in or out, eligible or not, with titrated care: generous in its eligibility, but carefully calibrated in the amount of resources actually allocated to a client. High-risk clients would get more care than current practice, to permit more aggressive treatment of their high risks and to take advantage of their high potential to benefit. Low-risk clients would get less care, enough to meet their satisfaction and to monitor their changing conditions, but not so much care that they have little potential to show marginal benefits equal to their marginal care consumption." (Weissert et al. 2003 page 121)

Option 8 – Redesign VHC to become a community care coordination and brokerage service

The role of VHC under this option would change from being an assessment and service provider to become an assessment, care coordination and brokerage service for a range of community care services. Key features of this option are:

- A single point of contact for veterans requiring community care
- VHC would assess for total community care needs, not just those currently provided by VHC.
- The first contact with a veteran would be an initial phone screening assessment (as occurs at present) with follow-up home assessments for those who require it.
- Based on either the initial screening or home assessment, veterans would be allocated to a funding band.
- Within the limits of that funding band, VHC would work with the veteran and their carers/family to agree on (and broker if necessary) the optimum mix of services required to maximise independence and quality of life. This function would be equivalent to that currently undertaken by Community Options agencies.

We have termed this option Veterans' Community Options Program (V-COPS).

Option 9 – Redesign VHC and absorb it into a total health and community case management and brokerage service

This option expands on Option 8 above. In Option 9, the scope would be expanded to include other services funded by DVA, including community nursing, allied health and post-acute care.

A new Veterans' Health and Community Care Options Program (VHCOPS) would be established, bringing together a range of services currently provided by different parts of DVA.

The local medical officer (LMO) would remain as the 'Case Manager' with VHCOPS as the 'Care Coordinator'. The new program would work closely with the LMO to organise and coordinate the required services. As health needs are identified, the LMO would contact VHCOPS who would organise and broker required services. Likewise, hospitals would contact VHCOPS to organise post-discharge services. Referrals for non-health needs would continue to be received from other sources, including self-referral.

Comparative assessment of the options for the future of Veterans' Home Care

These options are not mutually exclusive. For example, it would be possible for DVA to adopt Option 2 or 3 in the short-term (the next one to two years) while undertaking the required transition planning to move toward an option that represents a bigger change.

In terms of cost considerations, the options have different implications for DVA and for the government as a whole and these are discussed in Section 5.10.

There is no preferred option. This is deliberate. The scope of our Review was limited to VHC and yet most of the options have implications beyond VHC. We are not in a position to fully identify the implications of these options on other parts of DVA or to decide how important each criterion is to DVA.

Finally, it is important to note that the review did not involve any consideration of the legislative implications of the options. We understand that some options would require a change to legislation, a matter that DVA will need to take into account when determining its preferred approach and the best strategy to achieve the desired outcomes.

The preferred option/s need/s to be determined by DVA in the context of broader policy and planning considerations. In doing so, DVA (and the government more broadly) needs to decide on what is possible and desirable in both the short and longer term.

1 Introduction and background

This is the final report of an independent review of the capability of the Veterans' Home Care (VHC) Program and model to continue to meet the needs of veterans[3] in terms of quality of life, independence and health, in particular, maintaining independent functioning within the home environment. It is not a review of the way that VHC currently operates. The purpose is to identify options for the future.

The VHC program was established in 2001 with the aim of helping veterans and war widows/widowers with low care needs to remain in their own homes for longer. DVA contracts with service provider organisations around Australia to deliver four services:

- **Domestic assistance**: includes assistance with domestic tasks such as household cleaning, dishwashing, clothes washing and ironing, shopping for the veteran and bill paying;
- **Personal care**: includes assistance with daily self-care tasks, such as eating, bathing, toileting, dressing, grooming, getting in and out of bed and moving about the house;
- **Safety-related home and garden maintenance**: to assist in keeping the home safe and habitable by minimising environmental health and safety hazards; and
- **Respite care**: temporary relief provided to the eligible person's carer (or to the eligible person if they are the carer).

VHC is available to Gold and White card holders but access to VHC services is not automatic. Eligible veterans and war widows/widowers must first be assessed as needing home care assistance before receiving VHC services. Under the VHC model, the assessment function is separate to the service provision function. Assessments are undertaken by VHC assessment agencies and are conducted by phone using an on-line assessment tool (although the model does allow for in-home assessments to be conducted where necessary). Each assessment agency is allocated a notional budget each year and manage their service approvals within that budget.

The VHC program operates in an e-business environment, with assessments, approvals, generation of care plans and service plans, claims for payments, data entry, etc, all being done on-line.

The central strand of inquiry within the review has been to pose and seek answers to the question *'Does the VHC Program (as it is currently constituted) meet the changing needs of the VHC client population, which is ageing, becoming more frail and increasingly demanding both higher level services and additional services not currently available through the program?'* Two examples of this changing demographic are the average age of VHC clients, now 83; and a greater representation of females, in particular war widows.

Figure 2 below summarises the current model. VHC is one important part of a broader network of community health and care services that are available to veterans. Other elements not funded formally as part of VHC include:

- Other basic services such as HACC, Commonwealth carer respite services and state funded community health services. As an indication of the relative size of this sector, there were 777,471 people in receipt of HACC services in 2005/06 and 7.3% (56,424) were in receipt of a

[3] References to 'veterans' in the context of this review should be read to include war widows/widowers unless otherwise stated.

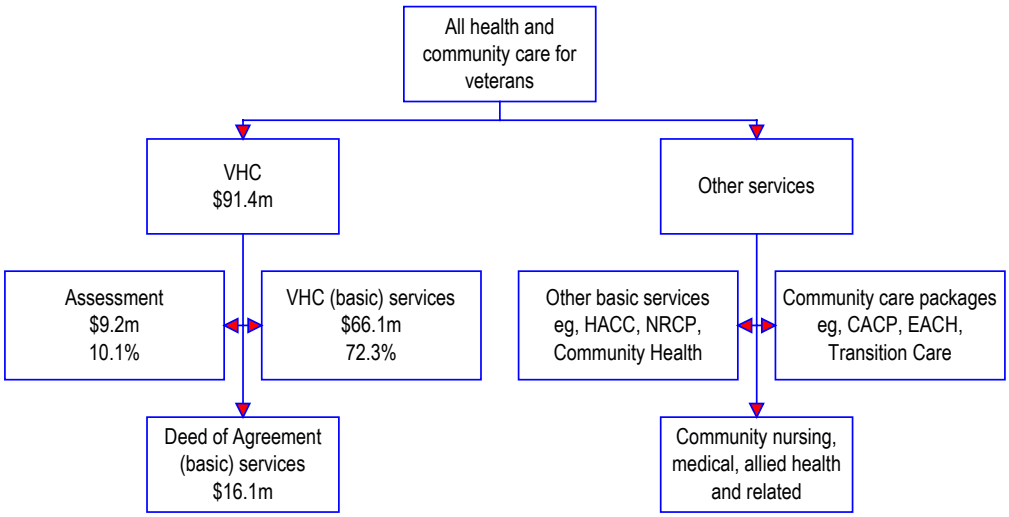
Department of Veterans' Affairs Pension[4]. This compares with the 80,343 veterans who received VHC funded services in 2006.[5]

- Community care packages such as Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) EACH Dementia and Transition Care. These are accessed after an ACAT assessment that is also not within the scope of the VHC Program. More than 20,000 veterans a year access a community care package.
- Community nursing, medical, allied health and related services (mostly) funded by DVA.

The VHC program funds three types of services:

- *Assessment* - $9.2m pa or 10.1% of the VHC budget in 2006.
- *VHC services* - $66.1m or 72.3% of the VHC budget in 2006. These are basic services grouped under four service types – domestic assistance, personal care, safety-related home and garden maintenance and respite care.
- *Deed of Agreement services* - $16.1m or 17.6% of the budget in 2006. Other *basic* services such as delivered meals, community transport and social support are delivered by or on behalf of state and territory governments. The Deed of Agreement with DVA represents a contribution towards these services. This contribution is not linked to the cost of these services (which we estimate to be much greater).

Figure 2 VHC in context



A veteran may receive several of these services concurrently. For example, a veteran may receive VHC services, supplemented by other basic services (eg, HACC services). One measure of the place of VHC in the wider community care system is thus:

- the number and type of veterans who are receiving VHC services only
- the number and type of veterans receiving both VHC services and other (non-VHC, which could include other DVA or non DVA) services concurrently
- the number and type of veterans who access other community care services but not those provided through the VHC Program

[4] Data provided by the Home and Community Care Program in October 2007. These 56,424 veterans receiving HACC include those also in receipt of VHC and veterans who are not eligible for VHC.
[5].The 80,343 VHC recipients include those assessed and approved for services irrespective of whether they actually received a service in 2006.

- the number and type of veterans who access no community services.

The outcome of the review is a set of options, set out in Section 5, on possible future changes to the VHC Program. The goal is to ensure that the VHC Program, as part of the broader health and community care system, is capable of delivering specified quality of life, independence and health outcomes that respond to the changing patterns of veteran need.

These options have been developed consistent with a range of issues identified by DVA as matters that the review might consider:

- the appropriateness of the current low care model in light of changing demographics;
- whether the existing four VHC service types should be expanded, either through increased hours of service or through the introduction of new services such as, for example, social support, accompanied shopping, assistance to attend appointments, routine garden maintenance;
- the factors driving service outcomes (for example, whether outcomes are driven by budget constraints rather than client needs);
- emerging issues such as, for example, mental health, dementia and other chronic diseases, and how these impact on the VHC program and its capacity to meet client needs;
- exit strategies for clients to move to other programs or enter residential care;
- flexibility in service arrangements, veteran choice in services and the frequency of those services (weekly, fortnightly, etc);
- the appropriateness and effectiveness of co-payment levels;
- the appropriateness of introducing 'tiered' level services to target clients with higher needs;
- issues affecting services in rural and remote areas;
- the relationship with, and transition to, other community care programs such as Community Aged Care Packages (CACPs), the Home and Community Care (HACC) program and other DVA programs;
- the impact of any changes to the VHC model on the capacity of assessment agencies and service providers to continue providing services to veterans;
- other program issues.

These options have also been developed within a framework of ‘givens’ provided by DVA:

- the separation of the assessment and service delivery functions is to continue;
- the program is to continue operating in an e-business environment;
- as per the current model, assessments are to be predominantly conducted by telephone using the standard VHC on-line assessment instrument (given the low level focus of the program);
- the program is to primarily provide low level services, but have the capacity to provide higher level services where warranted, especially on a short term basis; and
- as per the current model, veterans with higher needs than cannot be accommodated by the VHC program in the longer term are to be referred to other more appropriate programs such as the Aged Care Assessment Program (for assessment for CACPs and Extended Aged Care in the Home packages) or the Home and Community Care (HACC) program for HACC services, etc.

The options in the final section have been informed by an analysis of a wide range of data/information sources (outlined below), extensive and in-depth stakeholder consultations, the

findings from previous research and the findings from an evaluation of the outcomes currently achieved by the VHC Program.

There are several key issues that the review has addressed. These include, but are not limited to, the VHC service model itself, whether the range of service types should be expanded, factors driving outcomes, exit strategies and co-payments.

Our methodological approach to considering these issues has been predominantly qualitative and has involved surveys, interviews and focus groups. These issues have also been informed by a targeted literature review and extensive quantitative analysis. Likewise, possible refinements to the model have also been the subject of consultation and informed by a literature review. More detail on the methods used in this review is provided in the next section.

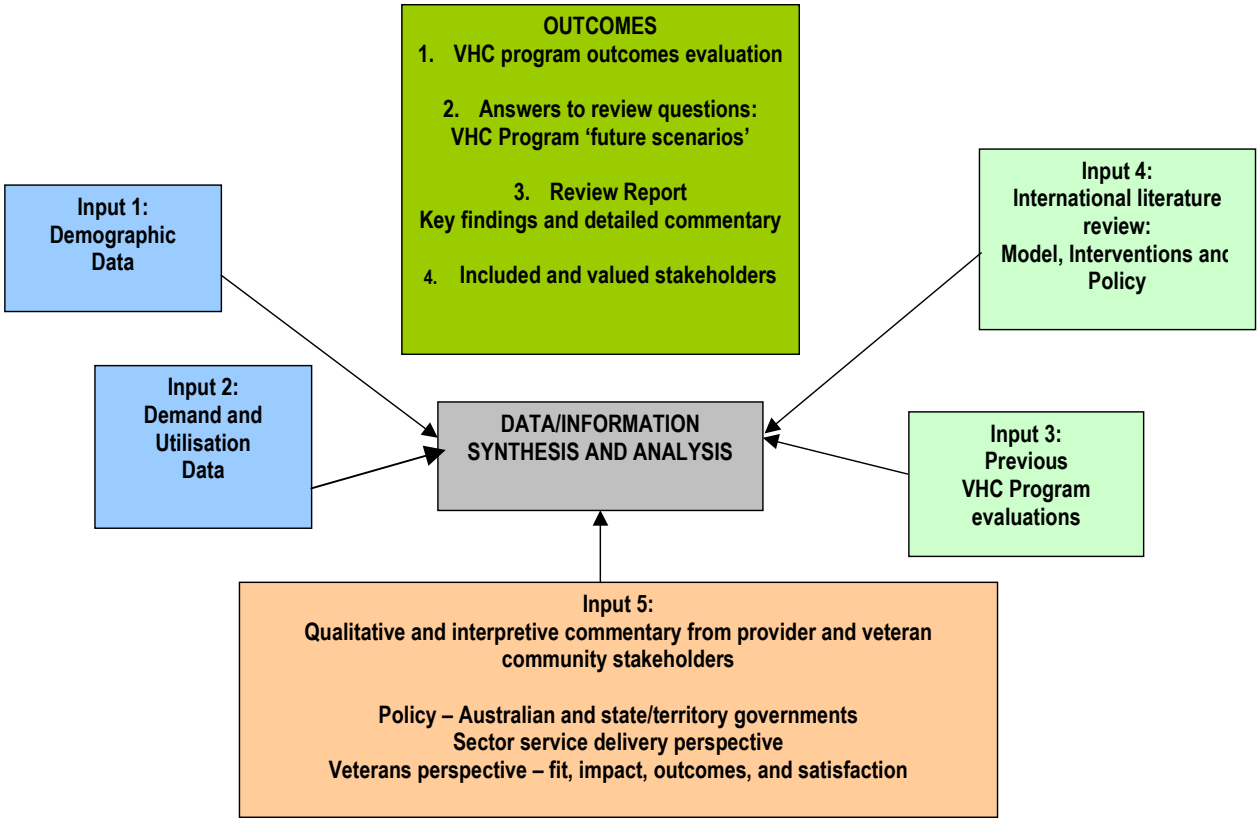
2 Methodology

The review has involved a series of related steps, which aim to evaluate the way that the program operates currently, and to predict the impact of current and future demographic trends on the level and type of resources required to serve the veteran community in the future.

Available databases, a literature review, previous VHC review documents, and program guidelines have been analysed for relevant information. Veteran participants and service and program-level informants have been invited to fill in surveys and/or be interviewed, attend focus groups and respond to key questions and the findings of the review process and draft reports.

The framework of the review is summarised in Figure 3 and in the description below. The data and information sources are identified as review 'inputs'.

Figure 3 The review framework - 'Inputs and Outcomes'



2.1 Overview of review inputs

The five review inputs have been:

- Demographic data
- Demand and utilisation data
- Reports of previous internal and external VHC Program reviews
- The findings of an international literature review
- Stakeholder engagement and consultation.

More detail on each of these strands of inquiry is provided below.

2.2 Quantitative analysis of demographic and utilisation data

Data relating to recipients of the VHC program, as well as data on the broader veteran population, were requested from DVA. In total, four datasets were requested.

- The first data set comprised information on veterans who were using, or who would be eligible to apply for, VHC services. It included sufficient demographic and service utilisation data to enable each veteran to be placed into one of the survey cohorts (described below). Veterans were then randomly sampled from each of the cohorts. At this stage, the definition of 'currently using' VHC services was questioned. All veterans who have participated in the VHC program remain in the database, even if it is some time since they last received a service. Because of the nature of the program, it is not uncommon for veterans to receive services at irregular intervals. This means that there would be some veterans who have not received a service recently, but who are still on the program. It was eventually decided that anyone who had received a service during 2006 or 2007 could be regarded as 'currently receiving' services for the purpose of the survey.
- The second data set included more detailed demographic and service utilisation information on all veterans in the DVA data set and was used to project future demand for VHC services. To assist with this, DVA also provided their projections of Gold and White card holders.
- The third data set related to veterans who had been assessed for, or who were currently using VHC services and included sufficient information to enable a profile of the VHC population and their utilisation of services to be drawn.
- The fourth data set requested was of assessment data, including functional scores collected during the assessment as well as the outcome of each assessment. DVA was not able to supply the data in the format requested, but did provide a file of VHC assessment data. It included demographic information as well as total ADL and IADL scores and administrative details of the assessment and recommended services.

Using the data in these files, a profile of VHC recipients was produced. An analysis of the assessment and service utilisation information was also undertaken. In particular, patterns of usage and their relationship with the demographic data were investigated.

In addition to the data from DVA, two other data sources were available. The number of HACC clients who also received a pension from DVA and the types of HACC services they received during 2005/06 were provided by the Department of Health and Ageing. Data on applicants for basic services from the NSW Home Care Service provided a second comparison group.

2.3 Review of existing program documentation and previous reviews

An important source of data and information providing insights into the functioning, performance and impact of the VHC program was available in the various internal and external review reports.

Reviewing, assessing and utilising relevant material from these reports has ensured that we were able to focus our review efforts on adding to what is already known, rather than duplicating forms of data organisation and analysis that have already been undertaken.

2.4 International literature review

The development of the VHC Program model was referenced to findings of relevant research prior to 2001. We have undertaken an updated literature review in relation to interventions with comparable aims to the VHC Program. Given the international policy and service development emphasis on maintaining the independence of older people within their home environment, we scoped the review to include both the academic and the practice literature. We have identified the evidence developed in a number of areas – various forms of research, quantitative and qualitative; and consensus based best-practice.

The search strategy for this literature review involved the identification of relevant academic and practice publications on interventions, models and policies. Additional searches were undertaken to find any studies that examine the relationships between domestic services and personal care and community nursing.

Academic (scientific) literature

A "MeSH Browser" was used to refine the search process using 'home care' and 'veterans' as the initial keywords. The search of one-off studies was limited to publications since 2001. In addition, the Cochrane Library via OVID was used to capture reviews that cover earlier periods.

Practice literature

The search for veteran-specific literature covered relevant documents on the following Departmental websites:

Australia	http://www.dva.gov.au/
Canada	http://www.vac-acc.gc.ca/general/
New Zealand	http://www.veteransaffairs.mil.nz/default.htm
United Kingdom	http://www.veterans-uk.info/
United States of America	http://www.va.gov/

Broader practice literature on home care and community care were sourced from a variety of sources including:

Amazon.com for books
Campbell Collaboration website
OVID Citation Search for key journal articles (Academic Literature)
University research centres and government departments.
The search for relevant publications targeted interventions, not specific population or disease groups.

Search results

In total, 2,354 references were identified. These include 177 Randomised Controlled Trials.

Given the size of the literature, it proved necessary to limit outputs to a manageable size by the use of the following criteria:

- Abstracts, Humans, English
- Publication Years: 2001 - 2007
- MEDLINE CORE Clinical Journals (AIM)

Outputs were then culled by reviewing article titles, each of which was checked by two researchers independently.

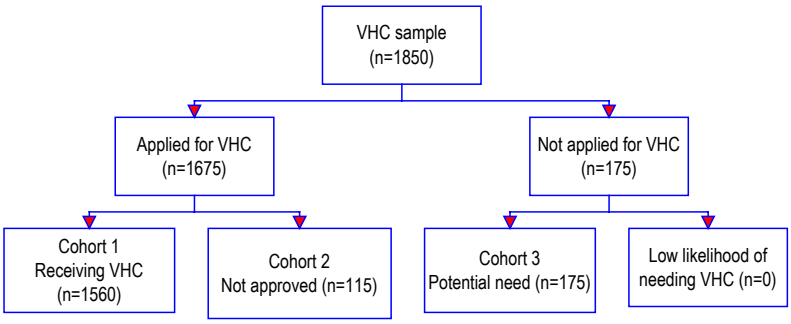
2.5 Consultation with veterans and their carers

A survey on the current and expected needs of veterans and their carers, including the range of services that they use, was conducted. This was an important part of the review because the aggregated information on veterans from the DVA data bases and other programs was not able to be linked in order to understand the full range of services being used by any individual.

Three groups of veterans were identified, depending on whether the veterans had been assessed for services and whether or not they had been approved. This sampling framework is summarised in Figure 4. In determining which particular veterans were to be sampled, we considered the

age/sex and geographic distributions of the veterans as well as the DVA policy to protect veterans from having to participate in too many surveys.

Figure 4 Sampling framework



In determining the number of veterans to survey, consideration was given to the expected non-response rate as well as to the relatively high mortality rate within this population.

The survey questions were designed and reviewed by the project team as well as DVA staff. In addition, a progressive piloting of the tool was conducted amongst a selection of veterans and their carers, with modifications being made as suggested and the modified tool being assessed by the next people to pilot it. Feedback covered acceptability in terms of broad content areas, layout and readability. These pilots of the survey were also used to estimate the time it would take to complete. The final version also incorporated changes required by the DVA Human Research Ethics Committee. Each cohort had a slightly different version of the tool, with questions modified where necessary to suit the particular group.

The aim was to have survey data on 1,200 respondents (73% response rate). Consequently, surveys were posted to:

- 1,560 VHC veterans who received services during 2006 or 2007, with an over-sampling of those receiving personal care. Only a small percentage of veterans receive personal care so over-sampling was necessary to achieve adequate data on this group.
- 115 veterans who have been assessed but were not approved for services
- 175 veterans who would appear to potentially have a need for VHC services (eg more than 75 years old, not in residential care) but who have never been assessed.

DVA provided the name and address details of suitable veterans to be sampled and the CHSD posted the survey out to veterans. The survey included a covering letter from the DVA's Principal Medical Adviser (Dr Graeme Killer) to highlight the importance of the survey and to reassure veterans that it was both appropriate and necessary.

DVA placed background information on their web-site that veterans and/or carers were able to access to support the Review. The CHSD provided a help-line phone number for veterans or their carers to contact with any queries or requests for assistance in completing the survey.

We followed up with a telephone survey of 225 non-respondents from the postal survey. We made up to three attempts to contact the veteran by telephone. We conducted interviews by telephone with 60 of these veterans.

A registration database was created to record return of surveys. Details in this database included:

- person's name, address and telephone number
- unique identifier

- date posted
- date death advised (DVA to advise)
- date refusal advised
- date survey received
- 3 attempts to contact person, date posted +14, +17, +21 days
- notes to record other contacts with person

As surveys were returned, the date of receipt was recorded in the database. After 2 weeks, CHSD staff reviewed the outstanding returns, phoned each person up to 3 times within the next week to follow up the reason for non-return, and assisted the person to complete the survey either by completing the paper form, or by entering it directly into the survey results database.

In addition, consultations occurred with individuals from peak groups representing veterans. These included the RSL Welfare and Benevolent Institution, the national president and immediate past president of the Vietnam Veterans' Association and Ex-Service Organisations.

2.6 Consultation with other key stakeholders

Stakeholder engagement is critical when interventions have significant and wide ranging impacts and need to be well integrated with a range of other services that are delivered across a range of jurisdictions. It is also critical if the results of the review are to be acceptable to those with a stake in the program.

We consulted extensively with the following key stakeholder groups:

- Veterans and veteran/older person support and advocacy bodies
- DVA (both VHC and other relevant sections)
- Department of Health and Ageing (relevant program staff)
- VHC Program assessment agencies and service providers
- Key community service networks, and
- Relevant State Government Departments.

Initial meetings with the VHC Program Reference Group and the assessment agencies were carried out in order to present an outline of the review and the methods to be used, and prepare the groundwork for the formal surveys. Those meetings also provided an opportunity to receive direct feedback from these stakeholders on the planned activities and methods, and for the review team to gain an early understanding of the range of current issues for assessors and providers within the program.

Subsequent key stakeholder face to face and telephone consultations built on the first meetings and were designed to supplement the information collected by survey. The direct contacts explored in more detail how the program might evolve in response to the changing needs of veterans. The review of documents and the first meetings assisted in the design phase of the surveys and the key questions for the direct contacts. The aim was, as much as possible, to avoid revisiting the current issues of program logistics and administration and areas already well covered by the information in the data bases, earlier surveys, evaluations and projects.

The following table identifies the major stakeholders involved in the review and the strategies used to facilitate consultation with them.

Table 1 Strategies used to facilitate communication

No.	Stakeholders	Communication strategy
1	Veterans and their carers	Postal survey to veterans DVA web-site information CHSD Helpline CHSD follow-up interviews
2	VHC assessment agencies	Semi-structured face-to-face consultations Participate in DVA forum for assessment agencies CHSD Helpline
3	VHC service providers	On line survey of all VHC service providers Semi-structured face-to-face consultation CHSD Helpline
4	Other community care providers	A sample of agencies identified by the Aged and Community Services Association (ACSA) in all state capital cities Surveys and background information distributed by CHSD CHSD Helpline
5	Relevant state and territory government departments	State/Territory officers relevant to Deeds of Agreement. Semi-structured face-to-face or telephone consultations
6	The Australian Department of Health and Ageing	Phone and face to face consultation with relevant officers.
7	Department of Veterans' Affairs and Veterans' Home Care Program	Regular consultation and interview as key stakeholder

We spent two days in each state capital, with half a day each to meet with:

- assessment agencies,
- service providers,
- state government officers, and
- local industry forums such as those organised through ACSA.

Two CHSD staff attended each session. CHSD and DVA jointly organised suitable venues in each capital city for meeting with the assessment agencies and service delivery agencies.

2.6.1 VHC assessment agencies

CHSD attended a DVA organised forum to explain the review and obtain early feedback from all sixteen assessment agencies. This provided useful background on current issues for the agencies to assist in targeting the areas to be covered in both the surveys and the direct consultations.

Semi-structured face-to-face consultations subsequently took place with fourteen assessment agencies, ensuring a representative sample throughout Australia. The two agencies unable to attend were subsequently contacted and invited to participate in a telephone interview or to provide feedback to the prompt questions used throughout the face-to-face consultations.

2.6.2 VHC service providers

An electronic survey of all current DVA service providers was undertaken. Additional semi-structured face-to-face consultations were also carried out with relevant service providers in each capital city.

