Benchmarks and Other Approaches to Planning Community Support Services: A Review of International Experience

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Benchmarks and Other Approaches to Planning Community Services: A Review of International Experience

by

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FOREWORD

The research presented here began with an apparently simple question: would it be feasible to establish 'benchmarks' measuring the adequacy of community support services, and if so would devices of this kind be desirable? The experience of other countries was expected to provide practical information about how national standards have been set elsewhere and the way such standards have contributed to the planing process. In the event the question was not so simple, and the consideration of benchmarks led the researchers into examining fundamental issues in community service provision.

Conceptual questions presented themselves about the nature of needs based planning and the meaning of measures of standards such as benchmarks. Both goals and means of community service provision are inherently multidimensional, while adequacy and equity are relative to time, place and social expectation. Conceptual issues are the subject of Chapter Two, in a discussion of the complex relations between needs, resources and planning.

Planning has always to be applied in a particular context, and the researchers have also addressed the question of Australia's planning needs. Chapter Three examines the Home and Community Care program and the particular issues of service planning and monitoring it has raised. The discussion served to clarify the objectives to be served by benchmarks and other planning approaches in the Australian context.

A review of overseas experience soon led the researchers to question the efficacy of centrally determined measures of adequacy and equity in service development. Chapter Four provides a systematic review of the planning modes in operation elsewhere. The discussion covers both planning based on a benchmarks type and approaches developed from other planning concepts.

The authors conclude with a discussion of alternative strategies for the development of planning of community support services. While the issues are fundamental and the discussion wide-ranging, the focus is a practical search for effective planning in Australian community service provision.

Sheila Shaver
Acting Director

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In undertaking this study we were very fortunate in having the assistance, advice and experience of Adrian Webb, Professor of Social Administration at Loughborough University. His contribution is not confined simply to Chaper 2 and the sections of other chapters he wrote, but is evident throughout the final report.

The study was funded by a Research and Development Grant of the Commonwealth Department of Community Services and Health, and the final report owes much to the direction, support, advice and constructive criticism provided by members of the Department. We are very pleased to acknowledge this support, without which this report would not have been written.

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CHAPTER 1

INTRODUCTION

In common with other developed nations, Australia has adopted the principle of community care for vulnerable people who are dependent on others on account of chronic ill health or disability. This principle is based on the premise that such people should be able to continue living in their own homes for as long as possible, moving to residential care only as a last resort. Indeed, research evidence supports the view that most people would prefer to stay in their own homes as long as possible. The principle has been adopted partly on humanitarian grounds, but it is also generally assumed that community care policies will be less costly than residential care. As the size of the elderly population grows both absolutely and proportionally, this must become an increasingly important consideration for government.

The Home and Community Care program (HACC) was introduced in Australia in 1985 as a joint Federal/State cost-shared program to help make this principle a reality for people with disabilities, including frail elderly people. The purpose of this program, which has grown very considerably since its enactment, is to provide support in the form of specific community and domiciliary services for adults with severe to moderate disabilities who live in their own homes. The intention is that these support services should prevent their inappropriate or premature institutionalisation. Because it is recognised that many people depend on informal carers to maintain them in their own homes another feature of the program is the provision of support for these carers, again in the form of specific services. In parallel, eligibility rules for publicly supported residential care have been tightened in an attempt to ensure that people who can manage at home with adequate support will continue to do so.

A key question for policy and planning is the level and kinds of formal support required by dependent people if they are to continue to live at home, and by their carers, many of whom are themselves elderly and potentially at risk, if they are to continue to perform the crucial task of caring. What are the relative costs and under what circumstances does community care cease to be the cheaper option? Is HACC providing enough support, is it providing the right sort of support and is that support appropriately organised to effectively implement the policy of long term care that the HACC program is intended to serve? Answers to these questions are needed not just to enable the planning of services but to establish the cost of an effective program.

This report is an attempt to answer some of these questions. The study on which it is based was commissioned in 1989 by the Australian Department of Community Services and Health which was concerned to obtain advice on the levels and range or kinds of support required and to gain some clarification of the issues that would have an important bearing on this. As the growth of disabled and elderly populations and the principle of community care are both well-nigh universal features of the developed world, the study explores how other countries have dealt with this problem and what lessons Australia can learn from their experience. But because services develop in quite different political, economic and cultural contexts it is also clearly important to ask how relevant the planning methods of other countries are for Australian conditions. One factor that is likely to be relevant is the question of who is responsible for providing services. In Australia, the fact that no single body or organisation is charged with this responsibility is a crucial feature. Here services are provided by a range of bodies and organisations which themselves initiate their provision and maintain a discretionary control over who receives them. The situation in other countries varies considerably (see chapter 4), but typically, as in Australia, there are a number of different bodies involved, from locally based service providers to central government departments. The applicability of any lessons learnt from international experiences is often limited due to historical, constitutional and economic factors, as well as differences in cultural expectations.

In the course of our enquiries it became clear that issues of level, range, mix, organisation and hence costs of services can only sensibly be considered in the light of two central questions. First, what is the nature of the target population the policy is intended to serve? Second, what role does public policy assign to unpaid care? Phrased differently, the cost of community support will clearly depend on who community support is intended for and how far it is proposed to depend upon and support unpaid carers. There is a tendency to assume that carers are a free and flexible resource but, of course, this is by no means necessarily the case.

Before moving on to a more detailed account of the study itself, it should be noted that the international comparative approach taken is only one of a number of possible strategies that could have been employed. In other projects the Australian Government has already begun a serious examination of many of the above issues. For example it is clear that some of the most important questions posed in this study can readily be addressed in the evaluation of Community

Options demonstration projects which should enable us to establish how services can best support highly vulnerable people in the community, with what outcome and at what cost. However, these evaluations will not enable us to forecast the total cost to the community of making each service generally available because we shall not know in what numbers those kinds of people helped by Community Options exist in the community at large. Other research on the demography of disability and the need for assistance in Australia, on the utilisation of existing services, and on the techniques referred to as 'needs based planning' do go someway in filling this gap in our knowledge. The value of the comparative approach is not that it replaces locally based information but that it complements it. As in this country, the rationale for the study of existing programs overseas is that it may prove of benefit by providing home grown examples to emulate as well as lessons to be learnt from the mistakes of others.

BACKGROUND AND METHODS OF THE STUDY

In the light of the above concerns **we were commissioned to examine the feasibility of developing national service provision benchmarks** for the Home and Community Care program in Australia. In order to achieve this broad aim we identified the following as objectives for the study:

a. to examine and critically appraise existing methodologies for the planning of community services;

b. to clarify the conceptual issues involved;

c. to examine, in the light of international experience, the feasibility of implementing national planning guidelines in Australia; and

d. to develop recommendations for establishing and costing the guidelines on a national basis.

In the event, as it was not possible to develop recommendations for establishing and costing service provision guidelines on a national basis, the emphasis in this report has been placed on the first three of the study's objectives.