DVA currently has contractual arrangements with 16 assessment agencies and 175 service providers across Australia for Veterans' Home Care services. Claims from service providers for services provided to veterans accounted for more than 70% of the VHC budget. A survey was developed to obtain input from this group.

The VHC Service Provider Survey was conducted during August 2007. The survey was conducted on-line using "Survey Monkey" on-line survey software. A total of 253 respondents were emailed a unique electronic link to the survey. Of these, DVA had provided 237 email addresses for providers. An additional 16 emails were also sent to specific individuals who had either a new email address or had requested their organisation be a part of the survey. Some service organisations have more than one outlet therefore a unique link was sent to each of these outlets to capture differences due to geographical location or client mix in those outlets.

This link enabled the respondent to access the survey and complete it over a number of sessions if required but could not be re-accessed once the respondent submitted the survey or emailed on to another recipient. This ensured that each service provider or service outlet had equal input into the survey.

Surveys were collected over a three week period. A reminder email was sent to non-respondents a week after the initial survey invitation to improve the response rate. Survey summary data were downloaded into an Excel file and both quantitative and qualitative analyses were conducted.

2.6.3 Other community care providers

Other community care providers were consulted in a series of meetings held in state capitals and these were primarily those agencies affiliated with the Aged & Community Services Association as these were representative of the community care service sector. We also consulted with a local government peak body and managers of Commonwealth Carer Respite Centres. A total of twenty-six organisations were represented through these consultations.

2.6.4 Relevant state and territory government departments

Targeted consultations occurred with relevant state/territory representatives to explore parallel initiatives that may have an impact on the VHC and its future development. State and Territory representative were invited to comment on the likely impact on their own initiatives or program restraints that might result from a set of hypothetical VHC program development scenarios.

2.6.5 The Australian Department of Health and Ageing

We consulted with the Department of Health and Ageing (DoHA) about current national reforms in community care and about the interaction of VHC and broader community care services, and also used the submissions to the Department's Review of Subsidies and Services in community care.

2.6.6 Department of Veteran Affairs

Formal consultations occurred with nineteen DVA officers both within and external to the VHC program and across the jurisdictions of Policy and Operations at both the state and national level. In addition, the CHSD and VHC team were in communication throughout the review via face to face meetings, email and telephone. This included teleconferences to discuss specific issues as they arose. The frequency of contact varied during the design phase and became more regular in the latter part of the review.

3 Results

3.1 Key findings from the international literature

An international literature and practice review was conducted to test the evidence in support of the current role of VHC in the service system and in particular the levels of support for its service types and the rationale for the model of service provision (see Appendix 2). The starting point was a brief review of the Australian policy context in the 1980s for the Home and Community Care (HACC) program on the assumption that VHC shared the same broad policy objectives, intended outcomes and economic rationale.

The combination of demographic changes and their associated changes in the morbidity profile and burden of disease, increased levels of dependency in older people maintained in the community, and the relative success of aged care assessment and more complex community care alternatives, has created a very different context for community care in 2007, from that existing in the 1980s.

The notion of 'prevention' is now more complex than expecting maintenance level services to prevent residential care admission or to minimise the impact of chronic diseases. The effectiveness of 'basic' care services as promoted by policy in the 1980s needs to be tested by more recent evidence. It is against this policy and demographic backdrop that the review of effective interventions was carried out.

A large number of service utilisation studies were found that included home care but these did not examine the efficacy or effectiveness of specific interventions. The utilisation studies examined the needs and personal characteristics (e.g. functional status, unmet needs, informal supports) of home care recipients. A paper by Kadushin (2004) is useful in this area as it reviews the literature on resource utilisation for home health care recipients.

3.1.1 Changing patterns of need and carer support

A recent publication of the AIHW on the burden of disease and injury in Australia in 2003 found that while the rate of disability will actually decline in most age groups, those 80 years and over are expected to experience an increase and that will mostly come from expected increases in diabetes and neurological conditions This will increase demand for services in the home, community care, residential aged care and palliative care sectors. (Begg et al. 2007, p.8)

An expected increase in longevity suggests the veteran population may live longer than previous generations, but that the extra years of life may be associated with increased dependency. Another report (AIHW 2006) gives an example of the increased burdens of disease expected to arise from dementia, representing a significant challenge to health, aged care and social policy with obvious implications for services. The report estimated:

> "… the number of people with dementia will grow from over 175,000 in 2003 to almost 465,000 in 2031, assuming the continuation of current dementia age-specific prevalence rates." (page xii)

Research by Access Economics (2003, p. 6) for Alzheimer's Australia estimated that growth of 6% per annum in the HACC program would be required to keep up with increasing demand, even after a 20% top up for current unmet need, plus additional respite services will be needed to better support informal caregivers.

There are also expected to be changes to the profile of carers in the future. The AIHW published a study on the future supply of informal care from 2003-1013 (Jenkins et al. 2003) where they estimated that the informal carer sector provides the equivalent of one million full time positions, and informal carers provide 77% of all the care that enables people with disabilities to stay at home. The study points out that structural and numerical ageing of the population signals higher

demand for primary carers and heightens concern about the circumstances of a growing number of older carers. Becoming unable to care can cause significant anxiety and practical difficulties for older carers in particular.

Over 50% of partner and parent carers said that they could offer the best available care for their family member, confirming the widespread preference for care in the community. Overall, 79% of primary carers in 1998 lived with their care recipient. Future provision of informal care to people aged 45 to 64 years, could prove vulnerable to higher rates of relationship breakdown than has been evident in previous generations. In particular this could make an impact on the veterans in the post-1975 cohort.

Assuming all other factors are held constant, in 2013 the ratio of primary carers to the population in need of assistance from a primary carer will have declined from the ratio observed in 1998 from 43 primary carers per 100 persons with a severe or profound restriction to around 40. This projection is driven by high growth in the age groups from which large numbers of primary carers are traditionally sourced, counteracting the effect of a moderate reduction in the proportion of working-age women who are willing to reduce paid work to care compared to 1998 (Jenkins et al. 2003).

3.1.2 The evidence on effectiveness

The full literature review in Appendix 2 summarises our findings in the area of interventions, service models and ways of organising care, and policy directions for home care, applicable to Australian veterans.

In summary, the evidence on effective interventions in home care that is particularly applicable to Australian veterans is:

- There is a lack of specific service-level information in the literature on the effectiveness of domestic assistance services, personal care services, and home and garden maintenance services. The support for these types of services comes from evidence of their effectiveness when subsumed into a care plan as part of a package of care (McCusker and Verdon 2006).
- Evidence was found which supported the targeted use of preventative health visits for the elderly, usually carried out after a comprehensive assessment (in order to improve the targeting) and with visits by nursing, health visitor or allied health professionals (Stuck et.al. 2002).
- Given the importance of carers for the VHC population, the scientific evidence base on respite care needs to be improved in order to derive reliable guidelines to assist the development of the most effective care practices (Mason et al. 2007, Ingleton et al. 2003)
- A review of identified high quality papers on care packages found the following key concepts described: service intensity, training of other providers in the community, assessment and monitoring, care planning and management, multi-disciplinary teams, care coordination and evaluation, home visiting, telephone contact, equipment and transport, referral to other providers and volunteer agencies, as well as respite services.
- Three major trends were noted from the literature on home care services: (1) the use of technology to improve health care delivery, (2) the rise of programs that address functional independence or restoration, rather than maintenance, and (3) the importance of physical activity or exercise for the elderly.
- Key clinical issues for the geriatric population at risk for hospitalisation include early detection, care coordination, and the integration of information; as well as the need for better targeting of health interventions for older people (Stuck et al. 2002, Lynn and Adamson 2003), and the use of screening algorithms (Fries et. al. 2002) followed by a classification approach (Weissert et al. 2003).

The summary by Johri et al. (2003) (page 223) points to the effectiveness of an elaborate and flexible combination of interventions, not basic level care. It points out that internationally, many jurisdictions have attempted to facilitate this by establishing a single entry point system, with case management provided for continuing care in the community and for admissions to long-term care institutions. Reducing fragmentation and improving the use of resources, is hard and significant limitations remain, including the residual barriers between medical and social care, acute and continuing care, and community and institutional care. The problems still remain when each agency continues to function autonomously in its own jurisdiction with its own budget.

The work by Wiener et al. (2004) in the US included a detailed literature review into home care services and the implications for programs wishing to develop a research agenda. In terms of the issues relevant to an Australian context, they found that:

- There needs to be further investigation into the role of home care services in reducing the total costs of long term care; and
- That new service approaches using technology, carer support and respite, and consumer self-direction need to be investigated.

Common policy issues identified in the literature were the development of person/client centred services, rather than a focus on more supply-side or service-driven responses based on determining eligibility for a narrow band of service types. Problems for clients and providers are brought about by a set of programs that are not consistent in how they operate, and create disincentives to making transitions to higher levels of support. Policy reform calls for a more flexible model of care than has so far evolved from the combination of all programs operating essentially independently, but with a common understanding of the issues for their shared population of clients.

Best practice examples of community care policy focused on early and broad assessment of individual needs and models for the assessment of service users that include their positive potential for improved functioning as well as their levels of functional dependency.

The case for developing programs of 'low-level' support such as the VHC and HACC programs is essentially one of increasing client choice. It is also based on the assumption that low levels of care are a preventive intervention to reduce the risks of admission to residential care institutions. The evidence on this assumption is by no means clear cut when assessed in detail by examination of the academic and international literature.

3.1.3 Review of Department of Veterans' Affairs documents

A number of documents were supplied to the Review by the Department of Veterans' Affairs (hereafter also referred to as 'the Department' or 'DVA') to provide background information for this project. They covered surveys of veterans, audits and reviews, management, organisational and costing studies, methodology papers, reports of pilot programs and information bulletins and are briefly summarised in Appendix 2.

The Department has used a large number of outside agencies to report on the needs and service usage of veterans, and the functioning and costs of services and to recommend changes to the VHC program.

A number of useful pilot projects are described, some of which have yet to report in detail, but will have findings of direct relevance to the options for the future of the program. In particular the Department has undertaken pilots to test the capacity of the VHC to meet the requirements of higher need clients, and to gain a better understanding of the clients with higher needs and on the same theme is undertaking an evaluation with NSW DADHC of the DVA and Community Options brokerage project (DADHC 2006).

There are areas where the scope of VHC services differs from the scope of HACC services, in particular when people seek services which are either not offered, or have limited hours available under VHC. These types of services are:

- Accompanied shopping (where there may be a socialisation component)
- Preparation of meals (as distinct from delivery of prepared meals)
- Non-medical transport (offered by community transport services)
- Respite care (the types of care and the role of respite carers available under VHC differ from those under HACC)
- Routine home and garden maintenance (where the issues are not safety-related).

The Auditor–General (2005) *Audit Report No.43 2004–05 Performance Audit Veterans' Home Care, Department of Veterans' Affairs* is a key document. Its recommendations were accepted by the Department and are still relevant in the context of the present review. These are outlined from the paragraphs of the key findings in the summary section and the recommendations, with brief comments below.

> "In 2000, DVA developed a reasonable approach to estimate the number of veterans it expected to receive VHC services, and developed budgets for services based on this estimate. However, the ANAO found that there is scope for DVA to develop a comprehensive profile of the eligible VHC veteran population. By doing so, DVA would be in a better position to refine the budgetary model. In addition, a profile would assist DVA to identify eligible veterans and provide these veterans with information about VHC. Profiling would also assist DVA's planning for VHC and ensure that those veterans most in need are receiving VHC services." Para.11.

The present review provides a useful profile for the purposes outlined by the ANAO.

> "Since VHC is a budget-capped program and veterans are not automatically entitled to receive services, DVA managed information about the program to ensure that it did not raise expectations which it could not meet. The ANAO found that while DVA has provided information to veterans, it has not evaluated whether this communication has been effective in reaching all eligible veterans or whether the information distributed was clear, accurate and appropriate." Para.12.

The consultations and veterans' survey conducted under the current review suggest that clear expectations about the capped funding environment, and the limited nature of the program, is still an issue in the field.

> "One of DVA's main sources of data about VHC and veterans receiving services is the information entered online onto the standard veteran assessment form. DVA does not require contracted Agencies to ask veterans all questions on the form, which affects the consistency of data produced by the VHC systems. In addition, the ANAO found that DVA does not aggregate the information. Therefore, DVA does not maximise use of information gathered through the assessment form. This inhibits its ability to describe the characteristics of veterans in the program, evaluate VHC service levels, and plan for the delivery of VHC in the future. As part of its current review of the assessment form, DVA is considering these issues, including the number of mandatory questions on the form." Para.13.

The consultations and provider survey conducted under the current review suggest that information management is still an issue in the field.

> "VHC is one of a range of community care programs available to veterans. The ANAO found that there were a number of factors that hampered effective coordination and integration of VHC and other community services. These included limited data about how veterans enter VHC and why they leave; the lack of strategies to move veterans to other programs when appropriate; and the absence of strong links with other relevant programs. Program coordination and integration are recognised as challenging issues across the community care sector. However, improved coordination between VHC and other services would assist DVA to achieve an integrated response to caring for veterans…" Para.14.

The evidence from the literature review, consultations and provider survey conducted under the current review suggest that coordination and integration are still very challenging issues, not limited to VHC but well recognised in the field.

> "In the latter part of 2002, VHC service provision budgets came under heavy pressure. The ANAO found that the reasons for this pressure include the higher than estimated cost of providing services to veterans who transferred from Home and Community Care (HACC) compared to other veterans, and the difficulty of referring veterans to other programs, when appropriate. In response, DVA implemented a number of strategies to relieve the pressure on the budget and improve budget management. These strategies included: the introduction of a recommended benchmark of 1.5 hours of domestic assistance a fortnight; ceasing the grandfathering arrangements for veterans transferring from HACC; the ability to re-credit unused hours of service; and the introduction of a notional budget buffer that allowed Agencies to approve services above their nominal budgets. The effect of these budget management strategies was a decrease in the hours of service approved nationally…" Para.16.

The evidence from the consultations and data analysis conducted under the current review suggests that the impact of what are still known in the field as 'benchmark' levels of service provision and lack of flexibility are well recognised in the field.

> "The ANAO found that the standard assessment form was adequate for straightforward assessments, but was not as effective for more complex cases, such as when the veteran had higher-level care needs, or hearing or cognitive problems. The VHC Guidelines, which were distributed to all Agencies, were clear and understandable and allowed flexibility to adapt to local initiatives. However, this flexibility meant that the VHC Guidelines did not contain details about how prescribed service levels should be applied, which caused uncertainty for some Agencies. Consequently, the ANAO found that some Agencies had developed their own service approval guidelines to supplement the VHC Guidelines, often without advice from, or in consultation with, DVA." Para.19.

The evidence from the consultations conducted under the current review suggests that assessments are not adequate for complex cases and the need to move beyond the guidelines is well recognised in the field.

> "The ANAO found that there have been significant variations in service levels across regions. Possible reasons for these variations include, inter alia, regional differences such as locality and availability of other care programs and providers, and inconsistent application of the VHC Guidelines. The ANAO found that DVA has not analysed the available VHC data to identify why these variations are occurring, nor has it set boundaries within which it considers variations to be acceptable or valid." Para.20.

The evidence from the consultations and data analysis conducted under the current review suggests that variations are still significant and the associated issues of equity in service provision are well recognised in the field.

> "The ANAO ascertained that veterans were assessed and received services in a timely manner, with the majority of veterans assessed within one week of referral and receiving services within three weeks of approval for services. However, DVA only collected waiting list data on veterans who were involved in some stage of the VHC process. It did not actively promote the program. Therefore, the ANAO considers that the number of veterans applying for assessment or services was limited. This, in turn, limits the number of people waiting for assessment or services…" Para.21.

The evidence from the consultations and data analysis conducted under the current review suggests that waiting lists are not required because there is usually no need to wait and that promotion of the aims and limitations of program is still limited.

> "DVA has not evaluated whether VHC is meeting its aim of enhancing the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting veterans to remain independent in their own homes as long as possible. However, DVA has reviewed various aspects of VHC since its inception in 2001. The reviews reported that VHC had made a significant contribution to community-based aged care services in Australia. Importantly, DVA's Veterans' Satisfaction Survey reported high levels of satisfaction with the program." Para.23.

The current review is a contribution towards dealing with this issue in more detail.

DVA has agreed with the list of ANAO recommendations and evidence from the consultations and surveys suggests it has made progress in responding to only some of them. The complexity of dealing adequately with the recommendations should not be underestimated and the current review makes a useful contribution to making progress on the more difficult issues that require a strategic and long term development pathway. These are in relation to the most important recommendations, which are two, three and four.

> "Recommendation No.1 Para. 2.24 The ANAO recommends that DVA identify and profile the veterans eligible for VHC, and use this profile to ensure that those veterans are provided with appropriate information about VHC. DVA's response: Agreed.
>
> Recommendation No.2 Para. 2.59 The ANAO recommends that DVA develop and implement exit strategies to support the transition of veterans from VHC to other, more appropriate, care when necessary. DVA's response: Agreed.
>
> Recommendation No.3 Para. 2.61 The ANAO recommends that DVA collect and use data, for example, entry and exit data, to improve integration and coordination and to further assist DVA to manage the current and future demand for VHC services. DVA's response: Agreed.
>
> Recommendation No.4 Para. 2.63 Recognising DVA's prime Commonwealth responsibility for veterans, the ANAO recommends that DVA adopt the lead role for veterans in developing links between community care providers, with a view to promoting better service delivery to veterans, including exploring common approaches to assessment, regional boundaries and data sharing. DVA's response: Agreed.

Findings in this review, reported in the following sections, are consistent with those of ANAO and the reform options outlined in Section 4 include implementation of these recommendations.

3.2 The profile of veterans and war widows receiving VHC in 2006

This analysis is based on VHC recipients from 2006 who were alive at the end of 2006 and were not classified by DVA as "grandfathered" (veterans who had transitioned from HACC). Among 154,093 veterans in the VHC database, 80,343 were receiving services in 2006. These 80,343 VHC recipients include all veterans who were assessed and approved for services during 2006, irrespective of whether they actually received a service in 2006. Among these, 6,277 died during 2006. A further 8,034 were grandfathered-transitional veterans and, on the request of DVA, this group was also excluded from analysis. The analysis in this section is based on the remaining 66,032 VHC recipients, using data from the files provided by DVA.

In 2006, 19% of DVA clients received VHC. Proportionally, fewer VHC recipients are veterans and more are dependants, including war widows (Table 2). Almost 17% of veterans receive VHC compared to 22% of dependants. This may be due to war widows outliving their veteran partners. Almost all VHC recipients hold Gold cards (98%), compared to only 68% among all DVA. Among all DVA clients, one in four Gold card holders receive VHC services, compared to only 3% of white card holders.

The most recent conflict of the veteran was not well reported in the data set we received from DVA. Of those reported, those receiving VHC services were twice as likely to be WWII veterans (84%) than DVA veterans generally (42%). Overall, one in three WWII DVA veterans and one in five Korea veterans receive one or more VHC services (Table 2). Please note that some veterans have been excluded from this table as, for them, these data items were missing.

Table 2 VHC population compared to the DVA population, 2006

Variable	Value	Number of VHC clients	% within VHC	% within DVA	VHC clients as a % of DVA
Status	Veteran	32,715	49.5	56.9	16.5
	Dependant	33,309	50.4	43.1	22.3
Card type	Gold	64,565	97.8	68.1	27.3
	White	1,451	2.2	15.3	2.7
	Other/Unknown	16	0.0	16.6	0.0
Most recent conflict (veterans only)	WWII	17,414	83.6	42.2	34.8
	Serving member	1,086	5.2	27.5	3.3
	Korea	893	4.3	3.5	21.3
	Vietnam	597	2.9	14.9	3.4
	Other	839	4.0	11.8	6.0
	Unknown	11,886	(36.3)	(40.0)	
TPI	Yes	3,222	4.9	7.8	11.9
	No	62802	95.1	92.2	19.6

One in twenty VHC participants are totally and permanently incapacitated (TPI), a smaller proportion than that in the whole DVA population (Table 2). Among all DVA clients, those that are totally and permanently incapacitated are less likely to also be VHC clients (12% compared with 20%). As a group TPI veterans were greater users of health services generally than VHC recipients, in particular allied health, private hospitals and mental health.

Table 3 shows there are more male DVA clients than female (56%), while conversely there are slightly more female VHC recipients (52%). Almost all males receiving VHC services are veterans, while almost all females receiving VHC services are dependants.

As a sub-group, VHC recipients are much older than all DVA clients (Table 3). One in four DVA clients are aged less than 70 years old, while almost four out of five VHC recipients are aged 80 years old or older. One in 50 DVA clients aged less than 65 receive VHC services, while one in four DVA clients aged 80 years or older receive VHC services. Among all DVA clients one in five (19%) were also VHC recipients, this proportion increases to 27% when considering only those aged 80 years or older.

Table 3 VHC population compared to the DVA population – age and sex, 2006

Variable	Value	Number of VHC clients	% within VHC	% within DVA	VHC clients as a % of DVA
Sex	Male	31,884	48.3	55.6	16.5
	Female	34,140	51.7	44.4	22.1
Age group	<55	363	0.5	9.2	1.1
	55-59	588	0.9	7.5	2.3
	60-64	711	1.1	5.7	3.6
	65-69	935	1.4	3.9	6.9
	70-74	2,286	3.5	5.2	12.7
	75-79	9,212	14.0	13.3	20.0
	80-84	29,553	44.8	33.0	25.8
	85-89	17,684	26.8	17.4	29.3

Variable	Value	Number of VHC clients	% within VHC	% within DVA	VHC clients as a % of DVA
	90+	4,692	7.1	4.9	27.7

Three out of four VHC clients are residents of the eastern states of Australia (see Table 4). This distribution is very similar to that for all DVA clients, and among those aged 80 years or older. DVA clients aged 80 years or older were more likely to be VHC recipients if they were from the ACT or Tasmania (39.9% and 38.7%), and slightly less likely if they were from Victoria or the NT (23.1% and 23.9%). Please note that some veterans have been excluded from this table as, for them, these data items were missing.

Almost all VHC recipients live in major cities or regional areas, as do almost all DVA clients. There is evidence of geographic inequity with only 11% of DVA clients living in remote Australia and 4% of DVA clients living in very remote Australia receive VHC services. This compares to 20% who live in major cities. Some of this inequity is accounted for by age differences in different parts of Australia. When the analysis is restricted to those aged at least 80 years old, 19% of those who live in remote areas and 7% who live in very remote regions receive VHC compared to 29% of those in live in inner regional centres.

Table 4 VHC population compared to the DVA population – location, 2006

Variable	Value	Number of VHC clients	% within VHC		% within DVA		VHC clients as a % of DVA	
			% all	% 80+ years	% all	% 80+ years	% all	% 80+ years
State of residence	NSW	22,317	33.8	34.3	32.0	34.4	20.2	27.0
	VIC	13,720	20.8	21.3	22.0	25.0	18.1	23.1
	QLD	13,819	20.9	20.2	23.0	19.0	17.4	28.9
	WA	6,467	9.8	9.5	9.3	8.3	20.1	31.1
	SA	5,449	8.3	8.5	8.4	9.0	18.8	25.8
	TAS	2,919	4.4	4.3	3.1	3.0	27.2	38.7
	ACT	1,224	1.9	1.8	1.8	1.2	19.3	39.9
	NT	94	0.1	0.1	0.4	0.1	6.7	23.9
Remoteness	Major Cities	41,416	62.7	64.0	60.3	64.5	19.8	27.1
	Inner Regional	18,361	27.8	27.0	26.9	25.6	19.6	28.8
	Outer Regional	5,819	8.8	8.4	10.5	9.0	15.9	25.3
	Remote	352	0.5	0.5	0.9	0.7	11.0	18.5
	Very Remote	27	0.0	0.0	0.2	0.1	3.6	7.2

Reflecting their poorer health status, VHC recipients are heavier users of health services than DVA clients generally (Table 5). Almost all VHC recipients had received medical treatment, pharmacy items and allied health. DVA clients receiving community nursing are likely to also be a VHC recipient (64%).

Table 5 VHC population compared to the DVA population – non-VHC health service usage, 2006

Non-VHC health service received	Number of VHC clients	% within VHC	% within DVA	VHC clients as a % of DVA
Mental health services	33,674	51.0	39.6	24.5
Medical treatment	65,476	99.2	73.8	25.6
Allied Health	59,380	89.9	58.2	29.4

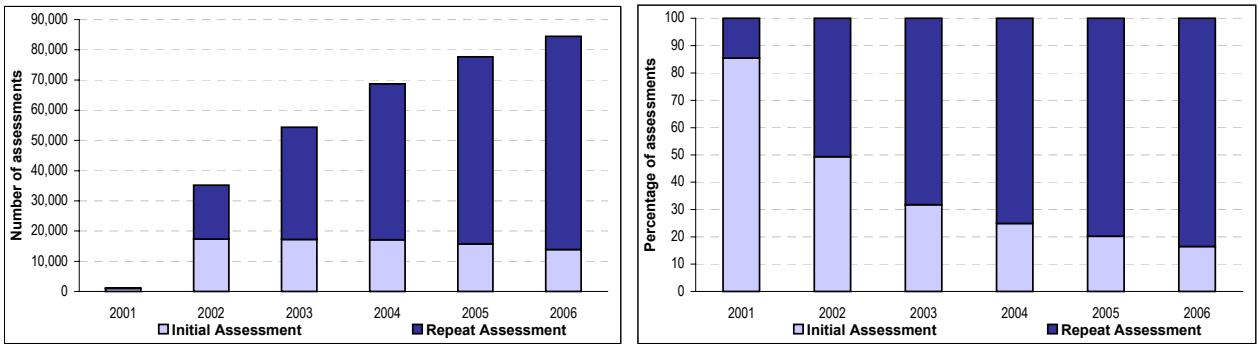
Non-VHC health service received	Number of VHC clients	% within VHC	% within DVA	VHC clients as a % of DVA
Pharmacy	64,179	97.2	77.6	23.8
Community nursing	15,956	24.2	7.2	63.6
Private hospital episodes	29,293	44.4	24.5	34.4
Other	13,895	21.0	7.3	54.5

During 2006, 64,777 VHC recipients were also assessed for VHC services, with the median number of assessments per client being two (Table 6). Although the number of assessments completed by VHC is rapidly increasing each year, the number of initial assessments is declining (see Figure 5), decreasing from 85% of all assessments in 2001 to just 16% of assessments in 2006.

Table 6 Number of assessments per client in 2006

Assessments	Number of clients assessed	Percentage of clients	Cumulative percentage of clients assessed
1	15,717	23.8	23.8
2	36,298	55.0	80.3
3	8,731	13.2	93.8
4	2,545	3.9	97.7
5–20	1,486	2.2	100.0
Not assessed during 2006	1,255	1.9	

Figure 5 Type of assessment (initial or repeat) each year, 2001–2006



Very few assessments are completed at the veteran's home, declining annually from 13% in 2001 to 0.6% in 2006 (Figure 6). Being an initial assessment, compared to repeat assessment, had no impact on whether the assessment was conducted at the client's home rather than over the phone see Figure 7).

Figure 6 Method of assessment (in-home or over-the-phone) each year, 2001–2006

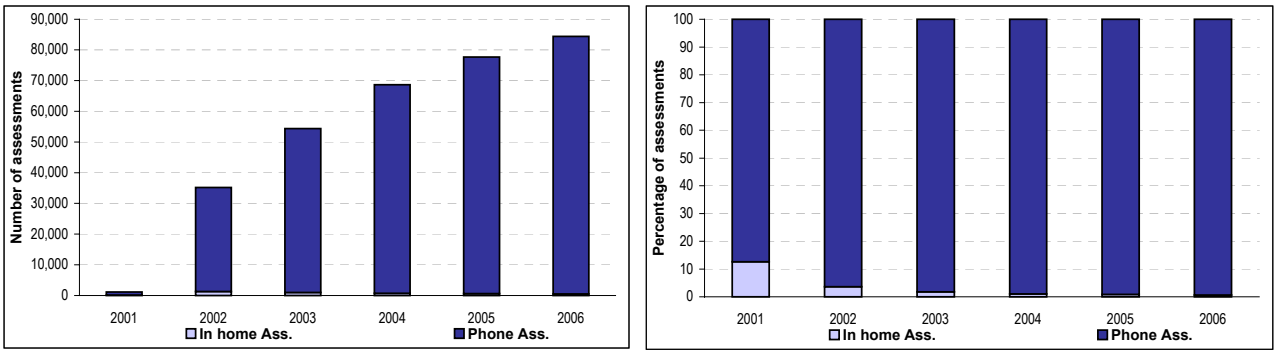
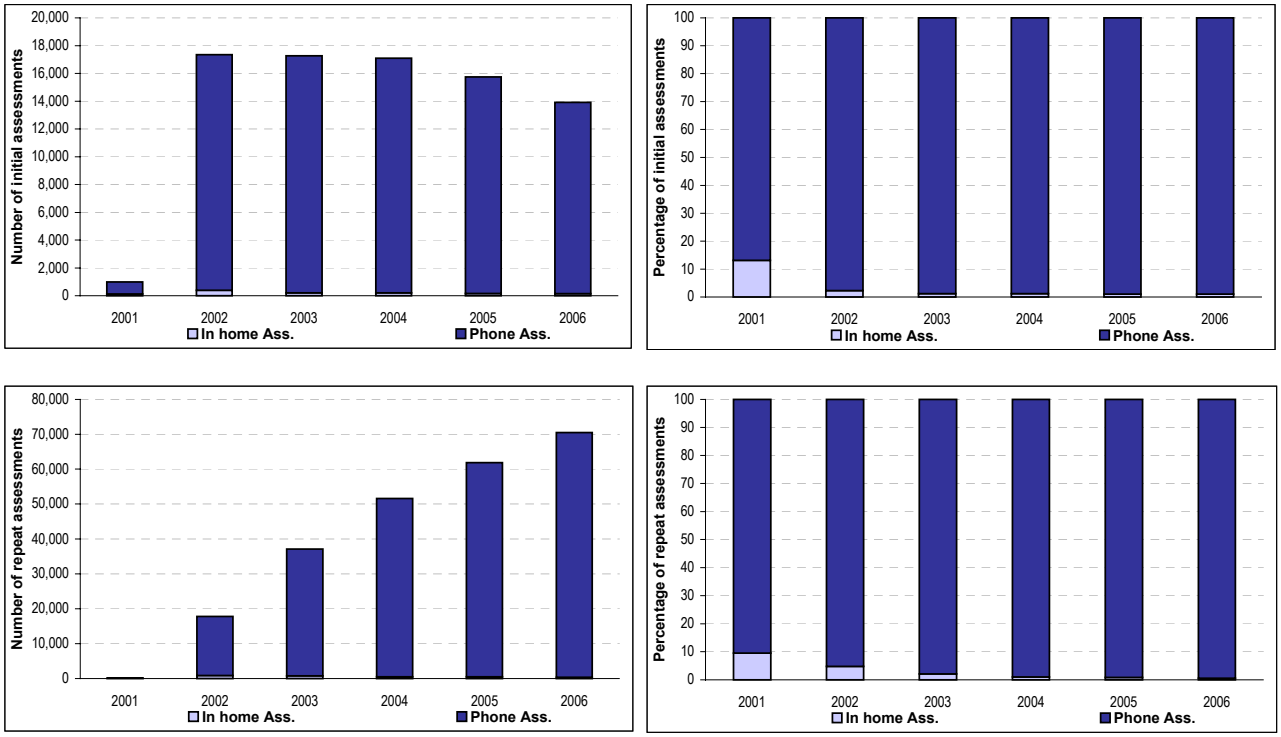
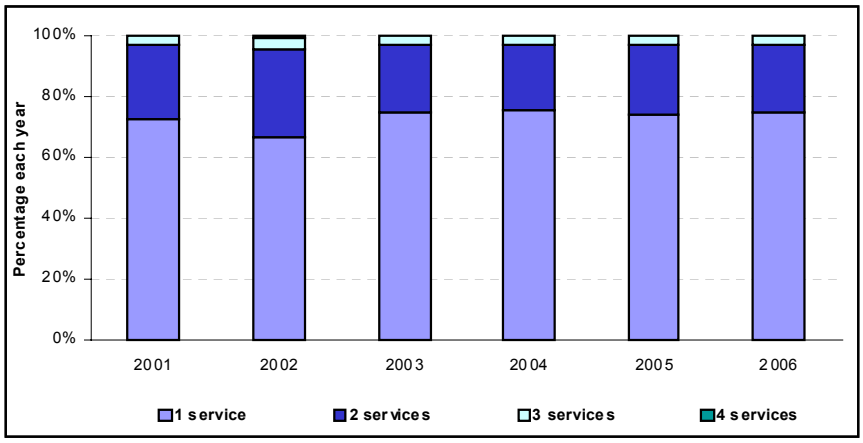


Figure 7 Method of assessment each year by type of assessment, 2001–2006



Three-quarters of all VHC clients were receiving only one service in 2006. A further 22% were receiving two services. Almost no-one was receiving all four services. This distribution has not changed much over the years (Figure 8).

Figure 8 Number of service types used, 2001-2006



Most VHC recipients (84%) received domestic assistance (Table 7). In 2006 the median number of hours approved was 39, although only 32.5 hours were claimed. Home and garden maintenance was the second most used service (17%) with a median of 3 hours approved and claimed, while personal care was the least used service (3%).

Table 7 VHC service usage in 2006

Service usage in 2006	Number of veterans	%VHC	Median approved hours	Median claimed hours
Domestic assistance	55,763	84.4	39.0	32.5
Personal care	2,026	3.1	37.5	21.5
Respite (in-home)	5,290	8.0	83.5	52.0

Service usage in 2006	Number of veterans	%VHC	Median approved hours	Median claimed hours
Respite (emergency)	54	0.1	33.5	27.5
Respite (residential)*	4,782	7.2	147.0	n.a.
Home and garden maintenance	11,298	17.1	3.0	3.0

* estimate number of claims based on number of clients with approved hours.

Section 3.2 of the VHC guidelines says that 'generally, around 1.5 hours per fortnight is sufficient service to meet most veterans' basic support needs'. This is known in the field as the 'benchmark'. For domestic assistance, this translates to 39 hours per year per recipient. The average time approved per recipient was 39 hours across Australia, varying from 36 hours to 42 hours across the mainland (Table 8). Tasmanians were approved for more hours of domestic assistance with an average of 53 hours per client.

A similar pattern was found for approved personal care hours, with the number of approved hours averaging 42. This compares with the guideline of 1.5 hours per week or 78 hours per year. Home and garden maintenance varied by state, from an average of seven hours approved for veterans in Western Australia compared with 2.2 hours in South Australia.

It should be borne in mind that grandfathered-transitional veterans have been excluded here, as have those who died during 2006. This means that the total approved hours and numbers of clients for 2006 may be less than those published elsewhere. However, the main purpose of presenting this table is to investigate the average hours per VHC client over a year. Because these records have been excluded, the average hours per client presented here can be regarded as representative of a "typical" VHC recipient.

Table 8 Approved hours by service type and State, 2006

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Domestic assistance									
Approved hours	738,043	417,280	436,697	218,293	163,379	126,402	45,523	3,039	2,148,861
Number of clients	19,311	10,893	12,162	5,187	4,542	2,394	1,078	80	55,654
Av hrs/client	38.2	38.3	35.9	42.1	36.0	52.8	42.2	38.0	38.6
Personal care									
Approved hours	24,631	39,803	2,855	6,245	10,881	6,895	87	98	91,495
Number of clients	613	896	71	181	281	128	2	3	2175
Av hrs/client	40.2	44.4	40.2	34.5	38.7	53.9	43.5	32.7	42.1
Home and garden maintenance									
Approved hours	9,541	9,423	4,235	23,396	2,179	5,764	289	31	54,870
Number of clients	2,760	2,881	1,573	3,319	1,009	1,219	75	5	12,844
Av hrs/client	3.5	3.3	2.7	7.0	2.2	4.7	3.9	6.2	4.3
Respite – in-home									
Approved hours	195,288	88,203	136,078	42,749	30,296	38,781	33,872	676	566,040
Number of clients	1,767	917	1,175	517	284	396	340	11	5,409
Av hrs/client	110.5	96.2	115.8	82.7	106.7	97.9	99.6	61.5	104.6
Respite – emergency									
Approved hours	1,560	365	212	709	-	121	188	-	3,156
Number of clients	30	11	5	13	-	3	2	-	64
Av hrs/client	52.0	33.2	42.5	54.5	-	40.3	94.0	-	49.3
Respite – residential									

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Approved hours	268,754	230,104	70,678	36,092	51,987	30,759	12,918	768	702,312
Number of clients	1,727	1,656	494	228	352	228	93	6	4786
Av hrs/client	155.6	139.0	143.1	158.3	147.7	134.9	138.9	128.0	146.7

While the hours approved for domestic assistance did not vary too much between major cities, regional areas and remoter areas, the average hours approved per client for both personal care and home and garden maintenance was highest in the remote areas and lowest in the major cities (Table 9).

Table 9 Approved hours by service type and rurality, 2006

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Domestic assistance					
Approved hours	1,304,801	630,118	201,362	11,002	665
Number of clients	34,755	15,684	4,886	282	18
Av hrs/client	37.5	40.2	41.2	39.0	36.9
Personal care					
Approved hours	55,462	24,357	10,620	976	-
Number of clients	1,371	547	236	18	-
Av hrs/client	40.5	44.5	45.0	54.2	-
Home and garden maintenance					
Approved hours	33,973	14,583	5,769	438	65
Number of clients	8,440	3,351	968	70	6
Av hrs/client	4.0	4.4	6.0	6.3	10.8
Respite – in-home					
Approved hours	321,833	160,246	79,207	3,708	454
Number of clients	3,096	1,556	707	38	4
Av hrs/client	104.0	103.0	112.0	97.6	113.5
Respite – emergency					
Approved hours	2,045	1,045	40	26	-
Number of clients	42	20	1	1	-
Av hrs/client	48.7	52.2	40.0	26.0	-
Respite – residential					
Approved hours	433,797	199,648	63,094	4,100	679
Number of clients	2,955	1,367	429	25	3
Av hrs/client	146.8	146.0	147.1	164.0	226.3

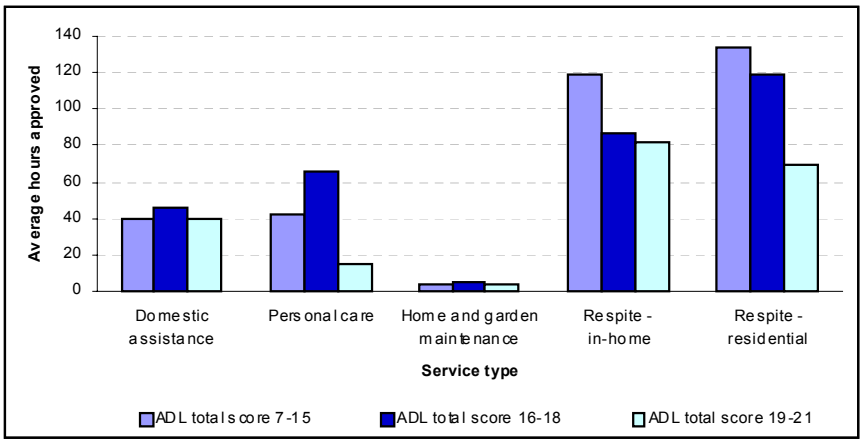
Survey data on veterans receiving services were matched with the service data provided by VHC. In particular, we were interested in discovering if there was any relationship between functional assessment scores from the survey and the number of hours approved for each service type, as recorded in the VHC data. Despite the fact that most VHC clients receive domestic assistance, and for many they only receive domestic assistance, no relationship was found between their functional ability as measured by the HACC functional screen score and number of hours approved (Figure 9). While many clients had very high functional scores of 19, 20 or 21 out of 21 (57%)[6], those veterans with lower functional scores were not approved for more hours of domestic

[6] A low score on this instrument is indicative of low functional ability.

assistance as might be expected if hours of service were based on the functional abilities of the veteran or war widow.

However, those with the lowest functional scores (total score range 7-15) were more likely to be approved for hours of respite, suggesting that the allocation of respite hours is more related to need. For personal care, more hours were approved for veterans with mid-range functional scores than for those with either low or high function. This result was expected, as those with poor function are likely to have needs that are too high for the VHC program, while those with high function are less likely to need assistance with personal care.

Figure 9 Approved hours by service type and functional score, those receiving services and responding to the postal survey



When considering all VHC recipients (including those that were 'grandfathered' or may have since died) there was a marked increase between 2001 and 2006 in the use of domestic assistance while the usage of all other services declined over the same time period (Table 10). The key difference between the genders is that males are 50% more likely to use respite services.

Table 10 VHC service usage by gender, 2001 and 2006

Service type used	%Males using service			%Females using service		
	2001	2006	Change	2001	2006	Change
Domestic assistance	72.3	88.6	+16.3	76.9	89.7	+12.8
Personal care	4.4	3.3	-1.1	5.3	4.0	-1.3
Respite	24.5	19.9	-4.6	15.3	12.9	-2.4
Home and garden maintenance	31.3	17.9	-13.4	31.1	18.7	-12.4

Comparison of the VHC and HACC populations

We compared the functional ability of those veterans (as measured by the HACC 9 item functional screen) from the VHC population who were surveyed with that of what should be a similar population. A low score on this measure indicates low functional ability. The VHC results are from our survey of veterans and their carers. The comparison group is applicants for basic services from the NSW Home Care Service. They were assessed over the telephone by the Home Care regional assessment centre. As Figure 10 and Figure 11 illustrate, VHC clients reported that they are much more functionally able than their counterparts applying for Home Care.

Figure 10 Functional screen total score – comparison of clients receiving VHC services and clients receiving NSW Home Care Services

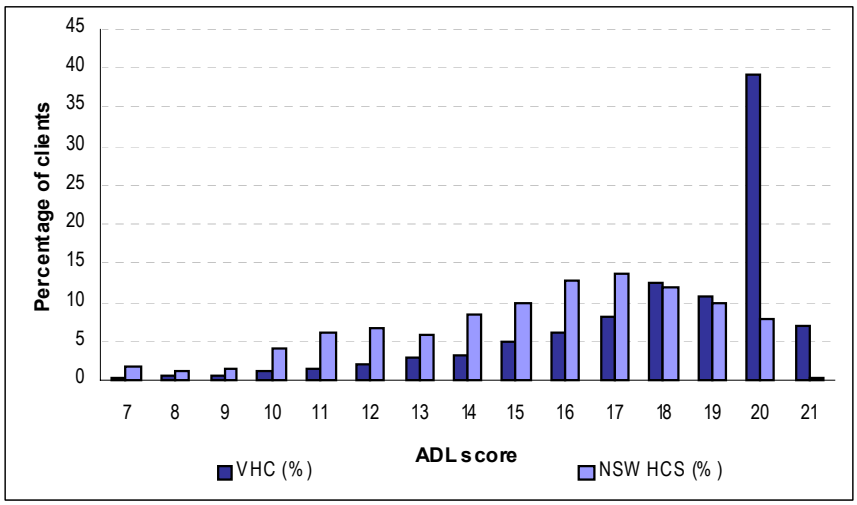
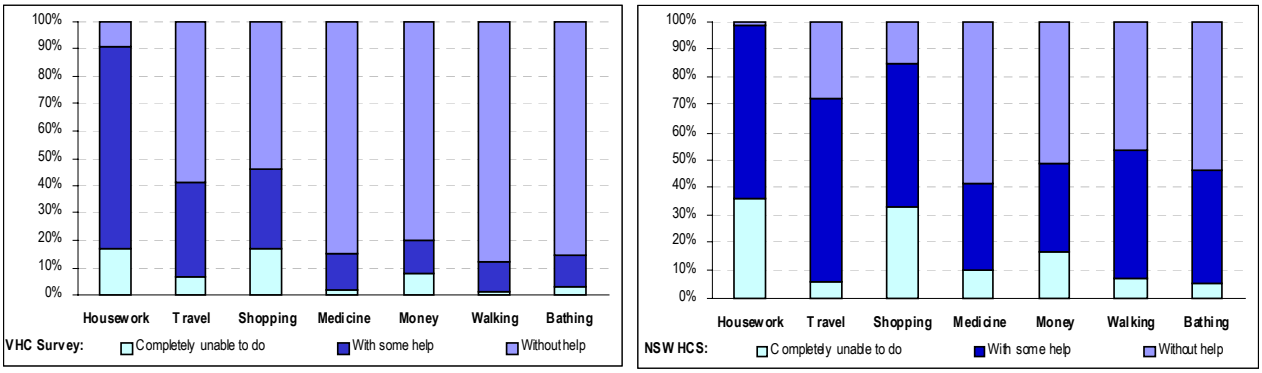


Figure 11 Functional screen individual item scores – comparison of clients receiving VHC services and clients receiving NSW Home Care Services



However, as reported in Appendix 4, veterans receiving VHC services rate their general health as much worse than people of a comparable age living in the community. This is to be expected, as only about 40% of people in this age group who are living in the community need community care support services such as VHC.

3.3 The profile of veterans in receipt of HACC services in 2005/06

The Department of Health and Ageing provided data on people in receipt of a DVA pension who received HACC services in 2005/06 (see Table 11). This file contained data on 56,243 veterans, not all of whom are VHC eligible and some of whom are receiving VHC services concurrently.

In total, 11,813 received domestic assistance, compared to the 55,763 in recipient of VHC domestic assistance. More veterans used HACC personal care services than VHC services (3,872 compared to 2,026). But, relative to VHC, fewer used HACC respite services (652 compared to 10,126 for VHC).

Table 11 HACC services used by DVA pensioners

Service type	Number of HACC recipients with DVA pensions	%
Service types similar to VHC		
Assessment	18,382	14.9%
Domestic Assistance	11,813	9.6%
Personal Care	3,872	3.1%
Respite Care	652	0.5%
Other services		
Case Management	11,723	9.5%
Transport	11,623	9.4%
Meals (Home)	11,103	9.0%
Home Maintenance	10,880	8.8%
Nursing Care (Home)	10,082	8.2%
Social Support	6,809	5.5%
Centre-Based Day Care	6,196	5.0%
Meals (Centre)	4,113	3.3%
Personal Care	3,872	3.1%
Carer Counselling Support	3,297	2.7%
Allied Health Care (Home)	3,055	2.5%
Allied Health Care (Centre)	2,811	2.3%
Client Care Coordination	2,393	1.9%
Nursing Care (Centre)	1,329	1.1%
Home Modification	1,070	0.9%
Other Goods and Equipment	880	0.7%
Self Care Aids	496	0.4%
Support and Mobility Aids	429	0.4%
Other Food Services	246	0.2%
Medical Care Aids	131	0.1%
Formal Linen Service	129	0.1%
Care Counselling Support	98	0.1%
Communication Aids	41	0.0%
Aids for Reading	15	0.0%
Car Modifications	15	0.0%

The quantity of HACC services used by DVA pensioners is presented in Table 12. The units in which the services are recorded differ between the service types. It can be seen that the services most used are meals, centre-based day care, transport, domestic assistance and home modifications. As with other tables in this section, not all veterans receiving HACC services are eligible for VHC and some VHC clients also use HACC services.

Table 12 Units of HACC services used by DVA pensioners

Unit	Quantity as values	Number of units	Average units per DVA client
Dollars	Home Modification	297,779	278
Hours	Centre-Based Day Care	876,847	142
Hours	Respite Care	22,592	35
Hours	Social Support	210,963	31
Hours	Personal Care	111,585	29
Hours	Domestic Assistance	318,496	27
Hours	Other Food Services	4,511	18
Hours	Nursing Care (Home)	174,399	17
Hours	Home Maintenance	83,255	8
Hours	Client Care Coordination	17,047	7
Hours	Nursing Care (Centre)	7,907	6
Hours	Case Management	48,616	4
Hours	Allied Health Care (Home)	13,583	4
Hours	Allied Health Care (Centre)	12,059	4
Hours	Carer Counselling Support	10,558	3
Hours	Assessment	45,803	2
Hours	Care Counselling Support	193	2
Quantity	Meals (Home)	1,210,437	109
Quantity	Transport	389,500	34
Quantity	Meals (Centre)	104,435	25
Quantity	Formal Linen Service	2,867	22
Quantity	Communication Aids	597	15
Quantity	Other Goods and Equipment	10,254	12
Quantity	Medical Care Aids	1,345	10
Quantity	Aids for Reading	110	7
Quantity	Self Care Aids	1,834	4
Quantity	Support and Mobility Aids	1,208	3
Quantity	Car Modifications	48	3
Total		**3,978,828**	**36**

From Table 13 it can be seen that a little less than half (44%) of HACC recipients with DVA pensions use only one HACC service. Approximately 16% use more than three types of HACC services.

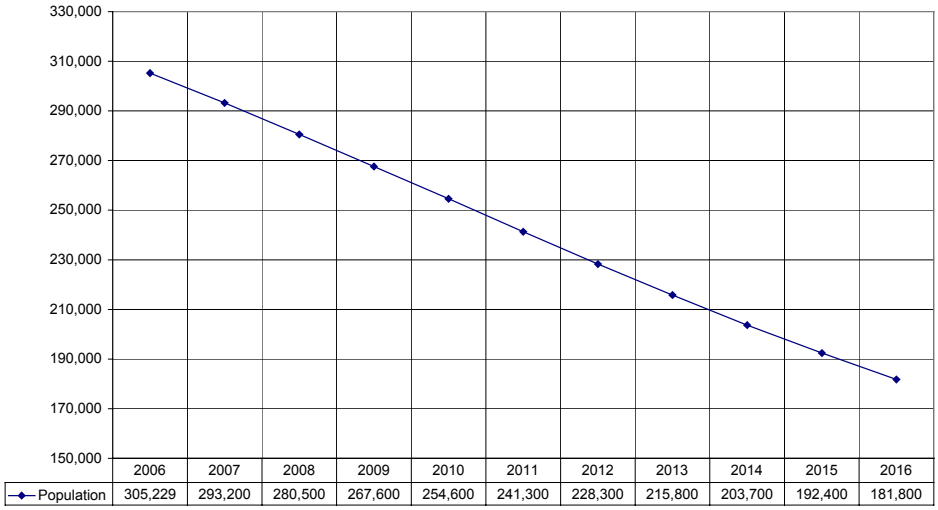
Table 13 Number of HACC service types used by DVA pensioners

Number of HACC service types used	Number of HACC recipients with DVA pensions	%
1	24,929	44.2%
2	14,198	25.2%
3	8,235	14.6%
4	4,227	7.5%
5	2,263	4.0%
More than 5	2,572	4.6%
Total	**56,424**	**100.0%**

3.4 The projected future demand for VHC services 2007-2016

As shown in Figure 12, the DVA treatment population is expected to decrease significantly over the next decade and beyond. The 10 year projection is that the treatment population will be approximately 181,600, down from the current population of 305,229 in 2006 (a 40% decline).

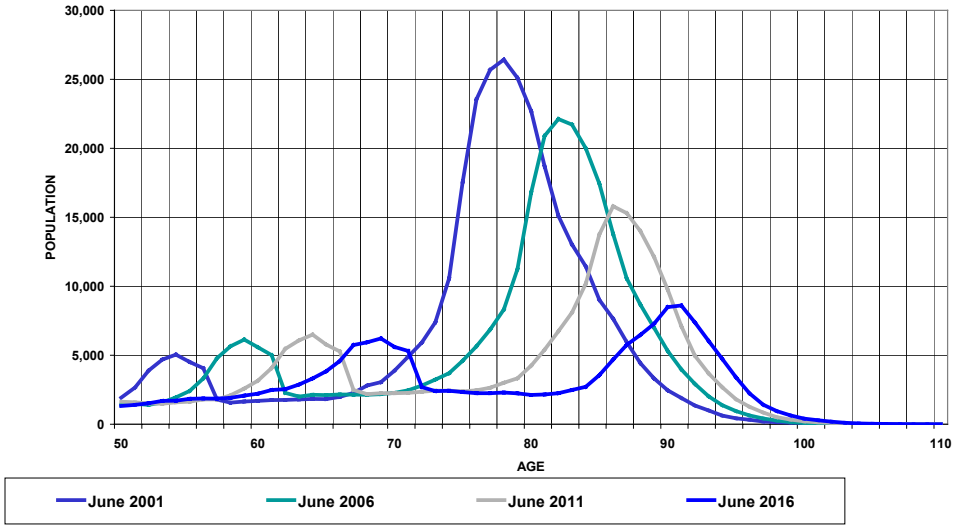
Figure 12 Projected DVA treatment population



Source: DVA 2007

At the same time, the average age of the remaining veterans and war widows will increase considerably (Figure 13).