To achieve the study's aims we studied the provision of community support services in Australia and other comparable countries using a variety of methods, but based largely on the study of published literature, government reports and other relevant documentation. In addition to using materials readily on hand in Australia, information was identified and obtained in a number of ways. These included:

- undertaking an on-line bibliographic search in July 1989 and repeating this in September 1990;
- writing to relevant Government departments and research institutions in 22 countries for information about their planning methods (see Appendix 1);
- contacting colleagues known to us personally;
- conducting in August 1989 a number of interviews with personnel involved in the planning and delivery of services in the UK at all levels of government, with the voluntary sector and with academics; and
- sending a questionnaire to the heads of relevant government departments of 22 countries in September 1990 which sought information on the scope of their services, the existence of benchmarks or planning formulae and the problems and issues associated with the planning and delivery of services in their countries (see Appendix 2).

Despite this extensive effort we cannot claim that the material available provided a totally comprehensive coverage of the topic. There are several reasons for this. In the first place, the response to our requests for information was partial. Secondly, despite the considerable amount of material obtained, the volume of material in this relatively new and rapidly growing field of social policy is overwhelming and it has not proved possible to locate or assimilate all the documentation which we considered to be relevant. Finally, the diversity of topics addressed, the level of detail provided, the recency and quality of the material all varied considerably in what was made available to us. Under

these circumstances we have found it difficult to draw out standardised and comparable information for all countries included.

Fifteen countries replied to our questionnaire, and we appreciated the interest shown. However we are not convinced that the method used to obtain information about the way services are organised yielded sufficiently reliable and valid results to report in detail. In fact the response confirmed our view that a postal questionnaire was inappropriate given the complexity of the area. A short summary of the findings of the survey is provided in Appendix 2.

One further reservation we hold about the approach taken in this study should also be noted at the outset. The field of community services is one which, by its very nature, appears to be dynamic and in a state of almost constant change and development. The material available to us, however, often presented information that did not distinguish sufficiently between policy and practice. Given the highly political character of any resource allocation system, it is also unfortunate that it has not always been possible to distinguish the motives for changes in a system of services. Although there does not seem reason enough to abandon the comparative approach taken in this study, caution is warranted in interpreting the evidence available.

The sparse international comparative literature that exists is a testimony to the difficulties encountered in any attempt to make international comparisons in the area of community services (Kamerman, 1976; Amann, 1980; Little, 1982; Doty, 1989; Cox and Monk, 1989). Indeed, this field presents particular difficulties as the problems of comparison usually encountered in the field of social policy are exacerbated by the absence of a common vocabulary, of comparable measures and definitions, by enormous gaps in the data available and by apparent factual discrepancies in different accounts of the same system. Unquestionably, accounts providing description, analysis and comment on the issues and concerns that are associated with the planning and delivery of services in different countries are far more complete and reliable than quantitative data about these services. The absence of such international comparative data clearly limits the sorts of analyses and comparisons that can be carried out.

The extent of the problems of international comparison in the field of community support services is illustrated by a series of attempts made in Europe over the last decade to develop comparative analyses of aspects of the systems of aged care. A pioneering collection of essays on the subject of 'Open Care for the Elderly in Seven European Countries' was edited by Anton Amann in Vienna in 1980. This collection, written by experts in each of the countries, compared a number of issues in seven different service systems, four in Western and three in Eastern Europe. But despite identifying a common trend towards the development of more extensive systems of community support, the lack of data available at both the local and national levels meant that it was not possible to make any but the broadest of comparisons. Five years later, an official comparative study of aged care policies in countries of the European Economic Community was co-ordinated by the Centre for Working Life in Dublin. Major reports were prepared in each of the participating countries, several of which have proven valuable in our own study. Nevertheless, despite an international research effort many times the size of that we have been able to undertake at the Social Policy Research Centre, the lack of comparative information was again striking, as the final overview report of the project makes clear (Fogarty, 1986).

The history of a third project, undertaken by the European Aged Care Research Project (ACRE) illustrates the extent of problems encountered in an exercise of this sort. Commencing in 1985 ACRE, under the direction of Professor Raymond Illsley and Dr Anne Jamieson, undertook an ambitious study of aged care in nine countries of the European community, emphasising the issue of community support (Illsley, 1987). Considerable governmental and official support has been provided to the project but to date only a limited amount of information from some of the countries has been made available, and even in these cases there are major inconsistencies and gaps in the data available (Jamieson and Illsley, 1990; Jamieson, 1989, 1990). The situation regarding information on the operation of services in North America is, by and large, similar. There, variations in policies as between States in the USA and Provinces in Canada make any large scale comparison difficult (Harrington, Newcomer and Estes, 1985; Kane and Kane, 1985).

Hence, at least on the basis of international comparisons, successful planning formulae in the field of community care remain elusive, despite considerable effort to date. Although community services have been developed throughout the post-war period, often on the basis of much older foundations, the associated research is a more recent development. Expectations of a generalisable quantitative analysis of the needs for, and effectiveness of, various types of community service provision have not been realised. Given these conditions it has been necessary for us to be guided by the material available, drawing our conclusions carefully from the evidence presented in the wide range of material available.

THE ARGUMENT AND OUTLINE OF THE REPORT

There has been cause for concern about whether domiciliary and community services funded by government for people with disabilities, including the elderly, are adequately, appropriately or equitably provided in Australia. Centrally determined benchmarks for service provision have been proposed as a method for overcoming these problems. Benchmarks, it has been proposed, would stipulate a nationally standardised level of service provision in order that the services delivered at a local level would be adequate to meet needs for assistance.

Our reading of the literature has led us to conclude that such benchmarks are unlikely to provide a long term solution to problems of service planning and provision. This is not to deny the crucial importance of planning for the delivery of services, but rather to suggest that we are not in a position to confidently develop funding formulae which would facilitate the optimal long term development of community services in such a way as to would enable service provision to match developments in the need for domestic support. In addition we see two other problems associated with the use of benchmarks. First, although there is currently a variety of 'needs indicators' used for the purposes of planning, there is no evidence in this field that they provide valid measures of need. Nor do they take into account the complexities of need or its changing character. Second, there is considerable danger that such benchmarks will impose rigidities upon the developmental process when all the evidence points to the needs for flexibility and a responsiveness to local circumstances. Stability and a high degree of certainty are essential ingredients for the good planning and delivery of services. The seductiveness of benchmarks is that they would provide such certainty. However the danger in such a strategy is that benchmarks would entrench a particular approach to service provision when the state of our knowledge about the needs for assistance and the optimal ways of satisfying these needs remains so contentious and the existing means of providing assistance are so varied across Australia.