Figure 13 Projected age profile of the DVA treatment population



Source: DVA 2007

In summary, while the treatment population will decline, the needs of that population will increase. A key question for the review is the impact on this changing demographic profile on the demand for VHC. This section projects the quantities of VHC services that will required for the next decade. The projections are based on data from files provided by DVA. Veterans who were "grandfathered" and veterans who have died have not been excluded from this analysis. The methods and assumptions are described in detail in Appendix 3. Briefly, total future service use is modelled by disaggregating the effects of:

- demographic change of the target population
- the proportion of the target population who are assessed for VHC services
- the proportion of the assessed population who utilise each service type
- the average annual occasions of service amongst those who utilise each service type
- the average number of hours per occasion of service for each service type

The strength of this approach is that changes in any of these domains can be explicitly modelled by VHC. The projected number of hours of service for each service type are shown in turn, below.[7] Figure 14 shows projections for domestic assistance, which is by far the largest service type in terms of total volume. The total quantity of domestic assistance is projected to peak in 2010, at 2.39 million hours, before decreasing. The total quantity of domestic assistance will not fall below 2006 levels until 2015.

[7] These projections are based on the number of hours claimed, not the number of hours approved. Projections have not been compiled for residential respite, for which service utilisation data are unavailable. A data item with the number of hours of residential respite *approved* is available, although we have been advised that it is not reliable. This service type has been excluded from the projections. Residential respite appears to be a large service type judging by the number of hours of approved services. However, it is unknown whether approved hours translate into actual service use.

Figure 14 Projected total number of hours of VHC domestic assistance

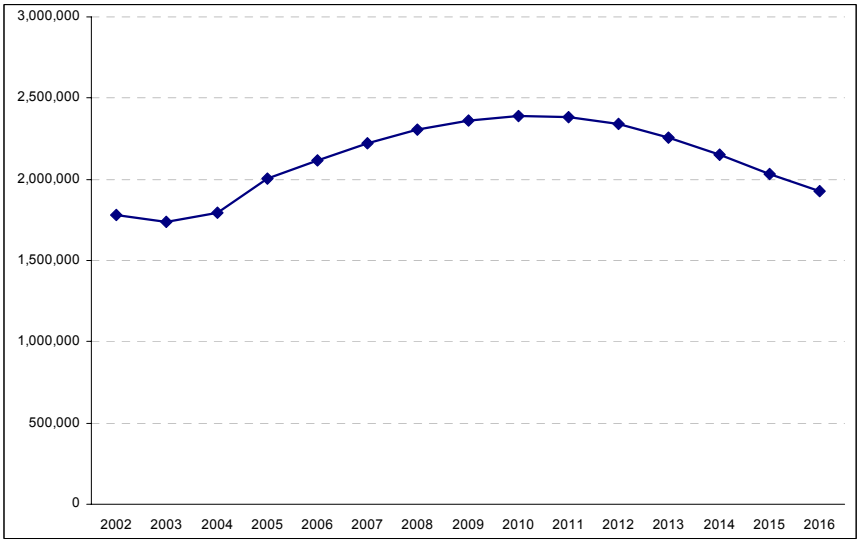


Figure 15 shows projections for in home respite. On the basis of these projections, the total quantity of home respite is also expected to peak in 2010, at 530,000 hours, before decreasing. As detailed in the appendix, the proportion of people assessed for VHC who receive in home respite has fallen considerably between 2004 and 2006. The critical assumption underlying this projection is that this recent decrease in the proportion of people assessed for VHC that received in home respite will not continue.

Figure 15 Projected total number of hours of in home respite

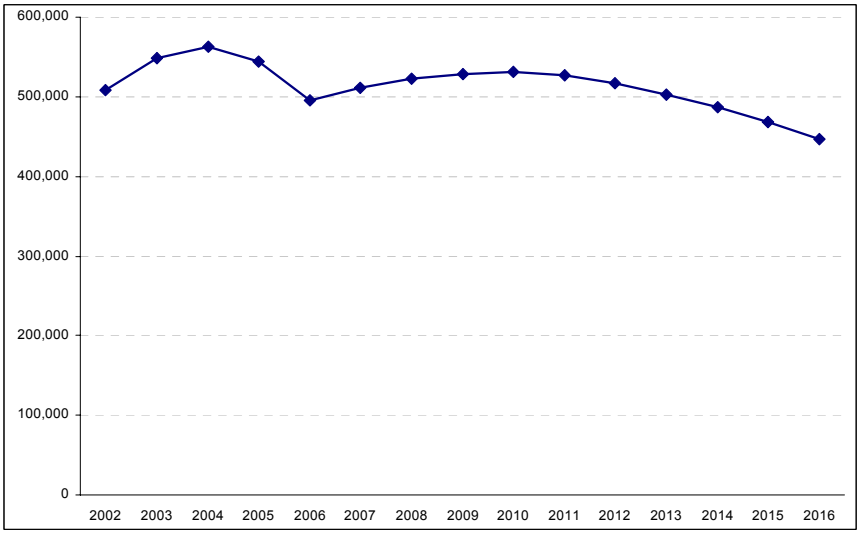


Figure 16 shows projections for personal care. On the basis of these projections, the total quantity of personal care is expected to peak in 2011, at 100,000 hours, before decreasing. The number of hours provided in 2016 will still be higher than in 2006.

Figure 16 Projected total number of hours of personal care

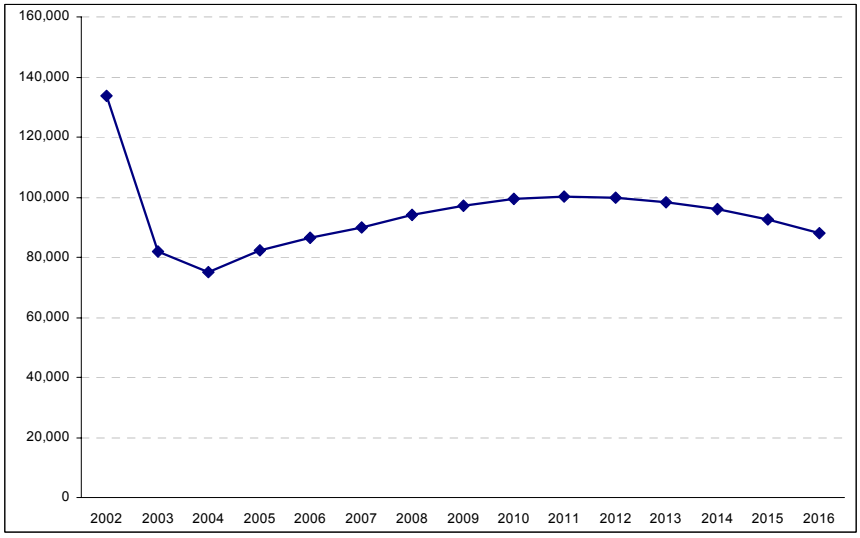
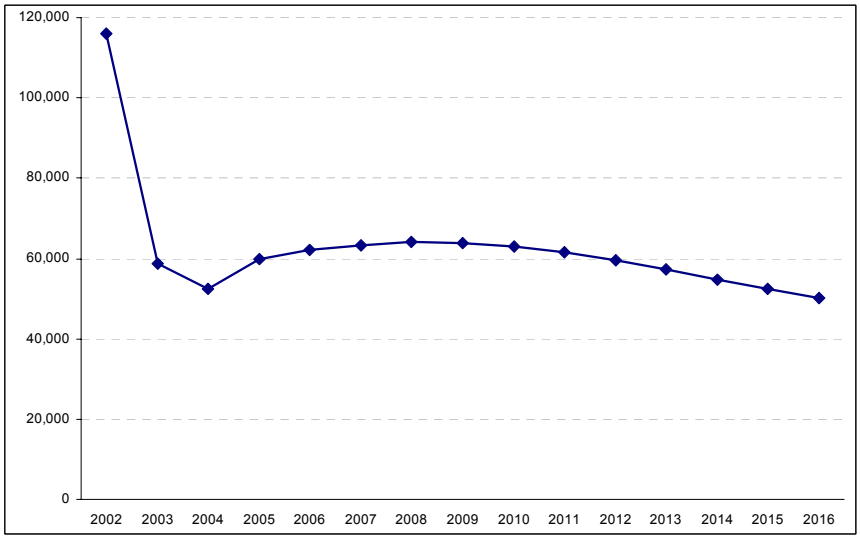


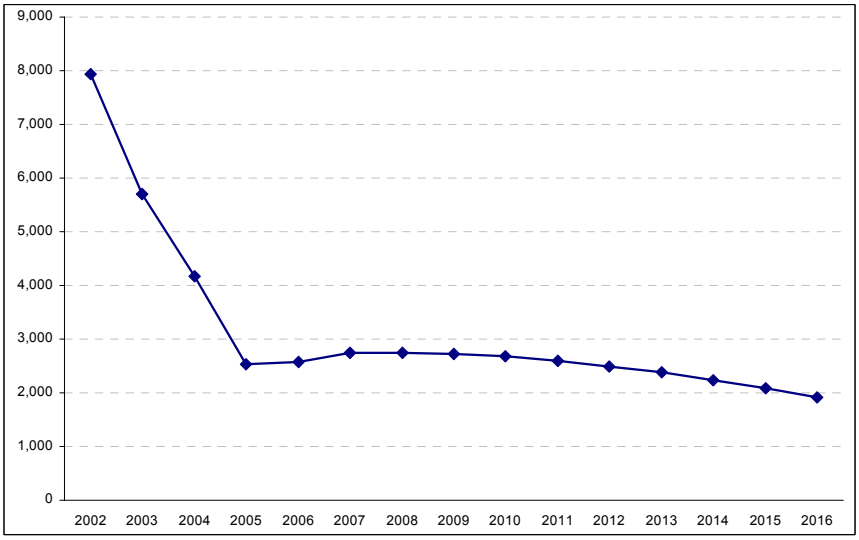
Figure 17 shows projections for home & garden maintenance. The total quantity of this service type is projected to peak in 2008, slightly earlier than the other services, at 64,000 hours. The number of hours provided will fall below the 2006 level by 2011.

Figure 17 Projected total number of hours of home & garden maintenance



Emergency respite is a very small component of VHC service volume. Figure 18 shows projections for the total number of hours provided. The total quantity of this service type is projected to peak in 2008 at 2,700 hours.

Figure 18 Projected total number of hours of emergency respite



3.5 The views of VHC service providers

A total of 167 providers responded to the survey with 145 completing the whole survey. Providers were asked 26 questions which are reported on fully in Appendix 5. Follow up telephone calls to non responders were not conducted as outlined in the methodology as the 145 completed surveys submitted represented approximately 80% of all contracted service providers. The survey dataset was therefore considered representative of service provider organisations.

The survey was not issued to VHC assessment agencies. Instead, the views of assessment agencies were sought through face to face consultations (see Section 3.7).

Services provided

The survey aimed to investigate what VHC services were provided and whether VHC recipients were different in any of their characteristics compared to other clients of the providers. It also asked whether clients were receiving care services *additional* to those received under VHC (i.e. to top up the range of existing service types) or *alternative* to VHC (i.e. instead of VHC services). The survey also asked service providers how the program could change to better meet veterans' needs.

The majority of providers provided services across all four VHC service streams. Almost all providers (98%) indicated that they provided domestic assistance to their VHC clients, followed by respite (89%) and personal care (85%). The number of providers providing home and garden maintenance services to VHC recipients was somewhat less at just over 72%.

While there were many providers who indicated that their service provided respite, personal care and home and garden maintenance, these services were relatively underutilised compared to domestic assistance. Approximately 51% of respondents who provided domestic assistance provided this service to more than 100 clients while the majority of respondents who provided personal care (67%), respite (57%) and home and garden maintenance (56%) provided these services to less than 10 or even none of their clients.

Clients receiving VHC

Living situation
VHC clients of providers who responded to the survey usually lived with a spouse or lived alone. Living situations of clients of the service providers' other programs were similar, although they were more likely to live with a parent, son, daughter, other relative or friend (see Table 44).

Health and ability of VHC recipients
The VHC program is servicing the marginally higher functioning end of community care clients. Over 80% of providers said that the health of their VHC clients was either the same as or better than the health of their general community care client group. Over 78% said their clients had the same or better ability to undertake the tasks that the providers perform for them (see Table 45).

Access to additional community and health services
VHC recipients get a lot of assistance beyond the VHC program through services from other programs (e.g. HACC) in addition to those provided by VHC or alternative to VHC. Providers indicated that VHC recipients often get additional domestic assistance and home and garden maintenance but are more likely to get alternative personal care services (see Table 47). Alternative personal care is likely to be received from nursing-based services. Other additional services identified by providers as those most commonly used by VHC recipients were food services, such as meals on wheels, and social support and transport services (see Table 48).

Modifications and equipment
Providers did not report high use of aids and equipment or home modifications. Over half of providers (54%) reported that less than a third of their VHC clients had home modifications. A majority of providers (68%) said that less than a third of their VHC clients used aids and equipment to make it easier to live at home (see Figure 82). There were more providers who reported that more than a third of their clients had home modifications (26%) compared to providers who reported more than a third of their VHC clients used aids and equipment (10%).

Overall, providers indicated that their VHC clients:

- live in mostly independent situations
- had similar or slightly better health and ability to other program clients
- accessed both additional and alternative services to VHC services and
- are low to moderate users of aids and equipment and home modifications

The need for change to meet veteran need

Providers were asked to think about the next 5 years and to state whether they thought the VHC program, as it is currently structured, would adequately meet the changing needs of the veteran community. Approximately 92% of providers who answered this question indicated that the program will need some level of change in the next 5 years (see Table 49).

Assessment
Providers were strongly in favour of changes to assessment. Approximately 89% of respondents felt changes were needed in the assessment process with the majority (54%) indicating that major changes were needed (see Table 50).

The change suggested most often was for the implementation of more in-home or face-to-face assessments or that the current phone based assessment was inadequate. In addition, providers often suggested that increased information flow, in particular the sharing of assessment details, with the service provider, and expansion of the current assessment tool would also improve the outcomes of assessment (see Table 51).

Range of services
Providers were in favour of changes to the range of services that VHC provides but were mixed in how important they thought these changes were. Approximately 47% of providers who answered this question felt only minor changes were needed and a further 39% felt major changes were needed (see Table 52).

The most commonly mentioned changes were the addition of accompanied or assisted outings such as shopping and bill paying, flexibility in care and the addition of care packages, social support, increased service times and additional services such a gardening, lawn mowing and meal preparation. Better transition to higher level care as well as recognition of mental health and complex needs and more flexibility in respite were also often mentioned (see Table 53).

Quantity of services
Providers were mostly in favour of minor changes to the quantity of services provided by VHC. Approximately 50% of providers indicated that only minor changes were needed and 37% indicated that major changes were needed (see Table 54).

The most common change suggested was an increase in the allotted hours for all service types, although 18 agencies also indicated that there was a need for allotted service hours to be more dependent on a client's age and level of need (see Table 55).

Care coordination
Change in care coordination in the VHC program was strongly supported by providers. Exactly 81% of providers thought there should be some level of change and the majority (43%) felt major changes were needed.

Suggested changes mainly focussed on care coordination issues, assessment issues and the role of case management (see Table 56). Care coordination issues mainly focussed on defining who has the care coordination role and the need to fund that role. Care coordination was time consuming and necessary and often fell to the service provider who was not funded for this time. Service providers also felt that the client need for care coordination was not currently being met (see Table 57).

An issue brought up again here, that is related to care coordination, was the issue of better information sharing of assessment details with the service provider.

Other Changes
The changes mentioned above were not the only changes that providers felt were needed by the VHC program. Approximately 54% indicated that other changes are needed (see Table 58).

Improvements in the administrative and IT aspects of the program was the issue suggested the most frequently, with flexibility in service provision and flexibility of time also mentioned a number of times. Also mentioned was the need for in-home or face-to-face assessment and client reviews.

In all aspects of the VHC program that providers were asked about, the majority of providers indicated that there needs to be some level of change. Changes to the assessment process and to care coordination were those aspects where the majority of providers felt major changes were needed, and extending the range and quantity of services were those aspects where the majority thought that minor changes were needed.

Changes to improve service delivery

Providers were asked to think about the rest of their current VHC contract period (i.e., the next 2 years only) and to indicate what the VHC program can do in order to improve how it delivers services to the veteran community (see Table 59). A broad range of issues about current services and suggestions for the future were discussed. The most common suggestions were:

- Sharing of client assessment information with the service provider (19 provider agencies). Access to assessment details would greatly improve their ability to provide appropriate services to a client and reduce time spent on care coordination. Putting this statement in context, the role of the VHC assessment agency is to approve and coordinate services. This is not the role of service provider agencies. However, as discussed above, many service

providers believe that care coordination is currently inadequate and often falls to service providers, despite the fact that this is not their role.

- Allow more flexibility in how service hours are used (18 provider agencies)
- Increase the hours of service available to clients (18 provider agencies)
- Add more substitutable service types to the VHC program such as social support, accompanied shopping and meal preparation (14 provider agencies)
- More information on services and what is available locally needs to be provided to the client (14 provider agencies)
- Fund the full cost of service provision, including travel time, care coordination time and staff development (11 provider agencies)
- Social support for the veteran (10 provider agencies).

Other comments

Final comments were invited to allow providers to raise any issues that may have been missed within the survey. A total of 70 respondents entered a comment. There were 103 issues raised and comments made on a broad range of subjects (summarised in Table 60).

There were many positive comments, including those that said that VHC was a valuable service, that there were good relationships between service providers and assessors and VHC staff and that there was client satisfaction and loyalty to DVA. Other positive comments were mainly in relation to the positives of working with veterans and the VHC program and the different types of support given to service providers.

> *"Veterans' program is a very valuable service to veterans. Overall interactions with VHC and Case Managers is very good. Proud to be part of the service."*

Given the focus on improving the program, the majority of comments related to how the program could be improved to better meet the needs of veterans into the future. This is consistent with the finding that more than 90% felt that changes are required to better meet changing needs.

A small number of agencies argued that incentives to stay with VHC (loyalty to DVA and cost issues) will be an increasingly problem as needs increase into the future.

> *"The veterans are a very proud group of people. They like the VHC programs & often don't want to move onto a more substantial program eg CACPs or EACH even within the same organisation as they feel an affiliation to the VHC, despite their best interests. It is theirs, especially for them & they deserve it. It stands them out from the mainstream service users making them feel special & not just one of the mob."*

Specific improvements to the VHC program included a number of recurring themes such as addressing the full cost of service provision, addressing administrative and IT difficulties and information sharing with the service provider. At a program level, six agencies argued for the merging of the VHC program with community care programs such as HACC and packaged care and a further four suggested one point of contact for both VHC and HACC.

> *"It may be worth considering the possibility that Veterans would have better access to support services if they remained with the HACC network and the funds allocated to Veterans were allocated to the HACC program."*

Overall, providers commented on both positive and negative aspects of the VHC program and while they did acknowledge that there were positive aspects to the VHC program, they also emphasised that the program requires change to both meet the needs of the veteran community and service providers in the future.

> *"The VHC program must remain responsive to the service needs of the changing veteran community. Service Providers need to remain viable. The VHC program does not currently cover*

costs associated with the provision of services and care coordination (but should do so in the future)."

"Yes, in offering points of view I am not attesting that the current program has been unsuccessful because it is good for Veterans and offers them value for their worthy contributions but I was asked for a further point in directional planning and like all programs there is always something that could be more streamlined - whilst recognising it is a low level care program - the Veterans in the 90+ grouping are more in need of higher levels of support, coordination and access and I believe from limited experience to date with Vietnam Veterans they will need more mental health support than their older counterparts."

3.6 The views of veterans and war widows

Veterans in receipt of VHC services expressed gratitude for the help provided, with the vast majority (87%) satisfied with services received through the program.

However, based on their increasing age, deteriorating health and that of their partners/carers, and inability to predict their future circumstances, many veterans reported increasing future need, in particular for domestic assistance (50%), home and garden services (50%), personal care (30%) and transport (35%).

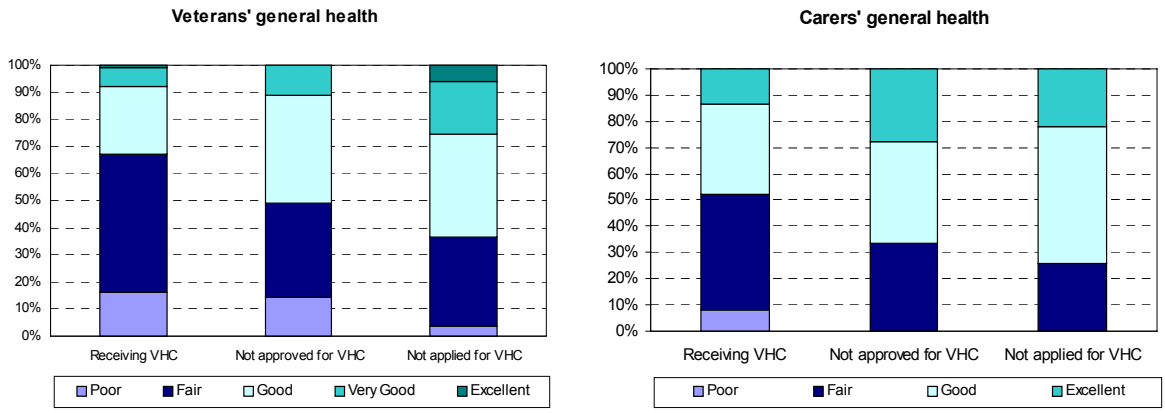
Health status

Veterans were asked to rate their current health. Those receiving VHC services reported the worst health status of the three survey cohorts. Overall, the general health of veterans aged 75 or more in this sample is much worse than people of this age living in the community, with the rates of both males and females reporting their health as being only 'fair' or 'poor' being approximately double the rates reported by a comparable age group in NSW in 2000.

About half the veteran population has someone whom they regard as a carer, but nearly all are family or friends. Many more male veterans than war widows live with another person, and almost all of these veterans (91%) live with spouses/partners. Carers of veterans receiving VHC services report substantially worse health than carers of other veterans and very few carers have respite from their normal caring role.

Reported health status of veterans and their carers are presented in Figure 19. Within each of the study cohorts, the reported health status for veterans was worse than that for the carers. However, the large proportion of carers with a health status of only 'fair' or 'poor', particularly amongst the VHC recipients, is of some concern.

Figure 19 Health status of veterans and their carers



Functional status

In the survey, veterans were asked to rate themselves on their ability to perform a number of tasks. Table 14 shows that veterans receiving VHC services are more dependent on others to help them with normal daily living activities. Domestic assistance, travelling to places beyond walking distance and shopping are the functions for which veterans have the highest need for assistance, with VHC recipients reporting the highest level of need amongst the survey cohorts.

Table 14 Functional profile: all veterans

Ability	Receiving VHC		Not approved for VHC		Not applied for VHC	
	Needs help	Independent	Needs help	Independent	Needs help	Independent
Housework	91%	9%	58%	42%	45%	55%
Travelling beyond walking distance	41%	59%	34%	66%	22%	78%
Shopping on one's own	46%	54%	44%	56%	24%	76%
Taking medicine	15%	85%	13%	87%	9%	91%
Handling money	20%	80%	10%	90%	11%	89%
Walking without help except for a cane	12%	88%	17%	83%	6%	94%
Bathing	15%	85%	6%	94%	2%	98%

On the other hand, the functional screen scores of veterans are better than those of NSW Home Care recipients (see Figure 10 and Figure 11). This is a little different to the perceptions of VHC service providers. As reported in the survey provider survey, only 15% of VHC service providers perceive VHC clients to have better abilities than their other clients, with 77% assessing them to be no different (see Table 45, page 204).

About 55% of veterans have made modifications to their homes and about 33% have bought aids and/or equipment to assist them to live at home. Some of these veterans said that they paid for these themselves, others reported that it has been funded through programs such as DVA RAP and others were not sure or did not specify.

Services used by veterans

Table 15 profiles the services used by veterans to help them live in the community. The two most commonly used are domestic assistance and home and garden services. A significant number of veterans not receiving VHC obtain domestic assistance and home and garden services from elsewhere. 44% of those not approved for VHC receive home and garden services from elsewhere compared to 22% of those who had not applied for VHC. Slightly less (38%) of those not approved for VHC were receiving a domestic assistance service compared to 22% who had not applied.

Veterans who have not applied for VHC receive fewer services than other veterans, reflecting their better health status and greater independence.

Table 15 Proportion of veterans receiving each service

	Domestic assistance	Personal care	Home and garden services	Nursing services	Delivered meals	Other services
Receiving VHC	90%	11%	48%	13%	16%	22%
Not approved for VHC	38%	4%	44%	9%	15%	12%
Not applied for VHC	25%	4%	22%	4%	5%	10%

	Domestic assistance	Personal care	Home and garden services	Nursing services	Delivered meals	Other services
Total	82%	10%	45%	12%	15%	20%

An important finding from the survey is that 16% of VHC recipients receive domestic assistance from providers other than VHC. Just over half of these received domestic assistance from non-profit organisations, with 27% receiving services from private providers and a further 22% from other government sources such as HACC. Likewise, about 60% received home and garden services from providers other than through VHC. About three quarters of these services were from private providers, with 15% from non-profit organisations and a little less than 10% from other government sources.

In their comments, many veterans noted the need for more assistance with transport at present (for shopping, medical appointments, banking or for social activity), with 39% indicating that their present transport needs are only partly met. However, they were also particularly concerned that their need for assistance with transport would increase in the future, particularly if a driver's licence was not able to be renewed or, for some women who had never had a driver's licence, if their husband died.

A sizeable majority of veterans indicated that they were willing to pay more both for a greater range of services, as well as for more of a particular type of service.