An example may help to clarify these issues. There is at present no universally recognised requirement for the frequency of personal bathing, nor is there any legal or professional standard for the level of skill, training and experience required by someone who provides assistance in this matter, nor any consensus on the most effective way to organise assistance to an individual who needs help with bathing. When allocating services, then, should there be a national standard which says that clients should be bathed daily, five times a week? Should the standard be seven times a week? Or is once a week, or even once a month sufficient? Do some people suffering from incontinence require bathing more frequently that daily? Is this purely a matter of personal preference, or does this depend on medical, hygienic or other considerations? What sort of skills are needed for this work? Is it necessary for a person to be a qualified nurse, or can a paid domestic assistant or an unpaid carer be entrusted with the performance of the task? Should personal preferences be entertained, or is this sort of matter best settled by decree? Equally telling questions could be asked of other types of domiciliary services provided in Australia through the HACC program. When considerations of quality of life are introduced over and above mere survival, there is always room to debate standards.

We see a further danger of benchmarks: that their development and implementation would divert attention from the key problems of service organisation and delivery which in turn have a profound effect on access. In this regard, recent interest in Australia in the case management and service brokerage approach (as employed by Community Options and Community Linkages projects) recognises and attempts to cut through many of the inadequacies of the standard provision of HACC services in Australia, as elsewhere (Dant and Gearing, 1990). Indeed it appears that the way services are provided can be as important as their amount.

Given these considerations, we believe that the introduction of short to medium term targets for service provision, in which objectives are well articulated and in which review is built into the process, represents a more appropriate response to the problems of planning, resource allocation and service delivery than does the establishment of benchmarks.

A more detailed discussion of many of the theoretical and conceptual issues involved in the approach adopted in this study is presented in Chapter 2. Here a model of the 'production process of community services' is introduced which makes explicit the links between the need for assistance, the allocation of resources, the nature of the subsequent intervention and the outcomes that are the result of the process of providing a formal community service to meet a particular need. It is argued that effective service planning can not simply be reduced to a consideration of the extent of the need for assistance. It must also take into account the effectiveness and efficiency of the service. Consequently contextual factors, as well as features inherent in the operation of a system of services are significant influences on the need for and operation of services which must also be taken into account in developing resource allocation mechanisms. This chapter, which sets out in a systematic manner many of the ideas underlying the subsequent

chapters of this report, was largely written by Adrian Webb, Professor of Social Administration at Loughborough University, in England, during his visit to the SPRC in September 1990.

In Chapters 3 and 4 we look at issues concerned with planning and the actual provision of services in Australia and overseas, respectively. In Chapter 3, we examine the development of the Home and Community Care program in Australia in the light of its origins and stated aims, drawing attention to a number of problems inherent in the planning and implementation of a national system of community support services. The structure of services provided under the HACC program, it will be shown, varies considerably between and within the different States. In addition, the complex organisational arrangements, the mix of state and local government and non-government providing organisation and the more general difficulties associated with identifying the outcomes of home support services, present a situation in which the introduction of a basic national planning mechanism has considerable appeal as a means of ensuring the equity and the longer term viability of the program.

The evidence of the overseas experience of community service provision presented in Chapter 4 does not, however, favour the use of centrally determined benchmarks for such goals. We analyse attempts in New Zealand, the Netherlands and the United Kingdom to employ service provision benchmarks in this chapter, and point to features that appear to be associated with their eventual abandonment in two of these three cases. In this chapter a number of organisational and other issues that have shaped the planning of services overseas are also highlighted. It is clear that the success of any planning process is dependent on an understanding of both the way in which services are affected by external factors associated with the particular context in which they develop, as well as by internal factors which directly affect the way they operate.

Drawing on the overseas evidence outlined in Chapter 4, Chapter 5 describes some of the alternative strategies used in the development of planning of community support services. We provide a number of detailed case studies and outline an approach which could be used for the development of planning strategies likely to be successful in the Australian context. Finally, in Chapter 6 we summarise our general conclusions and provide recommendations concerning the feasibility and desirability of benchmarks for the HACC program.

This report also includes a reference list of all cited reports, articles, books and documentation. A separate annotated bibliography of other relevant material which we would recommend to readers wishing to pursue issues raised in this study, has been compiled by Lynn Sitsky to accompany the report.

CHAPTER 2

BENCHMARKS AND NEEDS BASED PLANNING: SOME CONCEPTUAL ISSUES

1. WHAT IS A BENCHMARK?

In common with many other terms used in the field of social planning, the concept of a benchmark has no fixed and invariable meaning. But if terms are defined and re-defined by everyone and anyone who utter them we are 'through the looking glass' with Alice and in danger of heaping confusion upon mere complexity. The term benchmark can mean what we want it to, within reason, but in this context it ought to mean approximately the same thing to everyone.

For us, a benchmark implies a standard, a norm, a target, used in the planning and development of a system of services. Its use as a planning concept which concerns the allocation of resources for a given population is essentially a statement of what is to be attained or moved towards. It is therefore the product of a **judgement**: it is **approved** in some way and it is this approval which gives it validity.

In the field of health and community service provision in Australia, the term benchmark, in recent years, has been commonly used to describe a standard level of provision, fixed for the long term, which would stipulate an amount of services adequate to meet the need for assistance. But the term benchmark may also be used to designate a more temporary goal. This distinction may be obvious but it is important. As we note in Chapter 4, benchmarks can be almost more trouble than they are worth if they are thought of simply as fixed and rigid goals. Rather, we argue, if benchmarks for community services are seen as goal posts, to mix the metaphor, they should be seen as goal posts which are **meant** to be moved as circumstances change.

Above all, what is essential in planning community services is flexibility and a commitment to the process of checking where we are going and how effectively we are getting there - in the clear knowledge that we will never actually arrive because circumstances, expectations and therefore our chosen destination are subject to frequent change. Benchmarks may be useful in so far as they facilitate this process; they will be harmful if they become rigid goals in themselves.

2. BENCHMARKS IN AUSTRALIAN PLANNING

By comparison with some social welfare systems, the **Australian** approach to planning has not relied to any extent on the systematic use of benchmarks. But they do exist. One obvious and relevant example is to be found in the field of residential care where the aim is to **reduce** the supply of residential care places to 100 per 1000 of the population over 70 years of age and, **within that figure**, to strike a balance of four nursing home places to every six hostel places (DCS, 1986). This simple example well illustrates the essentially transient and conditional nature of a benchmark. It seemed clear by the mid-1980s that aged care in Australia had become overly dependent on the provision of nursing home care and that change was needed. But it is not at all apparent that 100 places per thousand is an appropriate long-term goal; it is a useful checkpoint along the route of desired change. As such, it is unsurprisingly and quite reasonably a compromise figure which reflects political and professional judgements. Benchmarks are not and cannot be the product of an exact science. They are the result of exercising judgement and **not** a substitute for such judgement.