CASE STUDY

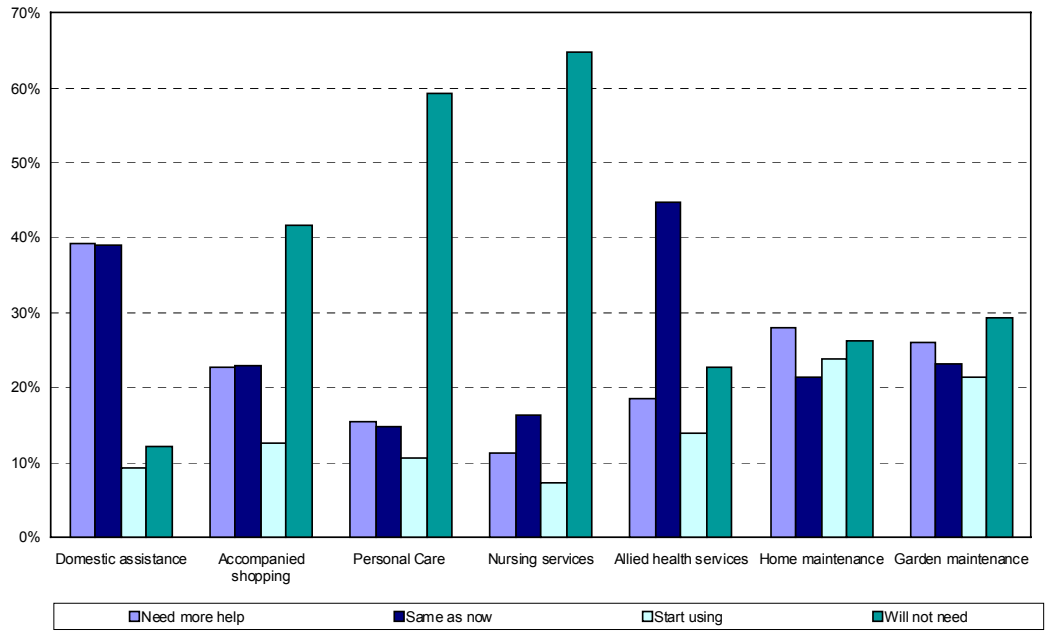
My parents can no longer drive and are isolated at home every day. They receive 1½ hours of domestic help every two weeks. I asked VHC if their 1½ hours could be used instead to take them for a drive to at least get them out of the house and maybe do a bit of shopping. I work through the week and can clean their house on the weekend. But I can't take them out through the week. VHC refused, saying it's not within the rules. But it wouldn't cost them any extra. Why can't they be more flexible?

Services for the future

Like others we consulted, many veterans had suggestions for how the program could be improved. Underpinning many is the need for increased flexibility coupled with the potential to substitute one service with another. A typical example is presented in the box.

Veterans emphasised increasing future needs for a wide range of services as Figure 20 shows. Many veterans commented on their likely future service needs, while not indicating the extent of that need.

Figure 20 Veterans' assessment of their needs in the next 1-2 years



In summary, the VHC program appears to be targeting the appropriate population, with veterans who have not applied for VHC reporting better health, more independence, better functioning, and the need for fewer services than either veterans in receipt of VHC or those who have not been approved for VHC. Veterans reported a high level of confidence that DVA will look after them. At the same time, they made many comments (some very critical) and many suggestions about how the program could be improved to better meet their needs. The survey results are presented and discussed in more detail in Appendix 4.

3.7 Findings from a national consultation with key stakeholders

A total of 140 persons representing 100 organisations, plus DVA staff, were consulted as part of the national consultation with key stakeholders. The organisations and groups targeted through this process were representative of those for which any program changes might have an impact. They were also those with knowledge of the program and a stake in the outcome of the review. The groups consulted are identified in Section 2.6.

Two observations are important at the outset about the circumstances that may have influenced the information we collected from the consultations. The first of these is that the review process started about six months after the selection and awarding of a new round of contracts for assessment agencies and service providers. The process and timing of the awarding of new contracts was raised at the meetings of both the forum for assessment agencies and the Reference Group for the Review in terms which indicated the process had encountered problems. The second issue was that in some regions there were significant changes in the allocation of contracts to assessment agencies and/or service providers, with some difficulties and problems of continuity created for veterans and war widows. We have taken account of these potentially disruptive factors in our analysis of the various stakeholder views.

Stakeholder response to the review

With few exceptions stakeholders responded positively to the review and understood its strategic significance. As a whole, stakeholders had a consistent view about the immediate priority needs for current VHC recipients and participated actively in considering possible scenarios that the program might consider to meet the changing needs of the veteran population and in particular the VHC target group. All respondents - assessment agencies, service providers and the broader

community care sector - identified social support, including accompanied shopping and transport, and routine maintenance services, as important inclusions in the program.

It was apparent to the reviewers that the issues raised through this Review, its timing and the consultation format were matters that had been previously aired through a number of other forums available to participants. This was confirmed by participants who expressed a level of frustration at the slow progress and perceived limited responsiveness of the national VHC program to adapt and change to meet the requirements of a program that is part of a wider and complex community care sector.

Participants welcomed this formal review process as an indicator that practical program changes might occur in the foreseeable future. In particular, external agencies considered the Review to be very timely given that all jurisdictions were undergoing a process of change in response to the national policy initiatives of *The Way Forward*.

All stakeholders participated actively and constructively, with an appreciation that their voices were being heard.

Stakeholder perceptions of veteran satisfaction with VHC

The majority of those consulted commented on the strong links veterans had to DVA, in terms that were often described as 'loyalty' to DVA. A recurring observation, particularly among those groups with direct contact with VHC clients, was a high regard for the veteran group as a whole. They were variously described as an independent, 'tough' (stoic) and feisty group who were highly appreciative of services. Both assessment agencies and service provider agencies reported that veterans regard VHC as an affordable or relatively low cost service support option.

However, these same agencies had difficulties managing commonly held veteran perceptions that VHC, like other DVA services, should be an 'entitlement'. This was a particular problem for assessment agencies. It was reported that this was (incorrectly) exacerbated for some veterans by DVA literature and newsletters in which the word 'entitlement' was often used, as it is in fact, under the title of the *Veterans' Entitlement Act 1986*.

This first observation, about the relatively low cost of VHC, can create difficulties when transitioning veterans into higher levels of community care. Stakeholders reported many instances of resistance by the veteran moving to CACP or HACC services because of the cost differential, even when the service is warranted by its better capacity to meet the veteran's needs. This issue was raised spontaneously by about half of assessment agencies. To a lesser extent, the same was reported for clients transferring from DVA community nursing where there is no co-payment for personal care to VHC personal care (with co-payment).

The second observation, the perception of 'entitlement', creates a different set of issues that were reported more often by assessment agencies than service provider agencies. The veteran's concept of 'entitlement' is at odds with the program's concept of need. Stakeholders reported that there is a (minority) group of veterans who are very demanding because of their belief in their entitlement to services. They assert their entitlement as strongly as is necessary to have their 'wants' satisfied. Where this occurs in small communities it raises the expectations of other veterans and also raises questions of equity or fairness in relation to other citizens, where expectations are about levels of provision being related to levels of need.

Stakeholder perceptions of VHC

All stakeholders acknowledge the value of the contribution the program makes to meet the needs of older citizens who require some form of support to age in their own homes. As the pressures of increasing demand on community based aged care services increase, veterans are perceived to have 'special' status among aged citizens because of their ready access to VHC. In particular,

VHC has no waiting lists, which is not the case for many other services. While not universal, most stakeholders support the view that veterans are a 'special' group within the community.

The contractual arrangement between the program and service providers ensures that there is a quick response time between assessment and the commencement of a service. While stakeholders believe the current telephone assessment requires improvement (this is further discussed below) the benefits of telephone assessment in terms of response time are also widely acknowledged. As might be expected, veteran advocacy groups strongly support a veteran targeted community care service.

The program works within a capped budget with assessment agencies taking responsibility for budget monitoring and management. They are, in effect, the program's 'demand managers'. The program guidelines act to aid the allocation process but importantly, do not stipulate specific expenditure targets for each of the four program service streams eg 50% for domestic assistance, 10% for in home respite etc. One assessment agency reported this as a significant advantage of the program in that it allowed assessment agencies better scope to meet demand. Agencies also reported that while the imperative to work within budget was clearly understood, the program was responsive to particular budget pressures experienced by assessment agencies.

A major initiative of the program is its electronic business system. This functions to capture assessment data and is linked electronically to the billing system. However, the 'interoperability' of the system with other agency-level software is limited, resulting in extra work to combine assessment data with existing client information systems. There also appeared to be no scope for feedback from service providers to be easily incorporated into the system and used as part of an information flow about any changes in the veteran or war widow's situation.

The Review did not set out to assess the electronic business system. We did however hear sufficient spontaneous comment that we believe may be useful to the program. It is acknowledged that the system is, in the main, efficient in processing invoices and payments. However, we heard reports from assessment agencies that system down time is considered to occur 'too often' for it to be considered to be as effective as required to managing veteran care. We also heard an example of an agency that has replicated the veteran information into hard copy so as to be able to respond appropriately to veteran need as and when required. Other agencies that attempted a 'paperless' business environment have needed to make concessions to maintaining paper-based versions of information. This is counter to the original intention of the e-business model, and the introduction of the new information system would appear to be timely if it can improve this situation for service providers.

The need for change to meet veteran need

The stakeholder consultations were structured to explore the ways in which the program might evolve in response to the changing needs of veterans in a more direct interactive process. This process invited participants to provide advice on what might need to change to meet future need, based on their consolidated experience and knowledge. It is inevitable that such an invitation opens the door to a critique of the existing system. While this did occur to a greater or lesser extent across all groups, those involved in the process were impressed by most participants' ability to move beyond this and to turn perceived existing problems into opportunities for service development and the enhancement of existing services.

What emerged was a set of themes and observations that were consistent across all groups, although they varied in emphasis. These themes are discussed below.

Capacity to meet the VHC program aims and objectives

The Review invited comment on the capacity of the program to meet its stated aims and objectives now and into the future.

There was agreement across all stakeholder groups that the program's aim "…to enhance the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting them to remain independent in their own homes as long as possible" was a valuable objective that held true for an older and perhaps more vulnerable veteran population as well as the emerging group of younger veterans. There was similar agreement that this objective was not able to be met by the current service model for the following reasons:

- The program's structure around four service groups does not foster independence. Independence is a much broader concept than basic maintenance care and includes, at the very least, a social integration and participation perspective. As well, it requires the capacity to objectively identify and meet a range of individual needs. As the target group becomes both older on average and more diverse in age, from the relatively young to the old-old, the need for a model that fosters independence will increase. The need to be independent is not well served by a model that focuses on substituting a service for a functional deficit, especially when there is no supportive component that addresses an individual's capacity to overcome functional limitations. The program is currently not structured to address the need/s of individual veterans but instead it operates a model that essentially fits the veteran into a relatively inflexible program structure.
- The program is not essentially a 'health' focussed service. Education and/or information on health maintenance including nutrition support and the benefit of exercise (for example) does not form part of the service model. The reliance on external resources to meet goals of improved social functioning, and thereby mitigate social isolation and retain good mental health, is not practical for the clients. The availability of alternative social support services across the country and even within a state or region is very significantly different, and the ability of RSL sub-branches to fill this gap is also uneven. The possibility of long waiting periods, or a veteran or war widow facing no service being available in their region is high, and this is counter to the philosophy of there being equity of access for veterans and continuity and consistency of levels between regions.

In spite of there being inconsistencies, stakeholders informed the Review that the level of support available through the program may in fact allow people to remain within their own homes longer than if there were no VHC Program. A caution here, which was related to the observations on the service model described in the first dot point above, was that the program needs to monitor whether the model acts to 'confine' people to their homes.

With regard to the program's specific objectives, stakeholders agreed that:

- the program response, once assessed, was timely;
- it was targeted at veterans who experienced limitations with their activities of daily living;
- it was unlike other DVA services in that the focus was on environmental and domestic support, as distinct from illness support; but
- it was not sufficiently flexible or comprehensive, and was not able to substitute more useful for less useful, or more timely services based on the veteran or war widow's needs.

Assessment

Assessment was raised by every stakeholder group, and in all forums conducted by the reviewers. The issues raised can be grouped into three major themes: the capacity of the existing *Standard Assessment Instrument* to discriminate adequately for varying levels of need and/or risks; the effectiveness of telephone assessment for the client group; and the perceived difficulties with out-of-region assessment.

Capacity of the existing *Standard Assessment Instrument* to adequately asses need and/or risk

A significant number of the assessment agencies reported that they have adapted their methods and assessment questions to gain better measures of need or to gain a clearer appreciation of the extent of the environmental risks to the veteran. Others reported that they use their own agency assessment tool which they consider is more robust and is better able to discriminate levels of need and risk.

Where the current assessment instrument is being used, participants identified the need for considerable hours of training for assessors, and for an internal method of quality checks to ensure consistent use. The use of a variety of assessment instruments or assessment processes is not necessarily an indicator of lack of capacity within the VHC instrument. It may in fact reflect the level of satisfaction within an agency with a pre-existing instrument, and their ability to streamline the agency's systems and training requirements to accommodate the VHC system.

What should be of concern to the program however is that this variability may result in inequitable levels of service provision to veterans and war widows residing in different assessment regions across Australia. Assessors alerted the reviewers to the fact that work has been previously undertaken to develop a more robust instrument, but noted that the introduction of this was not scheduled to commence until the roll out of the new information system in 2007/08.

Assessment agencies, service providers and the broader community care agencies acknowledged that telephone assessment can be effective for well informed and 'eloquent clients" who require low level care. Less competent people however, or those with some levels of cognitive impairment, are believed by service providers to miss out on the services they require. Assessment agencies acknowledge that they are reliant on the veterans' self-assessment and that the assessment instrument is limited (hence their use of additional questions or alternative assessment tools).

Most assessment agencies also report that they expect feedback from service providers if there are significant issues with the care plan. Not all assessment agencies however indicated that they welcomed feedback. Some took the view that service providers tend to want to be case coordinators rather than merely service providers. However, all commented that the current assessment instrument is not adequate to the task of assessment for complex care nor of assessing the 'household' circumstances of the eligible veteran including the level of carer support undertaken by the spouse, or received by the spouse.

Service providers pointed out that assessment requires an appreciation of this broader context beyond the need of the eligible veteran if it is to be most effective in organising a service response commensurate with the identifiable levels of need and risks. All agencies believe that this would become an increasing problem as veterans' needs expanded beyond the basic to more complex care commensurate with their ageing.

The level of inter-dependency in the relationship between the couple can be an important marker for future service use, including the need for respite care and widow/er support. VHC is planning for a new version of the assessment instrument and the design of this should take into consideration the need to capture and use information on carers and inter-dependency.

The effectiveness of telephone assessment for the client group

This was a contentious issue. Service providers offered many anecdotes indicative of assessment inadequacies that would not have occurred had the veteran received an in-home assessment. There is no easy way to quantify the extent of this problem, but it should be noted as significant nonetheless. On the basis of the information that could be gained through consultation, it may well be that these instances are no greater, and may in fact be less in number, than one might expect

from a complex assessment process undertaken by people with a range of experience, and within a model they are required to work within.

Assessment agencies acknowledge that, like any other assessment, their assessment is reliant on what the veteran chooses to tell them. Importantly, most suggested that they get very little feedback from service providers. Assessment agencies report that, when made aware of a significant issue for the client that results from the initial service provider contact with the veteran, at the OH&S assessment or from subsequent information, they will usually adjust the care plan if the required changes still fall within the scope of the VHC guidelines.

Alternatively, if what is needed falls outside the guidelines, they will encourage the client to self refer to other/additional appropriate services. While the majority of assessment agencies refer clients to DVA community nursing if warranted, only one assessment agency reported that they routinely refer a client to the broad range of other DVA or community care agencies. There were marked differences observed in the relationships between assessment agencies and service providers in different regions.

The conclusion from the observations made in the consultation is that telephone assessment can be effective if the program is able to foster strong and productive and cooperative working relationships between all those involved in client care. However, some people, including those who are 'low need', require a home-based follow up assessment. For example, a veteran might have relatively good functional abilities but may have some memory loss or get confused when speaking to someone on the phone that they do not know. Home-based follow up assessments need to be an integral part of the process for this group. They are also required when a more complex set of circumstances than that identified through the original assessment is developing so that an individually tailored response can be developed. According to the policy, home assessments are undertaken when required. However, as Figure 6 and Figure 7, the number of home assessments has been falling annually since the program was established and the number undertaken last year was negligible.

When taking account of the views of all stakeholder groups, there was a level of support for telephone assessment, with one important proviso. Telephone assessment works for articulate, mentally alert veterans who are primarily independent and who require limited low level support. In these cases it is both efficient and effective. Some HGM or domestic assistance might fall into this category. For all other veterans, the majority of stakeholders who were consulted believed an improved assessment instrument, greater use of the program's capacity for in-home assessment, and a more cooperative and interactive partnership between service providers and assessment agencies, would constitute a more effective assessment process for veterans and war widows.

There was a more general dissatisfaction with the capacity of the current telephone based *Standard Assessment Instrument* to adequately measure need. That it is not adequate to the task is best exemplified by the evidence that most assessment agencies have developed a hybrid version of the form. The result of this adaptation is that there is, in practice, considerable variation across the program that results in inconsistencies in the service level provided to veterans. This is at odds with a departmental ethos that puts a high value on consistency and equity of access.

In acknowledging that assessment is reliant on what the veteran chooses to tell them, assessment agencies expressed some concern that the increasing age of veterans and the likely increase in levels of some sort of cognitive disturbance or dementia will have an impact on their capacity to determine service need. These limitations are not always apparent through a telephone assessment.

Perceived difficulties with regional and out-of-region assessments

This was an issue raised consistently by regional and rural service providers and by the general community sector stakeholders. It appears to relate particularly to one very significant change that occurred during the last round of contracts. Assessment agencies concede that out of region

assessments could be a difficulty but that they attempt to overcome this by familiarising themselves with their region or by establishing liaison relationships with their outlying regions.

The community and service provider stakeholders report that out-of-region assessment can be a real block to effective service provision due to a lack of knowledge about regional conditions and support structures. We heard anecdotal reports of former providers choosing to pull out of VHC services because the logistics of meeting VHC requirements, and when coupled with the distances that needed to be covered in some regions, this made their continuation untenable.

Stakeholders reported that there are very few 'swings and roundabouts' efficiencies (i.e. cross-subsidies) available under the current program structure in regional or rural areas. Others raised the issue that any future expansion of service scope (eg, accompanied shopping) would need to adequately take account of distances and the time involved in providing even this basic service. That said, we are advised by DVA that the Department had more than enough providers tendering for services (under the current fee structure and program model) during the recent tender round. Presumably they would not have done so if they thought that the funding arrangements were not adequate.

The particular issues are illustrated by quoting one stakeholder group whose participants subsequently wrote to the reviewers.

> *"It is difficult to assess risks, hazards, neighbourhood support, distances and surfaces re walking to shops, bus, opportunities for local store deliveries, social activities etc, unless the person is seen at home in their own context and the community context is known."*

Range of services

There was consensus across all stakeholder groups that the current scope of the program was not consistent with achieving the aims and objectives of the program, or with the capacity to meet veteran needs now or in the future. This view was not the usual clamour for more and more services, but was a much more reflective and constructive response, and the level of analysis involved was quite impressive.

Stakeholders did not accept that the variability of genuine individual veteran need could be accommodated within a relatively narrow service structure. The result from the current model is that veterans are forced to fit into a centrally conceived service model, rather than there being a service model that is responsive to veterans' needs.

There was considerable agreement that a needs-based service model should incorporate a social focus, including the capacity for social interaction and accompanied shopping as well as some routine, as distinct from safety related, maintenance and 'environmental' support. The capacity to retain independence within a domestic setting was variously described as a 'wellness' model or an 'enabling' model of support. This would provide improved program capacity to help people learn new skills to overcome functional limitations, and to learn alternative ways of managing their personal and environmental needs. It would arguably reduce the need for ongoing long-term support, at least in the short term.

Stakeholder experience with the current range of service types drew the following specific responses and observations.

Personal care

The recommended 1.5 hours per week was considered as rarely enough for those with a genuine (even low level) need for personal care. This was true of both assessment agencies and service providers. The Guideline requirement that hours in excess of 1.5 (except in specific circumstances) be taken as the trigger for transfer to DVA community nursing was considered as inappropriate. This is especially true with an ageing veteran community where chronic or

physically limiting conditions (stroke was an example used) which were well managed by the veteran and their LMO, required additional hours than the current 1.5, but did not require a nursing service.

Domestic assistance

Domestic assistance was reported to be acceptable to most clients although again the limitation enforced by inflexible blocks of time (fortnightly) limits what can be achieved within the timeframe such as cleaning or shopping. Stakeholders expressed the view that greater flexibility applied to block allocation, such as monthly or six weekly, without necessarily increasing the available hours, might better serve veteran need and meet their preferences.

Home and garden maintenance

The reactive focus (safety) of HGM can make some services difficult to provide especially in rural/remote and some regional areas. Safety issues when they occur usually require a relatively quick response. Some service providers report that the sporadic nature of the work makes it difficult to keep staff employed. Without necessarily increasing the hours, it was proposed that a planned maintenance program for those with a need for HGM may be a better response to maintain a level of service for clients.

Occupational health and safety (OH&S) issues are also having an increasing impact on the ability to continue to provide services. All stakeholders reported the need for veteran assistance in routine garden maintenance (lawn mowing) and the equal, and sometimes greater, impact of this on the capacity to remain at home, when compared to house cleaning. Experienced service providers have highlighted that loss of capacity to maintain a yard can be a trigger for residential care. There may also be a safety-related aspect to this in that an un-maintained yard signals that a ‘vulnerable person lives here’.

VHC respite care

There appear to be significant variations and some confusion in the interpretation and application of the Guidelines as they apply to respite care. The confusion is whether respite is being targeted at the carer (if they are an eligible veteran to relieve them from their duties of care) or at the care recipient (if they are an eligible veteran who would not be able to stay at home during the temporary absence of a non eligible carer). Variability in the use of respite was also noted. Some agencies apply a strict interpretation of respite to be directly substitutable for the tasks undertaken by the carer. The reverse is also true, where assessment agencies interpret the Guideline flexibly, and use it to ‘top up’ services required by the veteran or the carer.

Although VHC respite is a subset of the broader community respite services that are available, it is considered by stakeholders to be an important part of the service mix available to veterans. However, a very significant limitation of the current service is that it is not able to substitute carer support for transport when that is required. As noted elsewhere, the availability of community and voluntary transport is very variable across regions. As the veteran cohort ages, they may become increasingly dependent on some form of transport support.

Our observation is that the variability in the use of respite care reflects the experience and approach of the assessment agency, the creativity that is enforced by the entitlement hours that DVA will pay for and the program model. This observation from our consultations is confirmed by the data. The guidelines allow for up to 196 hours of respite care to be approved, with additional hours available for ex prisoners of war. However, as seen in Table 8, the average number of hours actually approved in 2006 was highly variable across states and territories. As one example, the average hours of in-home respite approved varied from 61.5 hours in the Northern Territory to 115.8 hours in Queensland. The national average was 104.6 hours.

It is clear that some assessment agencies are clearly more able than others to find more creative solutions to address the range of individual needs of care recipients. It perhaps also reflects a limited appreciation at the time the program was developed of the complex interplay between the individual, their role within immediate relationships, their place within a broader community and what that community is able to offer.

Coordination, continuity and communication

Coordination

Assessment agencies have a formal role in coordinating services that have been assessed as being required, and are those approved in the care plan. These may include those available through other DVA programs or available through DVA arrangements with states and territories. Assessment agencies do not have a formal role in ensuring services are in place, are acceptable to the veteran and do not have a quality monitoring role. This function is undertaken by the state based contract manager. The assessment agency role is therefore essentially a referral function.

Nevertheless, some assessment agencies report that the work load associated with their role in service coordination/referral is increasing. In regions where service providers have increasing difficulty always maintaining adequate staff numbers, the assessment agency will be required to 'shop around' for a provider capable of providing a service. This is reported as a particular problem for HGM in some areas. The workforce issues and consequent need for a more intensive role for service coordination/referral need to be recognised by the program.

We noted significant variation to the coordination role on the part of assessment agencies. Some routinely coordinate (refer) veterans to a broad range of additional services both inside DVA and the broader community sector. Others adopt an approach that encourages the veteran to self-refer or seek referral through their LMO for services that fall outside the scope of VHC. All agencies report an increasing need of veterans for help to guide them through the process of accessing other or additional services. It was reported that in some cases this borders on a case management role. This may be a reflection of the difficulties experienced by older people generally in negotiating a complex system. Some assessment agencies report that for some clients they become the 'one point of contact' for the veteran into the more complicated community system.

Individually, these may appear as relatively minor issues. They were certainly not universally reported. Nevertheless they were repeated sufficiently often in various forums by a variety of different stakeholders, that we believe it is indicative of an important consideration for the Review.

Service providers have reported a similar need from veterans and often find themselves caught between the obvious need of the veteran to be assisted and encouraged to seek additional services, and the strict application of the guidelines. They report that veterans are at times reluctant to contact the assessment agency for any variety of reasons including the impersonal aspects of a telephone call to a reluctance to seem ungrateful and to risk being moved to another service provider.

We heard repeatedly, across all stakeholder groups, that we should not underestimate the power of the relationship between a veteran and their regular service provider. This is reported to be based on trust, familiarity, and the sense of dependability that evolves when a service provider is familiar with the particular requirements of the veteran household. While we heard (very rare) examples of providers who overstep professional boundaries, our own experience within the community service provision sector legitimises the observation of the importance of relationships.

It is apparent to us from both the experience of assessment agencies and service providers that service or care coordination will become an increasing demand as veterans require a broader range of services and will need encouragement, information and assistance to access these. This

will require transition planning and some initial monitoring role to ensure that needs are being met. This is not equivalent to case management.

However, short term and/or intensive case management may be appropriate for a small number of veterans. Examples given are those where the veteran household enters the community service sector after struggling independently for too long and where the wheels have essentially fallen off. A short period to manage and coordinate the necessary services and perhaps engage family support and reintegrate people into the wider community can often overcome a complete breakdown of the household structure. Likewise, some Vietnam veterans with multiple service needs across the health and social support spectrum may benefit from a period of intensive case management support.

Continuity

Both service providers and external agencies reported that veterans experience significant confusion and dislocation when:

- veterans have multiple service providers delivering a mix of services or
- the household has different service providers providing similar services to the veteran and spouse, as might be the case in a post acute situation or when the spouse is receiving support for a chronic condition.

The confusion is exacerbated when there are different co-payment systems, different assessment processes and different relationships encouraged with the provider. We have previously noted the seeming reluctance of veterans to move to higher levels of care. Co-payments and the move out of DVA services are two factors. Continuity of service provider is considered by some agencies to be a much stronger motivator, although continuity of provider with a move to a package such as CACP or EACH may sometimes be possible.

The recent contract round and the subsequent reduction in the number of provider agencies has put the spotlight on the importance of continuity to veterans. As one respondent (referring to the national competition policy) put it:

> *"The factor of continuity matters more to the clients than an abstract notion of benefits that result from competition."*

Communication

We observed marked differences in the relationships between assessors and service providers. We observed strong, cooperative working relationships that were focussed on the veteran and managing available resources and expertise to achieve the best outcomes for the veteran and the carer. We also heard and observed levels of distrust, what might best be described as disrespect and an 'us and them' mentality. This approach is more focussed on maintaining the program's integrity and viability than it is about maximising the resources and expertise that is available to benefit the veteran. Where this is the case, it is a major issue that needs to be addressed.