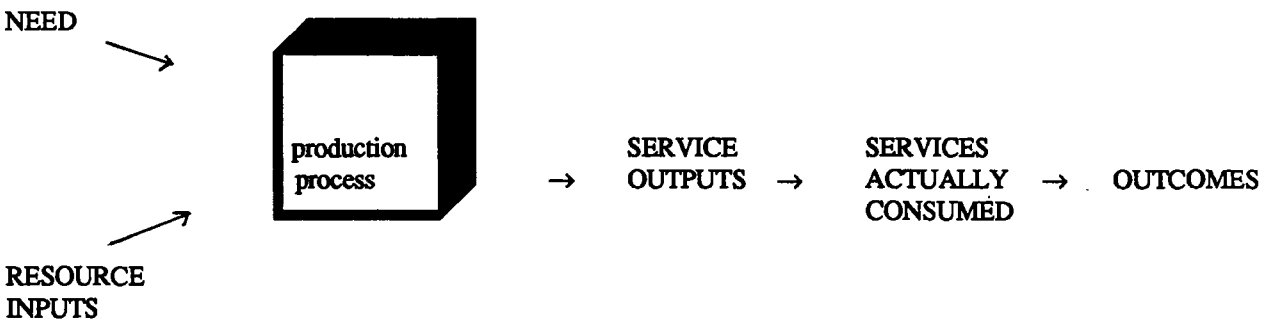
Interestingly, this example also illustrates other key features of benchmarks which are drawn out more carefully and in some detail below. The benchmark of 100 residential places for each 1000 people aged over seventy arose from a realisation that **by comparison** with international standards, Australia was over provided for in the nursing home field. It also reflects some sense of the appropriate **balance** between alternative forms of residential care: nursing homes and hostels. Thirdly, it reflects ideas about **cost and the cost effective use of resources.** Residential care is internationally believed to be a comparatively costly strategy (though this is by no means as clear cut or simple a judgement to make as is often implied) and community alternatives are almost universally emphasised. Finally, it should be noted that although the benchmark for residential care inevitably assumes the character of a long term standard as a result of the time span required for significant changes in the mix of provisions in this field, it does not

represent a final or ultimate standard. The *Nursing Homes and Hostels Review* of 1986 set out a twenty year scheme for reform which would not require a crash building program and the mass relocation of nursing home residents to hostels. Instead the benchmark was to be achieved largely as a result of the more gradual construction of new hostels and the demographic process of an increase in the number of aged people over this longer period (DCS, 1986: 47).

3. WHAT KINDS OF BENCHMARKS ARE THERE?

Although our interest is in benchmarks appropriate to needs based planning, it is worth noting other possibilities. A helpful way of thinking of community support services is as a 'production process' ranging from need to outcomes (see Figure 2.1).

Figure 2.1 The production process of community services



Benchmarks may be established in terms of each and every component within this production process model. They may also be specified for the administrative and professional processes which constitute the 'black box' of service production, for example, that all cases should be processed and allocated to a responsible worker within 3 days of initial contact or referral.

If benchmarks can be specified throughout the production process, they can also be deployed for a variety of different reasons. Illustratively rather than exhaustively, they can be identified in order to specify:

a. **levels of need** to be met (e.g. no-one who needs assistance to bathe to be without access to a formal personal care assistant);

b. **levels of resources** (e.g. total expenditure of X dollars per head of population, or Y number of community nurses per 1000 of the elderly population);

c. **equity** in the allocation of resources (e.g. between States, localities, client groups);

d. the **level, range and mix of services outputs** to be provided in general, or to be delivered to people with particular clusters of needs (e.g. home care supported by regular access to respite care);

e. the level, range and mix of **services actually received and consumed** by target populations (e.g. all aids to mobility to be appropriate and acceptable to the recipient and therefore actually used by them);

f. levels of **outcome and effectiveness** to be achieved by services (e.g. the percentage of people aged over 70 years suffering strokes to be reduced by 10% within 5 years); and

g. **levels and ranges of costs** (per unit of output) **and cost effectiveness** (e.g. an expenditure limit of Z dollars per person assisted, expressed as a proportion of the cost of an alternative care in a nursing home).

These uses of benchmarks can embrace the full range of planning activities, from the most strategic to the planning of individual packages of care for people with particular bundles of needs. They can be relevant at the level of national guidance as well as in implementing local changes at field level. Most of the uses specified above are straightforward enough but they warrant some words of explanation.

The underlying purpose in the case of **need related benchmarks** is almost universally to increase or improve the level of provision over time. **Resource input benchmarks** are also about the setting of a level, but they frequently specify a maximum or even a reduced level of resource use.

Territorial justice - the pursuit of equity between and within sub-national territories or areas of government - has been a preoccupation in many countries in recent decades. Resource input benchmarks have been typically used to specify a defined movement towards greater territorial justice, but other types can be used (e.g. outcome measures such as perinatal mortality).

Simple benchmarks of level of service can obviously be useful, but the field of community service provision is characterised by a high degree of complementarity and substitutability between services. For example day care, respite care and domiciliary services complement each other and in some cases provide a substitute for residential care. Typically, therefore, policy has been directed at expanding the **range** and altering the **mix** of services rather than merely increasing the **level** of provisions. Benchmarks can be used, in principle, to specify a **preferred service model** (specifying range and mix) as well as level. However, difficulties can arise in practice, as we shall note later.

Social policy remains a comparatively recent area of systematic human endeavour and much social welfare provision has been underpinned by rudimentary analytical and planning processes, at best. The social fervour and proper high mindedness which have often spurred development in services have left little room for careful evaluation of effectiveness. The emphasis has been on achieving growth in resources rather than on assessing and improving performance. However, in the current circumstances of resource constraint the desire to improve performance highlights additional types of benchmarks which are likely to be even more important in the future than in the past. One concerns program effectiveness; the other concerns unit cost or, preferably, cost effectiveness.

Effectiveness is essentially a matter of outcomes: any service is only as good as the changes achieved in the state, condition or well being of the individuals using the service. Some human services outcomes are readily measurable, but most are not. In particular, the outcomes of community services are notably difficult to capture through routine administrative statistics because they include such factors as the morale and psychological well being of vulnerable people and their carers. The multidimensional, subjective and partly indeterminate nature of these outcomes means that bespoke empirical research, rather than routine statistics, is needed to monitor them. Inevitably, therefore, assessing the **effectiveness** of service provision frequently becomes a matter of accepting the second best; of measuring service **outputs** rather than **outcomes**. **Service output** and **resource input benchmarks** have their place, providing these limitations are kept firmly in mind.

The same must be said of unit cost and cost effectiveness measures. Unit costs mean little, and can be dangerously misleading, if taken in isolation. Low cost products are of no merit whatever if they are ineffective or inappropriate products. Unfortunately, true cost effectiveness benchmarks are exceedingly difficult to develop precisely because defining and measuring effectiveness is so problematic. Many attempts to measure and compare the cost effectiveness of different forms of service have been forced to make **assumptions** about comparative effectiveness - not least the assumption that effectiveness does not vary greatly and that unit costs can therefore be directly compared. Notwithstanding these caveats, **the production of cost effectiveness benchmarks must remain a primary goal of planning**. Anything other than the most cost-effective use of inevitably scarce resources will result in social injustice; to waste resources is to needlessly deprive those at the margins of our welfare systems. The pursuit of cost effectiveness (which is not to be confused with the arbitrary compression of unit costs or total expenditure) should be intrinsic to the pursuit of social justice and not a mere exercise in managerialism.