Our assessment is that the critical factors that result in these relationship differences are:

- The structures that have been developed for regular communication and joint meetings to discuss issues related to service assessment and service provision
- The longevity of the assessment agency within a region and the networks and relationships that have been built over that period
- Variations between assessment agencies in their interpretation of the guidelines on the sharing of client information

- A lack of apprehension of the differences between coordinating services/referrals, coordinating care and case management
- The perception that the broader community care sector model is based on care coordination which is not included in the VHC program and that service providers are unable to step outside this role
- The geographic proximity of the assessment agency to the service provider
- The reliance by the program on assessment agencies being the gatekeepers and custodians of the service model and, to a much lesser extent, on them being the facilitators for veterans to an appropriate mix of services to meet their needs.

External agencies involved in the broader community care sector report that VHC is a difficult service to communicate with and that it is dissociated from the general community care sector. The program does not appear to participate for example, in HACC planning forums. This is not productive since VHC is reliant on HACC services to complement its service mix. The VHC program was reported as operating in a parallel universe that is impervious to what is happening in the rest of the sector. As one respondent noted:

> *"They sit so far outside the sector and every conversation is difficult and everything is too hard. It is lucky we have the capacity to cover it up."*

The recent DVA organisation restructure with national as distinct from state program managers runs the risk of creating a bigger chasm than currently exists. This is consistent with the observation by Leutz (1999) that 'your integration is my fragmentation'.

As the needs of the client group expand and more require a range of services beyond VHC, it will be in the interests of veterans for the program to take the initiative and develop better and stronger links with the community care sector on which veterans will become increasingly dependent.

In summary, those consulted responded positively to the review. They were fully aware of the need to consider the sustainability of a low level support service for a veteran population that was ageing, with the consequent expectation that low level support would prove to be insufficient to maintain many of these people in their own homes. There was wide recognition that the program has provided an important alternative service for veterans in need of low level care. There was also wide recognition about the program's capacity to provide the majority of services in a timely manner. Both assessment agencies and service providers commented on the high level of acceptability of the program by the veteran community and this is supported by the veteran survey.

There was surprising concurrence across all stakeholder groups that the program structure is not consistent with the achievement of its aims and objectives, particularly in relation to the achievement of independence and improved health outcomes. To this end, all stakeholders agreed that the scope of the program needs to be expanded to include, at least, accompanied shopping and social support, some routine garden maintenance and transport. This was again supported by the veteran survey. Likewise, stakeholders agreed that greater flexibility to meet the specific needs of the veteran (rather than fitting the veteran into the program) would enhance the service in the short term but would be essential in meeting the needs of the future. Both assessment agencies and service providers were of the view that the allowance for personal care hours needed to be expanded both for current recipients and for the future viability of the program.

Assessment agencies reported a significant increase in the demand for service coordination that can be expected to grow as the veteran group ages or as younger veterans with more complex/multiple conditions become eligible for the program. Perhaps a surprising finding was the degree to which assessment agencies had adapted the *Standard Assessment Instrument.* There was overall support for telephone assessment for some veteran groups, mainly the well-informed and eloquent requiring low level care. However, there was equal agreement that neither the existing assessment instrument or telephone assessment is adequate for the assessment of those

requiring more complex care or for those with cognitive limitations. Both groups will increase as the veteran population ages.

In concluding this section on findings from the national consultation with key stakeholders, and irrespective of which option DVA decides to pursue, we believe that the consultation highlighted some key service improvement issues that could with relatively little effort be implemented in the short term. The first is the earliest possible introduction of a more comprehensive assessment instrument. This needs to be introduced after an adequate testing phase undertaken in consultation with assessment agencies. The second is to work with assessment agencies to gain a better measure of the extent and nature of the coordination function and use this as a marker for future service development. Additionally, it is important to open up the process of communication between assessment agencies and service providers and in addition, with the broader community care sector. Finally, we believe that the program will need to address the veteran perception of 'entitlement', particularly in the context of future service expansion and the requirement to work within a capped budget.

4 Discussion of the results

The previous sections summarised the results of the review. These results have come from seven sources:

- An international literature review
- A profile of veterans and war widows receiving VHC services
- A profile of veterans receiving HACC services
- A national survey of veterans and war widows
- Quantitative analysis to project the demand for VHC services for the period 2007 to 2016
- Survey of VHC service providers
- Findings from a national consultation with key stakeholders.

This section discusses the implication of the results for the options outlined in the next section. In doing so, it is important to emphasise that the focus of the review has not been on how VHC operates at present. This review was commissioned to identify options for the future, not to evaluate the current program. Observations on the current program are only included in this section to the extent that they inform the options for the future.

Turning first to the literature, there is little evidence in the literature to support the proposition that low levels of domestic assistance, personal care, HGM and respite (basic service provision) is effective. This is not to suggest that the VHC program is ineffective. It is just that there is limited evidence that the VHC service types per se are effective in achieving the stated aims of the program.

The strongest evidence exists for:

- comprehensive geriatric assessment (not limited service based assessments);
- allied health interventions to improve function (aids and appliances, occupational therapy and physiotherapy) that are broadly environment-focussed (falls and hazard reduction focus);
- nurse-led home visiting; and
- care coordination across a range of services, with the flexibility to promote service substitution.

None of these effective interventions is offered directly to veterans and war widows and their dependants by VHC. But some are provided by other parts of DVA and others are provided by mainstream community care services.

This situation where programs are implemented, are well accepted by clients and yet have not been shown to be effective in achieving the programs' goals is not unique to VHC. It is common to community care generally (e.g. specific service types within the HACC program) and to respite care as well (under NRCP), where the evidence for the effectiveness of particular service types, except in combination with more restorative-type interventions, is not strong in the published literature. This is also a commonly understood issue in the evaluation of complex interventions to improve health, where the ability to find evidence for effectiveness is limited because the intervention is made up of various interconnecting parts (Campbell et. al 2000)

In spite of the lack of evidence, in the literature, on effectiveness, the program logic for services such as domestic assistance and HGM is compelling. Despite increasing frailties, many veterans and war widows have a strong wish to remain in their own homes and, on the face of it, services such as domestic assistance and HGM help them to achieve this goal. This is reflected, at least in

part, by satisfaction with the service. In total, 87% of veterans in our survey were satisfied with the service although less (71%) were satisfied with the assessment service.

Our veteran survey results confirm that veterans identify such services as critical to them remaining in their own homes. Likewise, other key stakeholders we consulted were firmly of the view that such services help to maintain frail, older people in their own homes. In that sense, programs such as VHC are demonstrably successful.

However, this does not imply that low-level, low-need programs such as VHC actually improve health outcomes or delay / slow down the rate of functional decline. Degenerative diseases such as dementia demonstrably increase in prevalence with age. And there is no evidence that low level maintenance programs such as VHC have any impact on this natural ageing process.

The average age of veterans is now 83 and the 10 year projection is that the DVA treatment population will decline by 40%. Based on current evidence, more than one in five people over 80 have dementia of one type or another. The implication is obvious – an increasing proportion of the veteran population will require comprehensive aged care and not simply low level maintenance services. A key question for DVA is where VHC fits into this inevitable equation.

4.1 The results in their historic context

In considering the question of where VHC fits in the future, it is useful to first consider VHC in its historical context. Community care programs have their origins in government policy that is driven by larger scale economic issues (growing expenditure on residential aged care) and popular consumer demand (preferences of frail older people to remain at home). In 1985 the HACC Program brought a limited range of disparate community care programs and subsidies for the frail aged, people with disabilities and their carers under one (albeit complex) program umbrella.

Various exclusions from HACC were then made (post acute, palliative care, rehabilitation) that added to the fragmentation of care in the community. This has subsequently led to continuing attempts from the 1990s onwards to improve integration (case management through Community Options/Linkages, numerous integration pilots, coordinated care trials).

These programs developed in a historic and theoretical context that assumed that increased longevity would lead to a '*compression of morbidity*'.[8] This theory suggested that cumulative lifetime disability could be reduced if primary prevention measures postponed the onset of chronic illness, while decreases in health risks may also increase the average age at death.

> "The hypothesis predicts that the age at the time of initial disability will increase more than the gain in longevity, resulting in fewer years of disability and a lower level of cumulative lifetime disability. There is some controversy in this hypothesis with some contending that healthier lifestyles may actually increase morbidity (and health expenditures) late in life by increasing the numbers of years with chronic illness and disability." (Binns 2007) *http://www.medicineau.net.au/clinical/obesity/obesit1404.html*

The increase in lifespan has not been matched necessarily by an extension of health and for many the extra years are spent with disability, disease and dementia, suggesting that, at the population level, the idea of the compression of morbidity has turned out to be a mirage. The prevalence of degenerative disease with age will lead to an expansion of morbidity, not a compression, with consequences for the relevance of the VHC service model, particularly given the profile of the DVA treatment population.

This analysis is confirmed in the recent publication of the AIHW on the burden of disease and injury in Australia in 2003, which stated:

> "The rate of disability will actually decline in most age groups, except for those 80 years and over, where it is expected to increase and thereby offset some of the gains for younger age groups. The

[8] The key reference to this theory is Fries J (1980) *Aging, Natural Death and the Compression of Morbidity*. New England Journal of Medicine, Vol.303, pp.130-135

> growing rate of disability in the oldest age group mostly comes from expected increases in diabetes and neurological conditions." (Begg et. al. 2007, p. 8)

The most relevant example of the increased burdens of disease from increased longevity is associated with *dementia*, as described by AIHW (2006):

> "Because Australia's population is ageing, there has been growing recognition that dementia represents a significant challenge to health, aged care and social policy. This report estimates that the number of people with dementia will grow from over 175,000 in 2003 to almost 465,000 in 2031, assuming the continuation of current dementia age-specific prevalence rates." (page xii)

In terms of the social impact these changes are likely to make, Access Economics (2003) for Alzheimer's Australia estimated that growth of 6% per annum in the HACC program would be required to keep up with increasing demand (even after a 20% top up for current unmet need), plus additional respite services will be needed to better support informal caregivers (p. 6).

The AIHW burden of disease study drew out the obvious implications for services:

> "Ageing of Australia's population will result in increasing numbers of people with disability from diseases more common in older ages such as dementia, Parkinson's disease, hearing and vision loss, and osteoarthritis. This will increase demand for services in the home, community care, residential aged care and palliative care sectors." (Begg et al. 2007, p. 8)

4.2 The results in their contemporary service context

It is also useful to consider the results of this review in a contemporary context. Community care in Australia is now a complex mix of different service types and overlapping goals of care. Some of these goals represent competing aims and emphases, driven by the origins of different programs. Few programs have been comprehensively evaluated against their stated goals. Available service types include:

- Services that have a ***preventive*** goal of reducing the *risks* of acute health care episodes and emergency department presentations (origins in acute health care) e.g. early detection and home safety-based assessments, Home Front and RAP.
- Services focussed on ***early discharge*** from acute care where the aim is driven by health service performance/efficiency (origins in post acute health care) eg Compacks (NSW), Transition Care, Better Hospital Discharge Planning for Veterans (2007-08 Federal Budget initiative).
- Services focussed on ***improving*** functional abilities with rehabilitative and restorative goals (origins in sub-acute and non-acute health care) e.g. outpatient clinics, community health-based allied health, Wellness Centres.
- Services with a ***maintenance*** focus such as VHC and HACC.
- Services focussed on ***offsetting*** more significant functional *limitations*, substitutable for residential aged care, and with the goal to *maintain* independent living in the community (origins in residential aged care) e.g. CACP, EACH, DVA coordinated care trials, RAP etc.
- Services focussed on ***carer support*** with goals to provide *respite* and practical assistance (origins in filling gaps for carers in community care programs) e.g. NRCP, Mental Health Respite Program (FACSIA).
- Aged care ***assessment*** services, information lines and referral and care planning services, where the aim is ***gate keeping and connecting*** those with a service or information need with a suitable response (origins in entry point assessment for residential care and community care) eg ACAT, Carelink, various community care access points pilots, GP based assessment/EPC Medicare items

Many more new national and state and territory programs are now available to address specific groups of clients and their carers and to respond to demands for greater consumer choice. These

include EACH Dementia, NRCP sub-programs such as for employed carers, and Palliative Care services.

The net effect of these contemporary initiatives is that the complexity of current services, driven by the plethora of new, sometimes competing and sometimes complementary small programs, and the proliferation of service types, is adding to the complexity of the system and creating integration, coordination and navigation problems for consumers.

The demand for more 'navigation support' is the natural outcome of a community care system made up of many bits, all with their own program structures, yet expected to cooperate in meeting consumer needs at the local level. As a consequence, there will be an increasing requirement for care planning and varying levels of case management for those with more complex needs. In addition, due to the sheer complexity of the system, 'navigation support' will be required even for those with more basic levels of need.

One of the findings of our review is that the issue of fragmentation and the need for better care coordination applies to VHC perhaps even more than in mainstream community care. This is a particularly important issue because VHC is not structured on a model of localised assessment and offers only a narrow range of services. The current scope of the program is predicated on an assumption that other services that veterans may require will be provided either through other programs provided by DVA or by mainstream services. The results in the previous section demonstrate that veterans will increasingly need both a broader range and more intensive level of services. Options that propose both a broader range and more intensive services are included in the following section.

The evidence in the literature on the need for a broader range and scope of services is reinforced by the results of the veteran survey. Veterans already use a wide range of services and expect to need more in the future. Other key stakeholders also recognise this. Approximately 79% of agencies in the service provider survey indicated that their VHC clients received additional community and health services not provided by VHC. All assessment agencies consulted believed that a broader range and scope of services would be better able to meet the variable needs of veterans in the short term as well as future needs. The consultations reinforced support for the focus on environmental and domestic assistance, as distinct from illness support. But the concern in the consultations is that VHC is not sufficiently flexible or comprehensive and is not able to substitute more useful for less useful, or more timely, services based on the veteran's or war widow's needs.

Not only will veterans need more services, they will need the services they receive to be better coordinated. All assessment agencies reported an increasing work load in coordination and more significantly, numerous instances where their coordinating role now borders on case management. One of the options we have outlined in the next section is to close VHC altogether and to transfer existing clients to HACC. The key finding that is relevant to this option is that 56,424 veterans received HACC services in 2006 compared to the 80,343 who used VHC. Based on our veteran survey, this includes a large number of veterans who receive services from both. And, as the literature review points out, many more will need the wider range of services provided by HACC in the future.

We also propose improved communication and collaboration with the broader community care sector as part of an option that maintains the current program but with some fine-tuning. Assuming that the current program scope remains unchanged, and given the certainty that veterans' requirements for additional services will increase, VHC cannot work in the same mode of relative isolation from the mix of local services as it moves into the future. To do so would not be in the best interests of veterans.

Broader options also need to be considered, with a key focus on how best to provide the navigational support that veterans will increasingly require. The consultations in the community service sector reinforced the value of a short and intensive period to manage and coordinate

necessary services, engage family support and integrate the veteran household into the wider community. Vietnam veterans with multiple service needs across the health and social support spectrum were also said to benefit from a period of intensive case management support.

One option for the future is that better coordination could be provided through mainstream services. Another, canvassed in the next section, is for DVA to provide this navigational support through a bigger reform agenda. This would be strongly supported in the field. As one indication of this, 92% of respondents to the service provider survey indicated that the program will need some level of change in the next 5 years. Only 8% of respondents felt the program needed no change. All assessment agencies also believed that changes are necessary if the program is to meet the future needs of the veteran population.

In summary, a combination of demographic changes, increased levels of dependency in older people maintained in the community and the proliferation of more complex community care alternatives have created a very different context for community care in 2007, from that existing in the 1980s when the model was established on which VHC is based. In social policy terms, the implication is that demand by veterans and war widows for higher levels of home-based support is increasing and will continue to increase. The key options are, in essence, whether the VHC program changes to meet those needs or whether those needs are increasingly met through other programs, either within or outside DVA.

As many of the informants to the review pointed out, a primary focus on maintenance-type services in this context, without a strong restorative component, can actually increase client dependency. The notion of "prevention" is now more complex than expecting maintenance level services to prevent residential care admission or to minimise the impact of chronic diseases.

It is against this backdrop that this review has anticipated the inevitable demographic and morbidity changes that will occur into the future. Key responses to these changes include a broader approach to screening for the characteristics of veterans that indicate need and risk, the requirement for better integration with other programs (inside and outside DVA), increased and more localised navigation support and the promotion of effective multi-component interventions.

A paper by Fries et al. (2002) explains the dilemma for program managers in home and community based services (HCBS) very clearly. Given the expanding population and increased demand for long term care (LTC) and the reality of constrained budgets, governments:

> "… were primarily motivated to initiate these programs under the assumption that home care would provide LTC services in more cost-effective ways than would institutional care. However, over two decades of research and evaluation in the area has not supported this assumption … The inability to reach the appropriate population, namely those 'who but for HCBS' would actually move to a nursing home, has been cited as the reason that home care has not been the financially positive alternative originally posited … (Large scale evaluations) have suggested that a screening process is critical to (the) successful use of home care to reduce nursing home admissions." (p. 463)

It is not a strategic option to simply abandon the approach of providing basic care for low levels of need, just because of a lack of evidence for its effectiveness in the academic literature. Nor would abandoning the program model be popular with consumers. In that sense, maintenance of the status quo is a genuine option, at least for the short term. As our survey results illustrate, many veterans are happy with the services they receive and would like them to continue into the future. In the same way, we found no support from assessment agencies, service providers or clients for abandoning the program.

But all had suggestions about how the program could be improved. These suggestions fell into a number of themes that have been addressed in the options that follow, particularly the one that proposes that the program continue as is but with some fine-tuning.

Another genuine option is to build on VHC to develop the approach to better meet the demands of the future needs of veterans. As the options outlined in the next section illustrate, this could be done in ways that would be popular, politically acceptable and supportable by evidence.

The elements of a more highly developed and client focussed approach, rather than the traditional and less flexible service focus, are readily available. A modified DVA approach to community care is already being pre-figured in various pilots and anticipated by the Department's integration and life-cycle policy directions. The various options for the program developed in the course of the VHC Review have synthesised many of these as yet un-assembled components that have useful lessons for the broader Departmental agenda:

- The Community Options Brokerage projects in NSW
- The Coordinated Care trials in Brisbane and Sydney
- The community nursing casemix methodology
- The opportunities afforded by revising the VHC assessment instrument within the context of *The Way Forward*
- The 2007-08 Federal Budget initiative on Better Hospital Discharge Planning for Veterans
- The potential for integrating information around the life-cycle focus by the ability to improve the linkages between the various DVA databases.

The options in the next section have been designed so that they can be considered by DVA as ends in themselves. Alternatively, they might be considered more broadly as a community care development pathway. The longer-term end point would be a more flexible, better integrated and more forward looking 'matrix' of programs, driven by data-based solutions and more capable of responding to veterans' needs over the whole life cycle.

5 Options for the future of VHC

This section sets out nine options for the future for consideration by DVA. They range from the maintenance of the status quo through to options that would represent a major realignment of service types and relationships within DVA. Each has different funding implications and would require different lead times.

In considering these options, it is important to reiterate the framework of 'givens' specified by DVA as part of the initial brief:

- the separation of the assessment and service delivery functions is to continue;
- the program is to continue operating in an e-business environment;
- as per the current model, assessments are to be predominantly conducted by telephone using the standard VHC on-line assessment instrument (given the low level focus of the program);
- the program is to primarily provide low level services, but have the capacity to provide higher level services where warranted, especially on a short term basis; and
- as per the current model, veterans with higher needs than can be accommodated by the VHC program in the longer term are to be referred to other more appropriate programs such as the Aged Care Assessment Program (for assessment for CACPs and Extended Aged Care in the Home packages) or the Home and Community Care (HACC) program for HACC services, etc.

Some of the options below fall, at least in part, outside this framework. Where this is the case, the reasons are discussed as part of the broader discussion of the option.

Each option is discussed using a standard set of criteria defined briefly below. Not all of these criteria have equal weighting. Some are demonstrably more important than others. This issue is discussed further in Section 5.10.

Consistency with the research evidence on health outcomes

The degree to which the option is consistent with the evidence on how to improve the health outcomes and quality of life of those in the VHC target group as summarised in Appendix 2.

Consistency with the research evidence on best practice

The degree to which the option is consistent with the evidence on best practice summarised in Appendix 2.

Projected needs of veterans

This criterion is related to the one above. The evidence is that people need different types and quantities of services at different times in their life. Section 3.4 reports on the projected need for VHC into the future.

Consistency with the perspectives of veterans

DVA has a strong commitment to both meeting the needs of veterans and listening to their views. Data from the survey and phone consultations with veterans (see Section 3.5 and Appendix 4) has been used to assess the degree to which each option would be acceptable to veterans.

Consistency with the perspectives of VHC assessment agencies

We used data collected in our consultations with VHC assessment agencies to evaluate the degree to which each option would be acceptable to them.

Consistency with the perspectives of VHC service providers

We used data collected in our survey and consultations with VHC service providers to evaluate the extent to which each option would be acceptable to them.

Consistency with the perspectives of HACC funding authorities (DoHA and states and territories)

We used data collected in our consultations with the Department of Health and Ageing and a cross section of states and territories to evaluate the degree to which each option would be acceptable to them. We also analysed the relevant submissions from the Department's Review of Subsidies and Services. This group of stakeholders manage the HACC program as well as other related programs including care packages and carer support services.

Consistency with the perspectives of broader community care providers

We used data collected in our consultations with community care providers and peak bodies to evaluate the degree to which each option would be acceptable to them. These agencies typically provide services under the HACC program as well as other related community care programs including care packages and carer support services.

Consistency with DVA policy and planning frameworks

This criterion assesses the degree to which each option is consistent with the broader policy frameworks under which DVA operates. For convenience, these have been synthesised into two main areas. The first is the core assumption that 'veterans deserve special consideration'. By this we mean that veterans have earned the right by dint of their contribution to the nation and their sacrifice, to be considered as a sub group within the broader community who are worthy of special consideration.

The second is 'National consistency and the life cycle policy framework'. DVA is committed to achieving more consistent service delivery across Australia. The life cycle policy framework is a concept used consistently within DVA where the aim is to achieve the horizontal integration of policy objectives within the Department, recognising the changing needs of veterans at different times in their lives, and covering the full spectrum including early intervention, key transition points (e.g. acute hospital to community care, community to residential care), maintenance of wellness, recognising family, carer and shared responsibilities.

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The discussion of the options below does not include any consideration of the legislative implications of each of the options. We understand that some options would require a change to legislation, a matter that DVA will need to take into account when determining its preferred approach and the best strategy to achieve the desired outcomes.

5.1 Option 1 – End the VHC program and transfer clients to HACC

Under Option 1, the VHC program would close and veterans would have their low needs met as others do through the Home and Community Care (HACC) program. This option is the way that services were provided prior the establishment of VHC.

Strictly speaking, this option is outside our initial brief, which was predicated on an assumption that VHC would continue. We have included it here both for the sake of completeness and because it was recommended as the preferred option by some of the key stakeholders we consulted.

A further reason to consider it is that a sizeable number of veterans (56,424 in 2005/06) are already in receipt of HACC services although we estimate that about 20% of them are not VHC-eligible[9].

Our summary assessment of this option is set out in Figure 21.

Figure 21 Assessment of Option 1

Criterion	Option 1
Consistency with the research evidence on health outcomes	★★★
Consistency with the research evidence on best practice	★★★
Projected needs of veterans	★★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★
▪ National consistency and life cycle policy framework	★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★
▪ VHC assessment agencies	★
▪ VHC service providers	★★
▪ HACC funding authorities (DoHA and states and territories)	★★★★★
▪ Broader community care providers	★★★★★

The major arguments put forward by those favouring this option are that the current system of veterans obtaining services from both the HACC and VHC programs leads to fragmented service provision. This situation maintains the current level of community care integration problems and reinforces boundary issues between programs and is not supported by the literature, which advocates for better care coordination and integration.

The factors affecting the outcome of community care service interventions were investigated over a decade ago in a relevant literature review by Fine and Thomson in 1995 for the (then) Commonwealth Department of Human Services and Health (Fine and Thomson, 1995). Their focus (like Johri et al. 2003) was on the large scale trials of the effectiveness of community care, especially using case management, in the US, the UK and Europe. It is relevant in the current context because, while the current program is targeted to low need clients, the population projections are for this group becoming more complex and high need over time.

> "One of the few consistent findings is that low levels of standardised services for people with complex or high levels of need are relatively ineffective. Case management was a favoured approach to service provision, but a number of studies indicated concern at the high costs

[9] The new HACC minimum data set includes a field to record DVA card status. The estimate of 20% is based on advice we have received from the NSW HACC information line on the proportion of veterans using NSW HACC services who are gold or white card holders.

> associated with it and questioned whether it was a necessary element in the organisation of services for most recipients." (Fine and Thomson, 1995, p.34)

As the program's target population ages, levels of functional dependency and disability are expected to increase, the rationale for basic levels of service provision diminishes and the requirement for additional levels of care coordination and access to additional services increases.

On the other hand, VHC was established (at least in part) because DVA recognised that some veterans were not having their needs adequately met by mainstream HACC services because of waiting lists, services not being available in their area, and so on. There is no reason to believe that the situation would be any different today.

In contrast, the VHC program prides itself in having no waiting lists. DVA sees this as a key point of difference with other community care programs.

Further, it is clear from the veteran survey that veterans see DVA as the government department that will look after them as they age. This is reflected by the comments of veterans:

> *Been with DVA since 1984, very happy with everything she has received. Treated very fairly.*
>
> *"Never been so well off in our lives."*

For these reasons, our assessment is that this option would not be acceptable to veterans, VHC assessment agencies or VHC service providers.

There would be some support from HACC agencies and the broader community care sector in that the option would provide administrative efficiencies that could be reinvested in veteran services. In addition, it provides a less complex environment in which to introduce initiatives around Access Points consistent with the work being undertaken by *The Way Forward.* This option would also overcome the lack of continuity currently experienced by veterans who receive a service from both programs. But this support would be predicated on the appropriate funding arrangements for such a transfer.

Finally, this option is not consistent DVA policy and planning frameworks that are premised on the assumption that veterans deserve special consideration and that aim to care for veterans across the life cycle.

5.2 Option 2 - Maintain the VHC model as is

Option 2 is the maintenance of the status quo. In the short-term, this is a real option for DVA. Because it has contracts with its network of VHC assessment and service provision agencies that have another two years to run, a major change in the way that the program works would not be possible until the end of the current contract period.

It is also a viable option for at least the medium term. As outlined in Section 3.4, we project that demand for VHC domestic support and planned respite will not peak until 2010. The projection for personal care is similar, with demand expecting to peak in 2011. The only exceptions are the two small sub-programs, with demand for safety-related home maintenance and gardening and emergency respite care both expected to peak in 2008.

Our summary assessment of this option is set out in Figure 22.

Figure 22 Assessment of Option 2

Criterion	Option 2
Consistency with the research evidence on health outcomes	★
Consistency with the research evidence on best practice	★★★
Projected needs of veterans	★★

Criterion	Option 2
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★
▪ National consistency and life cycle policy framework	★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★
▪ VHC assessment agencies	★★★★
▪ VHC service providers	★★★
▪ HACC funding authorities (DoHA and states and territories)	★
▪ Broader community care providers	★

There is a lack of evidence in the literature on the effectiveness of domestic assistance, personal care services, and home and garden maintenance without a more active framework of social support and some attempt to measure client outcomes. This absence of evidence will put significant pressure on the Department to provide rigorous cost-effectiveness and performance data in line with the Audit Office (ANAO) recommendation:

> "that DVA evaluate whether VHC is meeting its aim of enhancing the independence and health outcomes of veterans by reducing the risk of avoidable illness and injury and assisting veterans to remain independent in their own homes as long as possible." (ANAO 2005, 5.25)

Further, the ageing of the program's target population, increasing functional dependency and more complex care needs are expected to decrease the rationale for a model based on basic levels of service provision. The implication is that, even under Option Two, there is little likelihood of the program remaining essentially as it is for more than a few years.

There was a high level of agreement in the consultations that the objectives of the program to enhance the independence and health outcomes of veterans will not be able to be met into the future by the current service model. This is because increasingly veterans will need more than VHC can offer. Further, the structure around four service groups does not foster independence which is a much broader concept than basic maintenance care and includes, at the very least, a social integration and participation perspective.

As well, the current model requires the capacity to more objectively identify and meet a range of individual needs. As the target group becomes both older on average and more diverse in age, from the relatively young to the old-old, the need for a model that fosters independence will increase. The consultations suggested that the need to be independent is not well served by a model that focuses on substituting a service for a functional deficit, especially when there is no supportive component that addresses an individual's capacity to overcome functional limitations.

Nevertheless, regardless of the evidence on outcomes and service models, veterans themselves rate the current service highly, with 87% being satisfied with the program overall (see Section 3.6 and Appendix 4). Many would be happy for it to continue as it is, as illustrated by the following comments made in the survey:

> *… if I need to contact Veterans' Affairs I receive prompt and courteous attention. I have lived a long time (84) and have very few complaints.*
>
> *I can only speak very highly of the DVA as I have received the greatest of assistance and courtesy when required.*
>
> *I am a satisfied client. I would also comment on the personal patience and awareness that Veteran Affairs staff extend to elderly veterans.*

Very grateful for DVA assistance, I feel some outside service providers are not as honest as they might be and take advantage of seniors.

I appreciate the help I get through Veterans' Affairs as a war widow and feel confident knowing that as my needs increase I can approach the organisation to discuss them.

However, we anticipate that acceptability to would decrease over time. As their need for more and different community care services will inevitably increase, veterans will increase perceive the VHC services they receive as inadequate or, indeed, even irrelevant in meeting their needs.

While the current model is consistent with a policy framework based on veterans deserving special consideration, it is not consistent with the move toward consistent application of a life cycle framework. The VHC program has its own processes, policies and agencies that, in many ways, run in parallel to other parts of the department. As one example, DVA funds separate assessments for VHC, Nursing, RAP, Home Front and so on, and a veteran with many low level needs gets a separate assessment for each program.

In terms of acceptability to VHC agencies, our consultations suggest that, while, some assessment agencies believe that the program is quite effectively as it is and that relatively modest changes are required, VHC service providers had a somewhat stronger view. As the survey results demonstrate, only 8% of VHC service providers believe that the program as it is will meet the needs of veterans into the future.

VHC assessment agencies would keep their specialised role, but if the role did not change to include assessment of more complex needs, it would decrease in relevance over time. Service providers would be in a similar position where the service types and intensity they would be offering would gradually become a smaller part of the spectrum of veterans' and their carers' needs.

Under this option HACC funding authorities and other community care providers would be expected to meet a greater proportion of the need for community care within the veteran community. However, maintaining the status quo for a period of time while concurrently progressing work between DVA and DoHA on access points (single point of entry, eligibility, referral and data transfer etc) would gain support.

For the Department, there would be an advantage in the status quo option as it would require little change to manage for veterans in community care settings, but the significance of the role of the program will inevitably diminish over time. Other parts of the Department beyond VHC would take responsibility for provision across the continuum of care.

5.3 Option 3 - Maintain the VHC model but with some fine tuning

Option 3 is essentially the maintenance of the status quo but with improvements in some operational details to make the program more responsive to the needs of veterans and their carers.

In the short-term, this is also a real option for DVA. While the current contracts have another two years to run, a number of refinements to the program can be made to make it more responsive.

Our summary assessment of this option is set out in Figure 23.

Figure 23 Assessment of Option 3

Criterion	Option 3
Consistency with the research evidence on health outcomes	★★
Consistency with the research evidence on best practice	★★
Projected needs of veterans	★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★
▪ National consistency and life cycle policy framework	★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★
▪ VHC assessment agencies	★★★★
▪ VHC service providers	★★★★
▪ HACC funding authorities (DoHA and states and territories)	★★
▪ Broader community care providers	★★

There is limited support for this fine tuning option based on the scientific and practice literature, which highlights the need for better local coordination and integration of services, rather than fine tuning the delivery of a limited number of service types, for achieving health outcomes in the VHC-type population.

However, the VHC model could be improved if investments were made into routinely collecting more useful data, including outcome measures that could provide evidence on the effectiveness of the specific VHC services. In this way, VHC would be creating its own evidence base and creating a culture that clearly demonstrates effectiveness i.e. doing what works for veterans, as part of a quality improvement framework. This would also have the added benefit of improving the information flow between service providers, as well as eventually helping with the better targeting of services for veterans.

Following on from this logic and the organisational imperatives outlined in Option 2, there is a clear need to examine the performance and cost-effectiveness of VHC across the key areas in aged care. These include functional dependency, nursing home and hospital admissions (including emergency department visits) and mortality (see the paper by Stuck et al. 2002 for the possible outcome measures available). This program of work could form part of a Research and Development strategy for the Department.

An approach that could routinely produce and act on data including outcome measures would be in line with best practice in home care service delivery as applied, for example, by the Veterans' Independence Program in Canada. Other improvements in line with the literature review findings would be changes emphasising better coordination and integration of services across the life cycle and spectrum of needs, and in regard to the information flow between services providers.

Under Option 3 the program can easily respond to the ageing of the target population and more complex care needs by a number of small but useful changes, mainly associated with the flexibility of the program guidelines and the flow of information.

These include, but are not limited to, the following:

Assessment

VHC is proposing to introduce a new *Assessment Instrument.* This will provide an important opportunity to broaden the scope of the assessment in several important ways. The first is to

include assessment of the capacity of the carer/spouse and the inter-dependencies between couples. Carer/spouse health is an important marker for future risk and this is becoming increasingly apparent as the cohort ages. A new Instrument should be better able to flag situations where feedback from the service provider at first contact is required and allow greater capacity for a comprehensive home assessment where that is warranted. It is appropriate to revisit the Assessment Instrument that is due to be included in the new information system in the context of the findings of this Review and concurrent developments under *The Way Forward* with the goal of achieving consistency across the community care sector.

A bigger issue that needs to be explored, potentially as part of this fine-tuning option, is that there is no evidence in support of remote and locally unconnected assessment processes. A key question for the program is the options available to better link the whole assessment system into local community care networks. This is particularly important because, as the veteran population ages, veterans will be increasing reliant on services beyond those on offer through DVA.

Relationship between assessors and service providers

Adoption of a formal policy can enhance the links between assessors and service providers as 'partners in veteran care'. Such a policy would not compromise the separation of assessment from service provision but would instead encourage communication and feedback between these two key agents.

Choice and flexibility

DVA should consider changes to ensure that veterans have some choice in the way and the frequency at which services are delivered. One strategy for improving flexibility is to allow assessment agencies to allocate available hours for home based care more flexibly. The current Guidelines provide for a standard allocation that is equivalent to 6 hrs per recipient per week (1.5 hours of personal care; 0.75 hours of domestic assistance; 3.75 hours of in-home respite)[10]. However these hours are allocated for each specific service type and to specific time blocks – weekly, fortnightly and monthly. Veterans and carers would be better served if these hours were available in bigger blocks, albeit less frequently. Such an arrangement would also result in better efficiencies for service providers particularly in cases where travel in regional and rural areas compromise service availability and be more conducive to achieving better continuity of care for the veteran. Our findings in the surveys and in consultations are consistent on this issue - veterans do wish to have consistency in service providers and service timing/frequency. These are important aspects of achieving better continuity of care.

Substitutability

Another aspect of flexibility is the opportunity for a veteran to replace one service for which they are approved with another that would, in the view of the veteran, better meet their needs. The case study included in Section 3.6 is a good illustration of the issue. Without increasing the service hours, the potential to substitute one service (in this case domestic assistance) with another (accompanied shopping and social support) would be a significant service enhancement that would be strongly supported by veterans and war widows. They key to this is a more flexible definition of domestic assistance.

Planned home and garden maintenance

Without necessarily increasing the hours, a planned maintenance program for those with a need for HGM would be better than the reactive service currently provided. This would better suit the

[10] The guidelines state that 'generally, around 1.5 hours per fortnight is sufficient service to meet most veterans' basic support needs', that low level personal is defined as up to 1.5 hours of services per week, that the maximum amount of home and garden maintenance a veteran can receive is limited to 15 hours of service per financial year and that VHC will pay for respite care up to 196 hours per year.

needs of veterans at the same time making it easier for VHC service providers to attract and retain the right mix of staff.

Communication and coordination with the broader community care sector

DVA might consider aligning itself better with the broader community care sector at the state level so that better synergies and efficiencies are established within the whole community care sector. Such synergies will become increasingly important as veterans require a greater range of services provided by other parts of the community care system.

Communication with veterans

DVA might consider greater publicity for VHC throughout the veteran community to overcome the knowledge gap about the program that veterans have referred to.

Exit policy and outcome measurement

This fine tuning option is in accord with the ANAO report (Recommendation No.2 Para. 2.59) which recommended that DVA develop and implement exit strategies to support the transition of veterans from VHC to other, more appropriate, care when necessary. An exit policy presupposes better quality and routinely collected data, including outcome measures that could provide evidence to support the decision that a veteran or war widow should move on from VHC services. This fine tuning is an attractive option if it can help decision-making and create a culture that seeks to demonstrate the appropriateness of the decisions being made, i.e. showing that it is doing what works for veterans, as part of a quality improvement framework.

Use of data and information

A wealth of data is collected for VHC recipients and used for administrative purposes but these data are not currently well used for planning and management purposes. This was demonstrated by the significant extra work required by DVA to extract the data we have analysed in this review. Assessment information could routinely be linked with service utilisation data and with other data stored in other DVA databases. This would enable ongoing analysis of the needs of veterans for VHC services as well as the outcomes of the program.

+++++

This option is no different to Option Two in terms of its consistency with DVA policy frameworks. However, it would be more acceptable to veterans who would retain their own program, but with improvements that would increase its acceptability and better respond to their needs as they change over time.

Many veterans had suggestions about how the program could better meet their needs (see Section 3.6 and Appendix 4) and, while 87% are satisfied with the current program, 13% are not. The following comments are illustrative of others made in the survey:

> *It would be so nice to go for a short outing once in a while, if our health permits.*
>
> *If I could get half price taxi's I would be more independent.*
>
> *My two children live in Melbourne and are unable to help me. I would dearly love to have a carer for times of emergency. Could I nominate a friend to care for me if I had to go to hospital?*
>
> *We believe that the care of our mother is our responsibility. We accept and are grateful for the help that DVA give to us. Easier access to at home respite would be appreciated. Mum will not go into respite care as I think she is frightened that we will leave her there even though we assure her that won't happen.*

> *Paying of accounts is very inconvenient for me as I need to travel from Ulverstone to Devonport to pay accounts to Veteran Affairs. I do not drive so therefore have to rely on my daughter to take it over for me. It would be much simpler if we could get BPAY so my daughter can pay on internet, as a lot of the majority of older people do not drive.*

VHC assessment agencies would keep their specialised role, which would change only marginally to include some new assessment tools and procedures and changes to the guidelines and information flow. Service providers would be in a similar position where guidelines would change, but not significantly.

The HACC funding authorities and other community care providers would be expected to welcome increased flexibility and a more integrated approach to meeting the need for community care within the veteran community.

For the Department there would be advantages in the fine-tuning option as it would require less change to manage for veterans in community care settings, and more acceptability of the role of the program within the sector. As with the status quo option, as veterans' needs become more complex, other parts of the Department beyond VHC would gradually take more responsibility for the provision of care across the continuum of need as the focus of VHC would remain on basic level care.

5.4 Option 4 – Redevelop VHC as an environmental support program

Under this option, VHC would be re-developed as an environmental support program. Two of the four current service types provided by VHC would continue as part of VHC and two would be transferred elsewhere.

The VHC program would consist of 'environmental-type' services, designed to safely support veterans and war widows in their homes for as long as possible. It would have four service types:

- Domestic assistance
- Safety-related gardening and maintenance
- Home Front
- Rehabilitation Appliances Program (RAP).

Strictly speaking, this option is outside the parameters of our Review because it would result in changes in other parts of DVA. But the idea of bringing together all DVA environmental support is consistent with the evidence in the literature and was suggested in our stakeholder consultations.

There is strong support in the literature for the redevelopment of VHC into an environmental support program, as seen by the emerging focus on home modification and home safety in the scientific and practice literature (see Gitlin et al. 2006, Nikolaus and Bach 2003). This redesign is also supported by the emerging trends in the academic literature including the use of technology, as well as promoting functional independence and physical activity programs. Domestic assistance, if it is understood as a form of preventative home visiting for the elderly, is also well supported by the research evidence:

> "Preventive home visitation programs appear to be effective, provided the interventions are based on multidimensional geriatric assessment and include multiple follow-up home visits and target persons at lower risk for death. Benefits on survival were seen in young-old rather than old-old populations." (Stuck et al. 2002 Abstract).

A further reason is that the current program is predominantly an environmental program already. In 2006, domestic assistance represented 70.4% of all VHC claims and home and garden maintenance a further 14.3% (84.7% in total). This compares to 14.3% for respite and 2.6% for personal care.

The South Australian Department of Families and Communities' submission to the Review of Subsidies and Services put the position in support of this redevelopment option very clearly in respect of community care generally, and it applies equally to VHC in particular:

> Opportunities for prevention and early intervention which would improve the quality of people's lives, and a significant saving to Governments have not been taken advantage of… Whilst maintaining the integrity of community as distinct from rehabilitative care, a revitalisation of an approach promoting independence is in the interests of all. There is a clear role, for example, in home modification and equipment (often very basic) provision in setting the person and their family up to be able to manage independently, or at least with less formal support. An increased focus on allied health assessment and prescription and short term intervention would assist.

Within DVA, responsibility for personal care would transfer from VHC to community nursing (CN). The rationale for this is that the current distinction between VHC personal care and DVA community nursing is arbitrary. An increasing number of veterans will require more than the 1.5 hours benchmark service level provided by VHC and an increasing number will require more technical nursing. Management within CN would allow for a smoother transition to higher levels of personal care over time and better allow for variable levels of service to be provided if the veteran's needs fluctuate (eg, when post-acute).

In considering this option, it would be important for DVA to consider the possible impact on White Card holders. Under the present rules, White Card holders are only eligible to receive community nursing services for specific conditions:

- an accepted war or service caused injury or disease;
- malignant cancer (neoplasia) whether war-caused or not;
- pulmonary tuberculosis whether war-caused or not;
- post traumatic stress disorder whether war-caused or not; and/or
- anxiety and/or depression whether war-caused or not.

Unless this was changed, veterans with White Cards who require community nursing for unrelated reasons would need to access nursing through the HACC program. As reported elsewhere in this report, 2.2% of VHC recipients were While Card holders in 2006. There is no way of knowing how many of these are receiving VHC personal care for these conditions.

A further issue is that any personal care provided under the Community Nursing program does not attract a co-payment whereas all personal care provided under VHC attracts a small co-payment (currently $5 per hour capped at $10 per week). 'Grandfather' provisions, such as those introduced for veterans who transferred from HACC, would be required to ensure a smooth transition of veterans currently receiving personal care through VHC.

If this option were adopted, the other issue that DVA may wish to consider is to introduce co-payments for personal care provided under the Community Nursing program. The current situation in which a veteran makes a co-payment if personal care is provided under VHC but not if personal care is provided under Community Nursing is inequitable.

The other implication of this option is that responsibility for respite care would transfer to the Department of Health and Ageing through its network of HACC providers and Commonwealth Carer Respite Centres. The integration of respite with the mainstream of these service types is supported on the basis of reduced fragmentation and the resolution of program boundary issues. There is some evidence for the effectiveness of respite care services as a separate service type, though the evidence base needs to be improved (see Mason et al. 2007 and Ingleton et al. 2003). If respite were to remain inside VHC, this implies similar investments in routinely collecting more useful data under this Option to those suggested under Option 3, including collecting routine outcome measures that could provide evidence on the effectiveness of the specific VHC services.

Our summary assessment of this option is set out in Figure 24.

Figure 24 Assessment of Option 4

Criterion	Option 4
Consistency with the research evidence on health outcomes	★★★★
Consistency with the research evidence on best practice	★★★★
Projected needs of veterans	★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★
▪ National consistency and life cycle policy framework	★★★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★★
▪ VHC assessment agencies	★★★
▪ VHC service providers	★★
▪ HACC funding authorities (DoHA and states and territories)	★★
▪ Broader community care providers	★★

Many veterans (especially war widows) identified the need for more environmental support (see Section 3.6 and Appendix 4). Comments included:

> *Subsidised lawn mowing services similar to home domestic assistance would be appreciated.*
>
> *It would be nice to have help with doing jobs I cannot now do - such as washing curtains (taking down and putting back) cleaning windows - cleaning kitchen cupboards (inside as I cannot bend - back trouble)*
>
> *The weeds get on top of me at times as I can't bend down because of low blood pressure - and I dearly want to stay in my own home.*
>
> *Help for house cleaning, washing curtains, cleaning light shades, things that are not done every week or month. Cleaning windows. Would be **willing to pay** for these things, cannot kneel or climb have artificial knee*
>
> *Need help for the jobs they are unable to do - not so much the routine tasks.*
>
> *A general handyman is very hard to find and it would be great to have help to find one….Tradesman only are available and this is not what I need.*
>
> *I would **pay more** to have window cleaning, carpet cleaning, spring cleaning, curtains, tradesmen I could contact.*
>
> *I would like to have small trees lopped and taken away please as I find that is where I have my **falls** in the garden*
>
> *Tree pruning access to the back of the house. Back steps unsafe for me to use as there is only one rail to hang on to. No access to clothes line.*
>
> *I pay to have gardening done but realise I **will have to pay** for home maintenance as I will not use a ladder in future.*

> *I **would pay extra** if the fee wasn't too much more. I am a war widow, I live in a housing dept home and I could certainly appreciate someone for lawns, garden and cutting back a few trees. There is not many but as I have arthritis in my fingers and problems with my back I find this a bit hard.*

Some of the quotes highlight the willingness of veterans to seek (and pay for) additional or substitutable services to those provided under the program. The associated question of co-payments within the program is relatively complex. It requires the resolution of issues of consistency within DVA, as well as a measure of consistency across other programs such as HACC (where a national uniform approach to fees is still being resolved) and fees in relation to care packages. Another complicating factor is related to the veterans' willingness to pay more and consistency in communication to veterans of the expectations that costs might be related to the volume of services used, rather than a flat fee.

The co-payments issue is one that needs to be considered across all the options, and has particular relevance here as an example of 'fine tuning' that could be used strategically by the program to modify veterans' expectations about their 'entitlements'.

Some assessment agencies would consider this option to be a waste of nursing resources when the aim of the option is to focus primarily on more environmental concerns. However, they can be expected to support the capacity of this option to better meet the need of some veterans, especially if the links to community nursing are strengthened in the new arrangements.

It is anticipated that this option would have limited support from service providers. They currently employ Certificate 111 care staff whose skills they believe are already undermined by the VHC program domestic assistance service, which is essentially a cleaning service. They may have difficulty retaining staff to undertake a primarily cleaning role. However if domestic assistance should be expanded to include accompanied shopping and social support, our assessment is that it would receive support from provider agencies.

The broader community care sector would probably consider this as a 'tinkering around the edges' solution that would be more costly of scarce nursing resources and provide no great benefit to the community of veterans. There would be no direct impact on HACC authorities although it might be considered as a wasted opportunity to do something much more substantial and consistent with *The Way Forward.*

In terms of consistency with DVA policy and planning frameworks the redevelopment option with an environmental focus would have strong backing. It would serve to integrate a range of services that are currently quite separate and require their own eligibility and assessment processes and guidelines, and it would likely be popular with veterans in the sense that it would resolve a number of frustrating inconsistencies around the program. For veterans and war widows, this option would still give them special consideration beyond what is available in the mainstream and also be consistent with the Department's integration agenda and the life cycle policy framework.

5.5 Option 5 – Expand scope of VHC to include other basic services

Under this option, VHC would remain as a basic service provider providing comparable levels of service. But the range of services would be expanded to be equivalent to that provided by HACC including, for example, social support, accompanied shopping, assistance to attend appointments, routine garden maintenance and so on.

Our summary assessment of this option is set out in Figure 25.

Figure 25 Assessment of Option 5

Criterion	Option 5
Consistency with the research evidence on health outcomes	★★
Consistency with the research evidence on best practice	★★★

Criterion	Option 5
Projected needs of veterans	★★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★
▪ National consistency and life cycle policy framework	★★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★★
▪ VHC assessment agencies	★★★★
▪ VHC service providers	★★★
▪ HACC funding authorities (DoHA and states and territories)	★★
▪ Broader community care providers	★★

The literature does not adequately identify the specific components of basic care services that are effective (Frich 2003 and the discussion on Care Packages in Attachment 2), and most evidence relates to models where personal care and domestic assistance and other HACC-like services are subsumed inside nursing and other services with a rehabilitation or restorative focus. Consequently there is little evidence available for expanding VHC to include other basic services. The one exception is perhaps in the area of transportation services.

Under Option 5 the ageing of the program's target population, with consequently more complex care needs, suggests the rationale for expanding the scope of basic services is limited in the medium to long term. That means there is little support in the literature for the program remaining essentially as it is currently structured, even with additional services added.

But many veterans identified other basic services they need (see Section 3.6 and Appendix 4) and would be happy to see the program expanded. Comments included:

Shopping/transport

Seeing as I am 90 years old, but in reasonable health there are many things I cannot do on my own, as the only family I have do not live near me, and my legs, especially my knees are really not very good for shopping etc. Someone to help shop would be a help.

I am not able to travel or go out on my own. A neighbour takes me to supermarket once every 2 weeks and brings me home before 12 noon.

As I have never had a drivers licence, after the death of my husband 12 years ago, I needed assistance for shopping, mail and services. My daughter, who lives some distance away near Ballarat, visits every 2 or 3 weeks to take me to Bendigo for what I need. I can use a taxi to Bendigo but it is too expensive to use often at $90 a trip.

Delivered meals

My wife who cares for herself and prepares all meals is having difficulty sometimes with movement. How long we are able to care for ourselves is problematic and in the lap of gods.

Coping well at present but my wife has heart problems and cannot do much. Am thinking of having meals delivered.

I have meals cooked by a friend and pay towards cost of some. She takes care of me in times of need but is not a carer.

Other tasks

> *DVA do not supply as much as Community Care services do. They get carpets done, some gardening, shopping, cooking, hair done. They also get windows done*

> *Veteran suffers from Alzheimers…wife is 77, workload very tiring. Been trying to cope but gardens/windows getting out of hand. Appreciate all help but will be asking for more. Wife is lonely and exhausted. Been caring for husband since 1981.*

> *Up to date I can manage small jobs that are extra and above what the cleaning services I have do, but I do suffer pain after.*

> *My husband is 89 years of age, I am 82. We sort of look after each other. In the future, we may need extra help. My husband has developed cancer of liver…..My health is not really good. Some days I am better than others. I do not wish to have any surgery treatment at present because I feel Jim needs me to take care of him.*

Some of the above quotes highlight the needs of veterans for additional or substitutable services to those provided under the program. This again raises the question of whether co-payments within the program might be considered as part of an expansion of the scope, as well as the consistency of VHC with other programs such as HACC and care packages.

VHC assessment agencies and service providers would support this option if it were coupled with the capacity for flexible hours. They might consider this option as an important step to address the immediate needs of veterans and to close the gap between VHC and HACC services. The availability of services to meet these expanded needs might, however, create problems for both and may result in veterans, like the rest of the aged care community, needing to wait for services.

The broader community care sector and HACC funding authorities might question the benefit of providing HACC type services under the VHC banner as opposed to contracting those services from HACC providers. The availability of sufficient providers contracted to VHC in regional/rural areas may be a problem. Some in the community care sector would consider it a missed opportunity to do something more substantial and consistent with *The Way Forward.*

Consistency with DVA policy and planning frameworks would be enhanced under this expanded scope option as it would fill gaps currently left to other programs to fill. Veterans would be expected to be in support as it would include enhancements they have been requesting and would still be giving them special consideration as they would have fewer requirements to access other mainstream community care services.

Expanding the scope of VHC would be in line with developments to achieve better national consistency within a life cycle policy framework.

5.6 Option 6 - Maintain scope of VHC but increase service intensity

This option would maintain the current scope of VHC. But the intensity of services provided would be able to be increased as needs increase. There is currently a significant gap in the benchmark service hours provided through VHC and the benchmark hours available for those in receipt of community packages.

The current CACP subsidy rate is $33.97 per day or $237.79 per week. In its report of the Community Aged Care Packages Census 2002, the AIHW (2004, p.23) reported that CACP recipients were provided with an average of 6.1 hours of services a week. This included an average of 2.3 hours of domestic assistance and 2.3 hours of personal care.