4. PLANNING SERVICES AND THE PROBLEM OF NEED

Planning community services based directly on measures of need may seem at first glance to be the most logical approach to service development. However it can be seen that this is not necessarily the case. What are commonly thought of, and used as, measures of the need for assistance are often measures of the expected outcome, of service output and, especially, resource inputs. This is because need is a slippery concept and because in practice we have to use readily measurable statistical indicators as a proxy for 'real need'.

As Webb has noted: 'Various writers have tried to contain the gelatinous idea of need within a neat and pleasing intellectual mould, but it has the habit of flopping all over the place once the back is turned' (Charles and Webb, 1986: 12). The basic problem is that need is a **contested concept**. One reason for talking of need is to press a case for that which is not presently acceptable (e.g. the 'need' for a social wage for house bound mothers); need is therefore the currency of political persuasion. At the same time, we attempt to use it as a precise means of making fine allocative judgements within political, professional and administrative decision-making.

The concept of need is therefore used in different contexts, but it is also used with different degrees of specificity. This is well illustrated by juxtaposing two definitions of need offered by Knapp: 'need is said to exist when the there is the potential for improving the well-being of the individual' and 'need is a normative, social cost-benefit judgement about priorities in the allocation of resources' (Knapp, 1984; cited in Charles and Webb, 1986: 12).

The first of these draws attention in a very general way indeed to the possibility of doing something to create a better state of affairs, the second emphasizes the importance of specific judgements about **priorities for action**. In between lies a progression from need as a statement about 'social ills' to need as a statement of the required social action or solution. This progression in turn rests upon **theories** which may be far from explicit but which are none the less crucial: 'theories about social problems' and 'theories about solutions'. The fact that these theories are often implicit, ill developed and contentious helps explain why statements about need take a bewildering variety of forms.

Consider an example. Ideally, our understanding of social isolation and loneliness among elderly people would generate a smooth progression of statements: from vague ideas about the nature and size of a problem (social isolation as need); to more precise ideas about causes (death of spouse or partner); to even more precise ideas about causes (death of spouse, physical frailty, desolation and loss of morale as causes); to specific ideas about solutions (day care), or packages of solutions (day care, visiting services, occupational therapy, social work support, community transport services). Knapp's final definition of need implies all of this - and more. Unfortunately the real world rarely permits or produces such rational progressions from problem to policy - which is why his definition tends to imply too much.

Elsewhere, Webb has argued:

> *In reality, it is not uncommon to have needs, stated in terms of problems, about which there is no consensus of opinion concerning solutions (e.g. poverty); it is also not uncommon to have needs, stated in terms of solutions, about which there is no consensus concerning the nature of the problem (e.g. the 'need' for meals-on-wheels). Politics and policy-making processes play ducks and drakes with logical processes, academic distinctions and concise definitions.*
>
> *One of the most popular typologies of need recognises this by specifying four different 'types' of need. Bradshaw identified:*
>
> ***felt need** (that experienced by the individual);*
>
> ***expressed need** (actual demand for help);*
>
> ***normative need** (that recognised and expressed by professionals and experts); and*
>
> ***comparative need** (that revealed by comparing people with similar problems but with different forms of help and support).*

> *The typology is valuable because it identifies groups of people who may play a part in defining need and who may well offer different definitions. It recognises that any authoritive statement on need, such as that which is presumed in Knapp's final definition, is likely to be preceded by negotiation or conflict between divergent interests. Consumers, professionals, other experts such as policy advisers, administrators, politicians and the general public all have claim to a voice. But that does not mean that we can recognise four different types of need; it means that different ideas of need may be fed into a variety of different processes by which authoritive decisions are made about whether to help people who have problems.* (Charles and Webb, 1986: 13-14)

Measures of the need for services may take many forms precisely because the concept of need is itself used in a variety of ways. If we could always specify social ills precisely and simply without reference to possible solutions, clear need related benchmarks could follow suit. In practice, however, it is much easier to speak of a 'need for home care' or a 'need for day care' than to specify each and every problem to which home care and day care are a response, such as social isolation, loneliness, dementia, loss of morale, depression, pressure on carers, the maintenance of independence, and so forth. It must be accepted therefore that planning to meet needs will more often involve the use of resource input or service output targets, than direct measures of 'real, primary need'. Nonetheless, this tendency of need related benchmarks to take different forms must give us pause for thought. It is all too easy to fall into the habit of setting targets for better service production (e.g. more home care) without stopping to ask precisely **what** primary needs are supposed to be met by home care and whether in practice they are being met. If benchmarks obscure the need for **policy analysis** they will almost certainly prove to be substitutes for informed decision making rather than a means of implementing decisions.

5. NEED AS A FUNCTION OF SUPPLY

Using the concept of need to plan services presents a further complication to which we have alluded but which should be made explicit. It concerns the very way that need is understood and conceptualised. Should our definitions of need be independent of resource considerations, or can they only be meaningful if they take resources into account? And, depending on how this question is answered, what are the implications for planning service interventions?

Leaving aside the wealth of academic debate which can revolve around this question, there are obvious practical issues of policy and administration which hinge on the answer. It would be very convenient if needs could be assessed in an objective way, independently of resource considerations, and fed into the 'front end' of the social welfare production model and decision-making process. Resource decisions could then be made in the light of assessed needs and in the knowledge of how much need could be met by each dollar of expenditure. However, many commentators would argue that need is, in essence, relative, that it reflects society's capacity to mobilise resources and that definitions of need must reflect resource availability.

There is no need to become bogged down in this intellectual problem if we make the simple distinction between **conceptualising** need and **operationalising** it. When conceptualising and measuring need we may choose to favour absolute notions of need (food is essential to life and dietary minima are essential to good health) or relative ones (to be poor is to have an income below a given percentage of the average income available to people in society). Both ways of conceptualising need are valid and one or the other is to be preferred depending upon the circumstances and the purpose in mind.

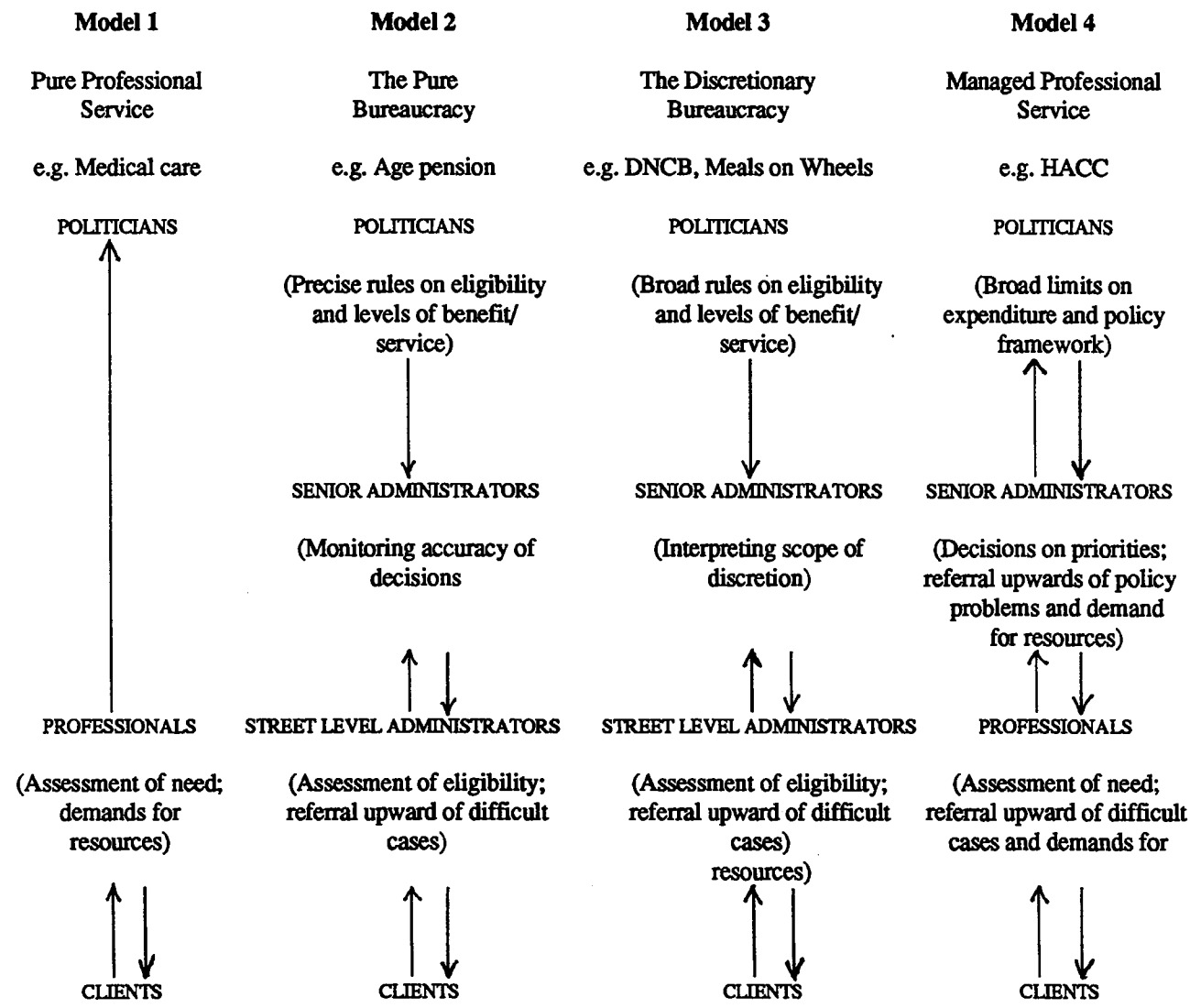
However, when we seek to operationalise need as a basis for social action it becomes essential to define need with at least one eye on the likely availability of resources. The closer we move towards specific decisions to meet a need, the more directly we must locate discussion of the need within resource constraints. Not to do so would simply be to risk discrediting the need definition and the operational goals based upon it. This is particularly so in the case of needs which lie close to the margins of current priorities. For example, support for the carers of frail elderly people has in practice been specified in quite modest terms for operational purposes in the HACC program even though radical changes - and need definitions - may seem to be appropriate.

What does this mean for benchmarks in need related planning? The social reformer who wishes to put pressure on the political process and influence the political agenda can afford to conceptualise need in general - possibly absolute -

terms without relating it precisely to resource availability. However, the planner who wishes to shape discrete decisions in the short to medium term must select operational definitions of need which are realistic in terms of the resources likely to be available. Benchmarks may take **both** forms. They may be ambitious targets to be aimed at in a general way over the long term or they may be reasonably realistic and attainable targets for the short to medium term. A mixture of both may be useful, but the latter are likely to predominate. For the most part, therefore, **needs based benchmarks are likely to be useful for planning purposes precisely because they reflect a careful judgement about the needs which could and should be met in the foreseeable future within explicit resources assumptions.**

This begs the question of how need judgements are to be located within resource considerations. The processes by which this happens and the type of actors involved in these processes vary by type of social provision. The types of control over the distribution of resources also varies accordingly. This can be illustrated by considering Webb's simple categorisation of how needs and resources are brought into balance in the provision of a number of different types of assistance (see Figure 2.2).

FIGURE 2.2: MODELS OF RESOURCE ALLOCATION



Source: Charles and Webb, 1986: 127.

If resources were no object, need could simply be recognised and referred up to politicians who would allocate the resources without any attempt to ration or constrain supply. This would be a pure need-led 'bottom-up' process (Model 1, Figure 2.2). Some aspects of health care provision in Australia and elsewhere come close to this model for a number of reasons: because health is a very high priority socially and politically; because doctors have successfully claimed historically that they could and should be the only people to define medical need; and because there used to be a naive tendency to assume that health needs were finite. Experience has proved just how rapidly health needs are re-defined and some form of supply led planning and rationing of resources has been imposed in even the most open ended health care systems. Compared with this 'bottom up' process of balancing need and supply, income maintenance services tend universally to be of the 'top down' variety (Model 2, Figure 2.2). Total expenditure may not be limited but the balancing of need and supply is enshrined in key political decisions about eligibility rules and levels of benefit. In simple 'bottom up' service systems, therefore, professional decisions are key and in 'top down' systems political decisions are key.

Community services are typically provided through hybrid decisional systems (Models 3 and 4, Figure 2.2). Professional staff or administrators exercise discretion in recognising need at the grass roots level, but total expenditure is far from open ended and, in line with an international move to greater supply side planning in recent years, is likely to be explicitly capped in some way. The reconciliation of these 'top down' and 'bottom up' forces ought to be achieved by strategic planning and priority setting at one or more levels in the administrative system. This is precisely the context in which benchmarks have greatest relevance and they can be chosen by and designed to guide decision makers at each level: the political, the strategic planning/managerial, and the professional/field level.

SUMMARY

In summary, benchmarks in needs-related planning within the community services are most likely to be effective when they are:

- statements of short to medium term targets or guide posts;
- statements of needs likely to be able to be met within realistic resource assumptions;
- statements expressed in terms of primary needs, but also in terms of resource input and service output targets;
- statements designed to influence or prescribe the behaviour of any or all of the different types of key decision makers (politicians, managers, field staff) at any or all of the principal levels of decision making.

In the following chapter we examine the development and structure of the HACC program in some detail and discuss some of the problems confronting policy makers and planners concerned with the program's continued development.