The guidelines have provision for up to 6 hours of care per week (1.5 hrs personal care, 0.75 hrs domestic care, and 3.75 hrs of in-home respite)[11]. However a separate approval is made for each of the four service streams and there is no capacity to substitute one with another. The potential hours available under VHC under the current guidelines are equivalent to the average CACP usage per week. Option 6 would allow the full utilisation of up to 6 hours per week by increasing the intensity of services as required by the veteran or war widow and without being constrained by service stream allocation (or blocks). Once a veteran or war widow reached the point of requiring more services, they would transfer to a community package (EACH, CACP etc).

Our summary assessment of this option is set out in Figure 26.

Figure 26 Assessment of Option 6

Criterion	Option 6
Consistency with the research evidence on health outcomes	★★
Consistency with the research evidence on best practice	★★
Projected needs of veterans	★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★
▪ National consistency and life cycle policy framework	★★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★★
▪ VHC assessment agencies	★★
▪ VHC service providers	★★
▪ HACC funding authorities (DoHA and states and territories)	★
▪ Broader community care providers	★

There is limited evidence available from the scientific literature for expanding VHC service intensity, without substantial additional components associated with packages of care including comprehensive assessment, multidisciplinary teams and case management. The scientific literature does not adequately identify the most effective (specific) components of care packages (see the paper by Frich 2003 and the discussion at page140 in Attachment 2) and reflections on current practice suggest that home care requires higher quality cost-effectiveness studies (Wiener et al. 2004). Under this option, only an approach that included routinely collected data with useful outcome measures would be in line with best practice in home care service delivery.

Increasing the intensity of service provision would also require additional funding – whether through direct funding from DVA or increased co-payments from clients. As noted previously in the discussion around Option 4, clients have indicated a willingness to pay additional amounts for improved levels of and flexibility in service provision.

However, the AIHW noted in their report on veterans' use of CACPs that the additional costs associated with accessing CACPs may be a factor in their lower utilisation rates by Gold and White card holders, compared to the general population. VHC clients currently pay on average $5 per visit to a maximum of $10 per week, whereas CACP recipients on a basic pension pay $6.33 per day, and slightly more for those on a higher income.

[11] The guidelines state that 'generally, around 1.5 hours per fortnight is sufficient service to meet most veterans' basic support needs', that low level personal is defined as up to 1.5 hours of services per week, that the maximum amount of home and garden maintenance a veteran can receive is limited to 15 hours of service per financial year and that VHC will pay for respite care up to 196 hours per year.

As with Options 3, 4 and 5, this option would be generally acceptable to veterans who would retain their own program, but with improvements that would increase its acceptability and better respond to their needs as they change over time. Many veterans identified that are starting to require more intensive services they need (see Section 3.6 and Appendix 4) and two thirds of veterans are willing to pay more for them. Comments included:

> *One hour per week for house cleaning is totally insufficient. This needs to be upgraded to at least 2 hours per week to enable the task to be performed properly*
>
> *Assistance with house cleaning has been wonderful from time to time BUT 1.5 hour sessions are USELESS. I would prefer a longer period once a month.*
>
> *I do not think that 2 hours a fortnight for house cleaning is sufficient. We have worked it out that she does one thing properly each time, which means there is never a good hygienic clean, which is not good for older person.*
>
> *Would like more help in home, at a guess 3 hours per week. At 87 years I feel I could stand another 3 hours per week to stay out of Gov. Res.*
>
> *Definitely more respite, ordinary times allowed twice per year would be wonderful.*

This option would have only minimal support from assessment agencies, service providers or the community care sector in that it does not address the scope of services available to veterans. It would have little impact on HACC agencies.

A risk with this strategy to increase service intensity is that the prevailing veteran belief in their 'entitlement' would result in increasing hours being used, without any commensurate benefit to independence, quality of life or better health outcomes. This would not be the case for personal assistance where increased hours would reduce the reliance on other services including VHC in-home respite.

Consistency with DVA policy and planning frameworks would be enhanced under this expanded scope option, as it would fill some gaps that are currently left to other programs to fill. As with Option 5, veterans would be expected to be in support as it would include enhancements they have been requesting and would still be giving them special consideration as they would have fewer requirements to access other mainstream community care services.

Increasing the service intensity of VHC would increase its ability to meet a wider spectrum of veterans' and war widows' needs and be in line with developments expected under the life cycle policy framework.

5.7 Option 7 – Expand both scope and intensity

Under this option, VHC would be re-developed as the total community care provider for veterans, up to the point when the veterans require packaged care. It would continue as an assessment and service provision program.

The design of Option 7 however, might need to carefully consider the relationship between this option and the new post acute packages announced in the 2007-08 Budget. These packages are being managed through the private hospital system. The ability to increase the intensity of VHC services for a limited time in the post-acute period needs to be considered in the light of this new program.

Our summary assessment of this option is set out in Figure 27.

Figure 27 Assessment of Option 7

Criterion	Option 7
Consistency with the research evidence on health outcomes	★★★
Consistency with the research evidence on best practice	★★★
Projected needs of veterans	★★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★
▪ National consistency and life cycle policy framework	★★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★★★
▪ VHC assessment agencies	★★★★
▪ VHC service providers	★★★★
▪ HACC funding authorities (DoHA and states and territories)	★★★
▪ Broader community care providers	★★★

The scientific literature does not adequately identify the specific components of care packages that are most effective in achieving improvements in health outcomes (see Frich 2003 and the discussion at page 111 in Attachment 2). As home care models require high quality cost-effectiveness studies (see Wiener et al. 2004), there is limited evidence available to support the expansion of VHC service intensity and scope under the existing service types.

As with previous options, Option 7 would be generally acceptable to veterans who would retain their own program, but with improvements that would increase its acceptability and capacity to respond to their needs as they change over time. A consistent approach to co-payments would need to be incorporated based on an examination of veterans' willingness to pay more to receive more services.

The option to expand both scope and intensity would have strong support from service providers and assessment agencies as well as the broader community care sector, especially if the program changes were to be well managed in the context of veterans' sense of their 'entitlements' and if there were to be parallel improvements in communication between the assessment agencies and service providers. HACC agencies would support this option in that it would very significantly improve continuity for the veteran. It would have little impact on HACC funding authorities.

Consistency with DVA policy and planning frameworks would be enhanced under this expanded scope and intensity option as, similar to Option 6, it would fill gaps currently left to other programs to fill. Similarly, veterans would be expected to be in support as it would include enhancements they have been requesting and would still be giving them special consideration as they would have fewer requirements to access other mainstream community care services.

Expanding both the scope and intensity of VHC would increase its ability to meet a wider spectrum of veterans' and war widows' needs and be in line with developments expected under the life cycle policy framework.

+++

The following two options go beyond the parameters set by DVA in our initial brief. Under both options, the program would no longer be limited to low level services and veterans with higher needs would not be referred out of the program. We have included these options because of the strong evidence base behind them in terms their ability to achieve improvements in health outcomes and because these types of models were suggested in some key stakeholder

consultations. Further, they solve the current paradox whereby veterans are 'special' when they are low need but not when they are high need.

> "An alternative is to replace targeting - the idea that a client is in or out, eligible or not, with titrated care: generous in its eligibility, but carefully calibrated in the amount of resources actually allocated to a client. High-risk clients would get more care than current practice, to permit more aggressive treatment of their high risks and to take advantage of their high potential to benefit. Low-risk clients would get less care, enough to meet their satisfaction and to monitor their changing conditions, but not so much care that they have little potential to show marginal benefits equal to their marginal care consumption." (Weissert et al. 2003 page 121)

5.8 Option 8 – Redesign VHC to become a community care coordination and brokerage service

The role of VHC under this option would change from being an assessment and service provider to become an assessment, care coordination and brokerage service for a range of community care services. Key features of this option are:

- A single point of contact for veterans requiring community care
- VHC would assess for total community care needs, not just those currently provided by VHC. The first contact with a veteran would be an initial phone screening assessment (as occurs at present) with follow-up home assessments for those who require it.
- Based on either the initial screening or home assessment, veterans would be allocated to a funding band.
- Within the limits of that funding band, VHC would work with the veteran and their carers/family to agree on (and broker if necessary) the optimum mix of services required to maximise independence and quality of life. This function would be equivalent to that currently undertaken by Community Options agencies.

Thus VHC would contract with a network of assessment and case management/brokerage agencies (abbreviated here for convenience as Veterans' Community Options or V-COPs). VHC would not contract with service providers. Rather, V-COPs would be able to broker or purchase services on behalf of the veteran (rather than on behalf of DVA) from whatever agencies (public, non-government or private) can best meet the mutually agreed needs of the veteran. A sub-option that could be carefully tested, at least in some cases, would be for V-COPS to provide 'vouchers' to the veteran for the veteran to use to purchase the services they mutually agree are needed.

V-COPS would be the 'care coordinator' of all veterans receiving VHC services. This would involve:

- Periodically reviewing (re-assessing) the veteran
- Organising any services they need
- Monitoring the services they receive in terms of quality, responsiveness, flexibility and value for money
- Reorganising services and service mix as required.

Care coordination would be provided at different levels, linked to each funding band but with some flexibility around the edges (eg, a veteran might need a lot of services but not a lot of care coordination or vice versa).

Our summary assessment of this option is set out in Figure 28.

Figure 28 Assessment of Option 8

Criterion	Option 8
Consistency with the research evidence on health outcomes	★★★★
Consistency with the research evidence on best practice	★★★★
Projected needs of veterans	★★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★
▪ National consistency and life cycle policy framework	★★★★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★★★
▪ VHC assessment agencies	★★★★★
▪ VHC service providers	★★
▪ HACC funding authorities (DoHA and states and territories)	★★★
▪ Broader community care providers	★★★

The present model is built on a paradox that would at least be partially solved by this option. At present, veterans are 'special' and have access to their own program while they are low need. But once they become high need, they are moved to mainstream services with higher co-payments. Veterans do, however, under the current model, continue to receive the benefit of access to DVA nursing services and respite care in addition to their CACPs.

The worthiness of veterans to be considered 'special' is well supported by the broader community including service providers and assessment agencies. Most of those we consulted believed that this 'special' status should also be accorded to widows. Many are believed to have gone through difficult periods with their veteran spouse and had been crucial in maintaining and supporting their husbands into old age, sometimes well beyond their own capabilities, thereby saving DVA very considerable costs in providing paid support. Carer/spouse support might not be as available or indeed forthcoming, with younger cohorts of veterans. DVA might need to prepare for a generation shift in attitude to ongoing carer support.

Another key reason to include this option is that there is no evidence in support of remote and locally unconnected assessment processes. Various reviews of best practice in linking medical care and community services including practical models for bridging the gaps (Leutz et al. 2003) indicate that approaches that are sensitive local concerns work best:

> On the one hand is the notion that each integration effort has to be implemented locally in a way that is consistent with the particulars of local systems and personnel. On the other hand is the idea that larger polices should facilitate rather than dictate the structure and pace of local action." (Leutz 2005, p. 9)

The practice literature also highlights new trends in models of service delivery such as 'functional enablement', the use of technology and physical activity programs. An innovative model of cooperatively achieving improvements in coordination and streamlining of the processes of home care delivery has been recently developed by the UK-based Care Services Efficiency Delivery Programme (CSED http://www.csed.csip.org.uk/). In particular this model illustrates ways that DVA can build on its e-commerce strengths to add value to local quality assurance, demand management and monitoring systems. The program has the aim to work collaboratively with all councils throughout England supporting them to achieve sustainable efficiency improvements in adult social care.

With movement on implementing the ANAO recommendations the program could keep a similar profile of services, orient them towards a more active model rather than maintenance, and attempt to systematically measure their outcomes. In the literature describing emerging practice in social

care in the UK there is a clear trend that points to home care having potential for reducing demand for social care.

> "This was generally evidenced at an anecdotal level, based on their own observations, and positive feedback from social workers, service users and carers. Many found it was difficult to quantify the impact on demand or any financial benefits because: there were so many variable factors; information had not been gathered systematically for this purpose; and/or they were unable to provide evidenced comparisons with service users who had not experienced re-ablement." (Newbronner 2007, p.27)

Geriatric assessment and care coordination is well supported in the literature (McCusker and Verdon 2006, Johri et al. 2003) and brokerage is well understood from the evidence on achieving positive health outcomes to provide an efficient means of service allocation. The Veterans' Affairs Department in New Zealand runs a similar brokerage model from Wellington and the model would be consistent with team managed primary care services for veterans in the USA, the 're-ablement' services in the UK and case coordination in the community in Canada.

The findings on the value of comprehensive assessment and care plans coordinated on the basis of that broad assessment are also reinforced by examination of the literature on programs for frail elderly people living in the community and at risk of hospitalisation. The key concepts are: service intensity, training of other providers in the community, assessment and monitoring, care planning and management, multi-disciplinary teams, care coordination and evaluation, home visiting, telephone contact, equipment and transport, referral to other providers and volunteer agencies, as well as respite services (see the section on Care Packages in Attachment 2).

The research project underway with Silver Chain (one of the VHC assessment agencies) is an example of the type of research to examine the effectiveness of the model proposed under this option that could be commissioned by DVA. It aims to determine whether a new paradigm for providing home care services achieves better outcomes and is more cost effective than home care as currently provided:

> "The new paradigm is based on the premise that early intervention to optimise functioning and promote healthy ageing can delay or prevent the development of further disability and reduce the subsequent need for home care and other aged care and health services. The new paradigm is operationalised within a service model in which older individuals referred and assessed as eligible for Home and Community Care (HACC) funded home care, are referred to the Home Independence Program (HIP) prior to being provided with "standard" HACC support and maintenance services if they still require them." (Ageing Research Online)
> http://www.aro.gov.au/aro/researchEntryView.do;jsessionid=IANDHEMGAONO?id=2621&type=keyword

Some features of this type of approach are already being tested in a more limited way within DVA. The DVA Community Options Services (COPS) Brokerage project is a fixed term project of targeted brokerage of HACC services, which are not available under the VHC program for VHC eligible DVA Gold and White Card holders through Community Options Services (COPS). This DVA COPS Brokerage project is a partnership between DADHC, DVA, VHC Agencies and COPS with the aim: (1) to assist VHC eligible veterans to access HACC service types, which are not available through VHC. These services include; social-support services, centre-based day care, case management, non-medical transport and home maintenance services through the Home and Community Care (HACC) program; (2) improve the interface between VHC and HACC Programs and build service capacity.

Eligible clients are identified and referred by VHC Agencies as part of the VHC assessment and coordination process and may be clients with non-complex or complex needs. Clients may be referred to COPS for brokerage for single or multiple specified HACC service types. This project has also been extended in its timeline to allow more referrals to be made and more data to be collected. Early indications of the impact of the project that were picked up from the consultation component of the Review are that the aims are being achieved, but that the numbers of referrals are fewer than expected because of the deliberately limited promotion of the initiative in the community care sector.

The key difference between this option and the current pilot is that the pilot is being undertaken within the context of existing assessment systems and processes. Option 8, if adopted, would require that the assessment and brokerage functions are combined and not be undertaken separately as they are in the current pilot. This implies a more sophisticated assessment tool than is being used at present as well as significant system change. Nevertheless, the current pilot can be expected to provide useful lessons in how to move towards this option should DVA wish to do so.

The issue of coordination (and advocacy) is increasingly an issue for veterans themselves (see Section 3.6 and Appendix 4). Comments included:

> *In general there is poor coordination of all services available and they are limited in the hours provided.*
>
> *I had assistance with house cleaning through XXX; unfortunately I had to stop this service as it became too stressful…. I consider this service very badly organised and extremely frustrating and stressful for elderly people - so I just muddle along and do the best I can.*
>
> *My mother resists change and will not discuss the future. My mother needs organised services to support her in staying at home.*
>
> *I do find it difficult that the cleaning organisation is in Victoria and the statement's overlap so you don't know if you are up to date or lagging behind, or are in credit. It is very messy.*

The brokerage concept is relatively complex and not always well understood within the sector and the introduction of this brokerage service option would need to engage assessment agencies and service providers in its development.

A stand alone DVA service which maximises continuity and the substitutability of different service types for the veteran and minimises administrative variation would be supported by HACC agencies. In the context of such significant change the opportunity to develop congruencies between two access points through shared demonstration projects would be welcomed by HACC agencies. It would still be seen as a special service for veterans and be acceptable to the veterans' community.

A community care coordination and brokerage service under VHC would greatly increase its ability to meet the full spectrum of veterans' and war widows' needs and be closely in line with a number of current pilot projects exploring the extension of access to community care for veterans, as well as developments expected under the life cycle policy framework. DVA may, however, want to consider factors associated with equity and consistencies in services available to veterans versus the non-veteran population.

5.9 Option 9 – Redesign VHC and absorb it into a total health and community case management and brokerage service

This option expands on Option 8 above and, like Option 8, goes beyond the parameters set by DVA in our initial brief. Again, we have included it as an option because of the evidence base behind this option, because it was suggested in some key stakeholder consultations and because it would solve the current paradox whereby veterans are 'special' when they are low need but not when they are high need. It is also included as it is a logical extension of the trials currently underway in Queensland and NSW (see below).

In Option 9, the scope would be expanded to include other services funded by DVA, including community nursing, allied health and post-acute care.

A new Veterans' Health and Community Care Options Program (VHCOPS) would be established, bringing together a range of services currently provided by different parts of DVA.

The local medical officer (LMO) would remain as the 'Case Manager' with VHCOPS as the 'Care Coordinator'. The new program would work closely with the LMO to organise and coordinate the required services. As health needs are identified, the LMO would contact VHCOPS who would organise and broker required services. Likewise, hospitals would contact VHCOPS to organise post-discharge services. Referrals for non-health needs would continue to be received from other sources, including self-referral.

Our summary assessment of this option is set out in Figure 29.

Figure 29 Assessment of Option 9

Criterion	Option 9
Consistency with the research evidence on health outcomes	★★★★★
Consistency with the research evidence on best practice	★★★★★
Projected needs of veterans	★★★★★
Consistency with DVA policy and planning frameworks:	
▪ Veterans deserve special consideration	★★★★★
▪ National consistency and life cycle policy framework	★★★★★
Consistency with the perspectives of key stakeholders:	
▪ Veterans	★★★★★
▪ VHC assessment agencies	★★★
▪ VHC service providers	★★★
▪ HACC funding authorities (DoHA and states and territories)	★★★
▪ Broader community care providers	★★★★

This model is well supported in the literature that has reviewed evidence on how to achieve the best health outcomes for the segment of the population most like those currently using VHC, and is consistent with the recommendations made by Johri et al. (2003):

> "To date, the only reform initiatives that have been successfully implemented on a large scale are single-entry point systems with geriatric assessment and case-management, in publicly funded systems of care." (p. 234).

The review outlined the set of common mechanisms to promote integrated care for the elderly:

- Single point of entry
- Breadth of service provision
- Degree of responsibility for patient
- Case management
- Geriatric services
- Multidisciplinary team
- Financing mechanisms
- Physician integration and patient choice

The evidence on best practice models currently operating in community care settings suggests that the elements included under this option would be a locally based single entry point system, geriatric assessment, multi-disciplinary teams and case-management / care coordination; as well

as for early detection and the targeting of services. These are described in the sections in Appendix 2 on the practice and academic literature on service models for the prevention and avoidance of hospitalisation and best practice service models in community care (page 125). In the Canadian case coordination model, nursing, occupational therapy and domestic assistance were found to be the main services used.

The current Brisbane trial is one possible model to consider. The DVA Queensland Coordinated Care Trial provides a coordinated care program for veterans with moderate to high care needs who reside within the GP Partners Ltd's catchment area. The care coordination is undertaken by Service Coordinators who liaise with a veteran participant's Local Medical Officer, nurse and other health care providers who work with each other and the veteran to optimise health care outcomes.

The care coordination is supported by an Electronic Health Record that the veteran's nominated health care providers can access. The model is designed to assist veterans to remain healthy and active in the community. The health outcomes for veterans who participate in the trial will be compared with others outside the program. Evaluation of the outcomes will inform DVA of the benefits and cost effectiveness of care coordination.

Although the pilot was originally scheduled to end on 30 November 2007, early indicators are that the program is producing significant positive benefits. With the final evaluation report due in December 2007, an extension until March 2008 was recently sought from the Repatriation Commission in order to continue the trial in maintenance phase until the evaluation report and recommendations have been fully considered. It is envisaged that after 24 months the evaluation team will be able to evaluate the pilot and the treatment group's outcome on the basis of:

- The cost to the provider;
- The level of satisfaction for the veteran and their LMO; and
- Quality of life measures.

The team will compare the outcomes of the evaluation of the treatment group with the control group by comparing the service utilisation of the two groups over the 24 month period. The final evaluation of that trial could then be used by DVA to consider whether and, if so, how it might best implement such a model.

Irrespective, the concept of graduated levels of care coordination is well established in the literature but has not been routinely established in the Australian context. The idea is illustrated in Figure 30. An expert clinical panel in the Illawarra region developed these four levels. The intention was that frail, older people would move between care coordination levels over time as their needs change. We are not suggesting that these levels and indicative time commitments are correct. Rather, they are included here simply to illustrate the ideas that could be teased out in the current trial.

Figure 30 The concept of graduated levels of care coordination

Care coordination Level 1

- assessment
- assertive management of complex problems within context of multidisciplinary team
- coordination of range of services/programs
- commissioning services/programs
- expected time commitment: 26 hours a quarter (2 hours a week)
- review each 3 months or as needs change

Care coordination Level 2

- assessment
- management and commissioning of services/programs for veterans with less complex problems

- commissioning services/programs
- make referral for assessment when appropriate
- expected time commitment: 8 hours a quarter (45 minutes a week)
- review each 3 months or as needs change

Care coordination Level 3

- purchase of one-off early identification/preventive/information services
- 3 monthly telephone contact with consumer using screening tool.
- make referral for assessment when appropriate
- expected time commitment: 1 hour a quarter
- review each 3 months or as needs change

Care coordination Level 4

- discharge planning
- "hospital in home" coordination
- commissioning services/programs skills
- expected time commitment: 8 hours per discharge, after which the person would move to one of the other care coordination levels
- review after 2 weeks or as indicated by diagnosis

Veterans understand that their need for community care is linked to the state of their health. Many did not see the program distinction that is currently made between community care and health care. Comments included:

> *My health has deteriorated recently due to a heart attack - my experience in getting varying types of assistance to stay in our house is on a learning path.*
>
> *My mother just had cataract surgery; organising nurse to put drops in was difficult. Could be improved. She attends 2 clinics which are good. We will need more help in the future. Can we get home nursing if needed?*
>
> *I think greatly expanded daily nursing services are urgently needed if people are to be cared for at home more - often than the dreaded option of a nursing home.*
>
> *I had worked in aged care so was ok with most services available but unless doctors or nurses advise patients they are not aware of how much help they can get to be able to stay in their own homes.*

In theory, a total, comprehensive and tiered service would gain significant endorsement from assessment agencies, service providers and the broader community care sector. However, all sectors would have reservations about the practical impact of the wide scale adoption of such a model. This option goes well beyond the scale of changes proposed under *The Way Forward,* and a broad range of agencies within and beyond the DVA community would need to be included in the development of the model as part of the change process.

A stand alone DVA service which maximises continuity and the substitutability of different service types for the veteran and minimises administrative variation would be supported by HACC agencies if synergies around access points were developed concurrently. It would still be seen as a special service for veterans and be acceptable to the veterans' community.

A total health and community case management and brokerage service would have the greatest capacity to meet the full spectrum of veterans' and war widows' needs and do so in a way that integrated health and community care services using the unique opportunity afforded by DVA's responsibility for a defined population.

This option would be popular with veterans and be able to build on the expected (based on the literature) outcomes and lessons learned of a number of the current pilot projects on case

management. This ability to integrate health and community care under one coherent framework would be a substantial step towards the changes expected under the life cycle policy framework.

5.10 Comparative assessment of the options for the future of Veterans' Home Care

We noted in our introduction to this section that the options above have different funding implications and would require different lead times. They are not mutually exclusive. For example, it would be possible for DVA to adopt Option 2 or 3 in the short-term (the next one to two years) while undertaking the required transition planning to move toward an option that represents a bigger change.

Not all of the criteria above have equal weighting and, for this reason, it is not simply a matter of adding up the stars to give a total score. Some of the criteria are demonstrably more important than others. We considered weighting the criteria but decided against it. The weighting that should be applied to each criterion is fundamentally a policy issue and not a technical issue. It is thus a decision for DVA and not a decision for us. A further issue is that the legislative implications have not been considered.

In terms of cost considerations, the options have different implications for DVA and for the government as a whole. There is a strong government commitment to meeting the needs of veterans and war widows and there is no evidence that VHC is any more or less cost efficient than equivalent services such as HACC. Whether the future needs of veterans are met by increasing the services provided by DVA or by having those same needs met through other government programs such as HACC or community packages should therefore make little or no difference to whole of government costs.

However, there are clear implications in terms of the level of funding that DVA will require to meet the needs of veterans into the future. Option 1 would result in increased costs for HACC. The HACC program is cost shared between the Australian Government and the states and territories and DVA is already making a contribution to this program through its Deeds of Agreement with the states and territories. The net cost to the Department of Health and Ageing and the states and territories under this option is the difference in the cost of the contribution currently made through Deeds of Agreement and the cost of providing existing VHC services through VHC.

Options 2 to 4 involve administrative and organisational changes within DVA but no expansion of services. As such, the only increase in cost to DVA would be that resulting from increased demand.

Option 5 would result in decreased costs for HACC and presumably involve the cessation of the current Deeds of Agreement. The net cost to DVA under this option is the difference in the cost of the contribution currently made through Deeds of Agreement and the cost of providing a similar range and level of service through VHC in addition to costs resulting from increased demand.

Options 6 and 7 have different cost implications over time. As Section 0 indicates, the projected demand for VHC will peak in around 2010-11 and then start to gradually decline. Prior to the peak, implementation of either of these options would require an increase in funding. Some of that increase would be offset in later years as the population declines.

The cost implications of Options 8 and 9 would depend on the detailed design of the option selected. In particular, the costs vary considerably between models based on graduated levels of assessment and care coordination and models based on a 'one size fits all' approach. Both of these options are based on a graduated model and the actual costs could only be determined through detailed planning, something that is outside our brief.

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In conclusion, it is important to note that we are not recommending a preferred option. This is deliberate. The scope of our Review was limited to VHC and yet most of the options have implications beyond VHC. We are not in a position to fully identify the implications of these options on other parts of DVA or to decide how important each criterion is to DVA. The preferred option/s need/s to be determined by DVA in the context of broader policy and planning considerations. In doing so, DVA (and the government more broadly) needs to decide on what is possible and desirable in both the short and longer term.

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