CHAPTER 3

THE HOME AND COMMUNITY CARE PROGRAM IN AUSTRALIA

1. INTRODUCTION

From its introduction in 1985, the Home and Community Care program (HACC) marked an important development in the provision of support to elderly people and younger people with disabilities in Australia. The program aimed to establish a national system of community services to assist in maintaining in their own homes people with moderate or severe disabilities who need ongoing personal support, to prevent what the program's guidelines call their 'premature or inappropriate admission to long term residential care' and enhance their 'independence, security and quality of life' (HACC, 1988: 22). For 'frail aged' people, the HACC program was established to provide services at home as an alternative to institutional care provided in nursing homes and hostels. For 'younger people with disabilities' the program was intended to complement provisions of other community based programs, in particular those established under the Disability Services Act, 1986 (DCS, 1986; Hardwick, et al, 1988; HACC Review, 1989).

In this chapter we give a brief account of the introduction of the HACC program which highlights some of the more fundamental planning issues associated with this type of program. First, we review the circumstances surrounding the program's introduction to draw attention to factors affecting the capacity of the HACC program to allocate resources to its client group on the basis of need. Then, we examine a number of the more general or generic difficulties encountered in the planning of community support services for people with disabilities, including disabled aged people. The final section of the chapter highlights problems specific to the Australian context of the Home and Community Care program.

2. THE INTRODUCTION OF THE HOME AND COMMUNITY CARE PROGRAM

Despite the innovative nature of the HACC program, many of the services actually provided under the program have a long history as locally based community service or charitable initiatives. Direct Commonwealth government support for domiciliary and community based services commenced in the mid-1950s. Home Nursing was the first major service to receive direct Commonwealth funding, benefiting from the enactment of the **Home Nursing Subsidy Act** of 1956. Some years later there were a series of further initiatives in the field: the **States Grants (Paramedical Services) Act 1969,** providing a small amount of funds which enabled people in some States to receive services such as podiatry, physiotherapy and speech therapy; the **States Grants (Home Care) Act 1969,** which provided funding for housekeeper services and general domestic assistance in the home as well as for the establishment of Senior Citizens Centres; and the **Delivered Meals Subsidy Act 1970** which established Federally funded Meals-on-Wheels projects across Australia (Brennan, 1984; Sax, 1985; Auditor-General, 1988).

Direct Commonwealth subsidy of these services was introduced at the time for the purpose of:

- providing appropriate supportive service primarily to aged people to enable them to remain in their own homes as long as possible;
- fostering co-operation between governments and encouraging community effort in providing services for the aged;
- providing opportunities for advice on and co-ordination of welfare services at the local level. (The purpose of the States Grants Home Care Act, 1969, as cited in McLeay, 1982: 7)

Certain other locally based support services, including information centres and day care centres, also developed through the years with the support of other sources of subsidy in a few regions, especially following the introduction of the Australian Assistance Plan (AAP) and the Community Health Program in the 1970s.

TABLE 3.1: THE PROVISION OF HOME HELP SERVICES IN SELECTED COUNTRIES, 1976-1977

Selected Countries	Total Population (thousands)	Number Home Helpers	Ratio per 100,000 Population	Number Work Hours (thousands)	Ratio Per 1,000 Population
			December 1976		
Australia*	12,500	60,000	21.97	-	-
Austria	7,525	340	4.5	-	-
Belgium	9,957	8,661	87.0	9,934	998.0
Canada	22,000	3,290	15.0	4,110	510.0
Finland	4,500	6,073	135.0	8,115	1,800.0
France	50,000	7,144	14.3	-	-
West Germany	60,000	12,685	22.0	-	-
Great Britain	49,000	129,724	265.0	-	-
Israel	3,300	350	10.6	300	91.0
Italy	54,000	50	0.1	-	-
Japan	111,934	8,706	7.7	-	-
Netherlands	13,800	82,700	599.0	68,765	5,000.0
Norway	3,988	33,478	840.0	38,135	9,560.0
Sweden	8,200	75,900	923.0	59,000	7,170.0
Switzerland	6,000	2,505	41.7	-	-
USA	209,000	60,000	28.7	-	-
			December 1977		
Australia*	750	108	14.0	818	11.8
Austria	-	-	-	-	-
Belgium	9,823	9,953	101.0	11,404	1,161.0
Canada	-	-	-	-	-
Finland	4,700	6,943	148.0	9,822	2,089.8
France	53,000	51,062	96.0	32,996	622.5
West Germany	-	-	-	-	-
Great Britain	-	-	-	-	-
Israel	3,500	500	14.0	380	108.5
Italy	-	-	-	-	-
Japan	115,276	11,369	9.8	25,924	217.0
Netherlands	13,500	101,057	748.0	55,924	4,143.0
Norway	4,051	41,184	948.0**	-	-
Sweden	8,200	77,550	946.0	50,700	6,183.0
Switzerland	6,000	3,760	63.0	-	-
USA	-	-	-	-	-

* Figures for 1977 are for West Australia only. 1976 figures may include part-time staff.

** All but 2,343 of the workers are part-time.

Source: Little, 1982: 92. Adapted from International Council of Home Help Services, Utrecht, Holland.

In the field of aged care, a number of national inquiries in the late 1970s and early 80s pointed out that one of the results of the post-war underdevelopment of community support service, was that the level of assistance available to people needing help to remain at home was inadequate, leaving them with little choice other than to rely upon nursing home care (Social Welfare Commission, 1975; Holmes, 1977; Auditor-General, 1981; McLeay, 1982; Giles, 1984). Further, the provision of services varied considerably from State to State and between different localities within the one State.

The McLeay Report of 1982 summarised the situation as follows:

> *A feature of the domiciliary sector is its disorganisation. ... The situation reflects competing priorities, with individual organisations all attempting to maximise their share of the resources available. ... it is apparent that there are marked regional variations in the services available, and in many areas there are few service options available.*
>
> *In summary, it is apparent that many of the problems in the home care area arise from the fragmented yet restrictive programs under which various services are provided.* (McLeay, 1982: 84, 93)

Criticisms concerned not only the organisation of domiciliary services, but the amount of assistance provided. The Australian Council of the Ageing, for example, argued that:

> *Once established there appears to have been few attempts at systematic monitoring of services to establish levels of effectiveness and efficiency in relation to clearly defined goals. This has led to haphazard development that is patchy in coverage and often dictated by needs other than those of the supposed beneficiaries, i.e., the aged.* (Cited in McLeay, 1982: 4)

Evidence from a comparative international perspective appeared to confirm that in this respect too, the Australian system was wanting. In an international comparison made of Home Help services in the late 1970s, for example, it was found that there were 22 home helpers per 100,000 population in Australia, compared with 265 in Great Britain and 900 in Scandinavian countries (See Table 3.1; Little, 1982; cited in Healy, 1990: 130). The lack of adequate community and domiciliary services, it was argued, was a major factor in the rapid and disproportionate growth in the numbers of nursing home beds in this country in the 1960s and 70s.

Established by the Commonwealth **Home and Community Care Act 1985,** the HACC program has attempted to build upon the existing foundations of community support services, as well as to introduce a more rational and equitable basis into the future development of services. The Act authorised the Federal Minister for Community Services to establish an Agreement with each State in order to give effect to the program. These Agreements were negotiated and signed in 1985 and 1986 (Auditor-General, 1988). Details of the expenditure under the program in the years 1985 are presented in table 3.2 below.

The HACC program is primarily a funding system through which the Commonwealth and State governments jointly sponsor a range of non-profit agencies to provide domiciliary services. Services listed as eligible are:

> *home help or personal care (or both), home maintenance or modification (or both), food, community respite care, transport, a community paramedical service, community nursing (which may include personal care), assessment or referral (or both) education or training for service providers and users (or both) information, co-ordination and such other service as is agreed upon by the Commonwealth Minister and the State Minister.* (HACC, 1988: 7)

The range, extent and total cost of services provided under the program is indicated in Tables 3.3 and 3.4 (below). Some caution should be exercised in interpreting these figures, however, as there have been some data collection problems associated with the monitoring of the program to date.

TABLE 3.2: GROWTH IN EXPENDITURE ON THE HACC PROGRAM 1985-1991.

Financial Year	States $m	Commonwealth $m	Total $m	Commonwealth Share of total %
1984-85	74.2	78.1	152.3	51.3
1985-86	91.5	100.9	192.4	52.4
1986-87	104.0	135.4	239.4	56.6
1987-88	125.8	169.4	295.2	57.4
1988-89	145.3	205.1	350.4	58.5
1989-90	165.7	241.8	407.5	59.3
1990-91(est)	n.a.	282.9	477.1*	59.3*

Note: This table presents actual expenditure, including Commonwealth unmatched money and planning and development, but excluding running costs, up to the year 1989-90. For 1990-91 figures marked * refer only to estimates derived from projected expenditure by the Commonwealth. In producing these estimates calculations have been based on the assumption that the Commonwealth's share of the total expenditure will remain stable, at the 1989-90 level.

Source: Department of Community Services and Health, 1990, **Annual Report 1989-90**, Table 29, Statistical Supplement: 16; Commonwealth of Australia, 1990, **Budget Paper 1**: 3.139-3.141 and 3.117-3.118.

TABLE 3.3: USE OF COMMUNITY SUPPORT SERVICES AUSTRALIA WIDE, NOVEMBER 1988.

Service	Total people	Average hours per week	Average occasions per week	Users as % 65+
Home Help	120,338	1.5	0.9	6.78
Home Nursing	44,995	0.9	1.8	2.53
Home Paramedical	3,712	0.4	0.6	0.21
Centre Paramedical	7,843	0.3	0.4	0.44
Home Respite	5,728	2.6	0.8	0.32
Centre Day Care	14,781	3.1	1.1	0.83
Home Delivered Meals	53,388		4.1 meals	3.01
Centre Delivered Meals	11,100		1.4 meals	0.62
Home Maintenance/Modification	17,921	0.6	0.3	1.01
Program Support and Information to clients	47,085	0.3	0.4	2.65
Transport Services	36,877		1.0	2.07
Other Home Based Services	4,397	0.4	0.4	2.07
Other Centre Based Services	9,026	0.2	0.4	0.50

Note: This table is of indicative value only. The statistics avaliable on HACC Services are somewhat unreliable, as the notes to the statistics publication points out.

Sources: Home and Community Care Program **Services Provision Data Collection No. 1**, August 1990.
ABS: **Projection of the Populations of Australia, States and Territories 1984-2021**, Catalogue No. 3222.0.

TABLE 3.4: HACC SERVICE TYPES: EXPENDITURE ESTIMATES AND CLIENT NUMBERS

Service Type	Expenditure (a) $'000	Expenditure (a) %	Clients (b) No.	Clients (b) %	$ per Client
Home help (incl. special home help)	148,795.8	37.0	118,770	40.5	1253
Community Nursing	111,340.1	27.7	45,000	15.4	2474
Day care/respite	41,954.6	10.4	24,100	8.2	1748
Program support/information	30,114.6	7.5	47,000	16.0	641
Home Maintenance	14,261.7	3.5	17,000	5.8	839
Meals/food services	13,599.5	3.1	64,500	22.0	211
Paramedical	8,762.2	2.2	10,900	3.7	804
Transport	6,343.4	1.6	35,000	11.9	181
Total (c)	**375,171.9**	**100.0**	**293,092**	**100.0**	**1280**

Notes: a) Expenditure estimates are for Commonwealth and State expenditure for 1990-91, as at December 1990.

b) Client data are taken from the HACC Service Provision Data Collection. Figures for November 1988 and Febraury 1989 have been averaged. The total number of clients is less than the sum of clients receiving each service due to variations in the way in use of multiple service use was reported.

c) Total excludes $27,026.2m allocated to State administration, land and buildings, vehicles and equipment, and maintenance of recreation centres, for which $2.1m was allocated to Victoria only.

Source: DCSH (1991).

Organisations receiving subsidy and providing direct services include Local Government authorities, State Government departments, statutory authorities registered under State legislation (this includes some home nursing agencies as well as the Home Care services operating in New South Wales), and a wide range of non-profit community-based agencies, including many traditional charitable and voluntary organisations as well as a number of recently formed, locally based groups established specifically to utilise the HACC subsidy finance. There is no provision for services to be supplied by private profit-making agencies, although in some cases under the Community Options Program they may be contracted to carry out certain specific activities for particular individuals.

Two other closely related developments from the same period, 1985-86, were the expansion of the Geriatric Assessment Teams (GATs) and changes in the provision of residential care, including the tightening of the admission criteria for nursing homes and the expansion of hostel-type accommodation. The residential care benchmark of 100 beds for each 1000 people aged seventy or over, discussed in the previous chapter, was also introduced to limit nursing home beds and encourage an expansion of hostel places. These policies were deliberately introduced along with the

HACC program to restrict the numbers of people being admitted to nursing homes and shift the balance of the extended care system in Australia towards support in the home (DCS, 1986).

As a result of these reforms total Commonwealth expenditure on aged care increased by 27.4 per cent between 1985 and 1991 (standardised to 1991 dollar values), a growth rate just slightly above that of the population aged 70 years and over. Within this total figure, increases in nursing home benefits have been only 8.5 per cent, whereas hostel subsidies have increased by 142 per cent and Commonwealth expenditure on HACC by 98 per cent (see table 3.5). Expenditure on HACC increased from 8 per cent to 12 per cent of Commonwealth funding on aged care. If State expenditures are included, it has been estimated that the combined expenditure on the HACC program accounted for around 20% of the total for aged care (DCSH, 1991: 5). Changes of this magnitude in the use of residential care services would be expected to have considerable significance for the HACC program's goals and the identification of its target population, as increasingly, people who had been admitted to nursing homes would be likely to require support to remain at home.

TABLE 3.5: COMMONWEALTH EXPENDITURE ON LONG TERM CARE, 1985-86 AND 1990-91

Program area	1985-86 $m	1985-86 % of total	1990-91 $m	1990-91 % of total	Per cent increase 1986-91
Residential Care					
NH benefits	1429.9	81.0	1552.1	69.0	8.5
Hostel subsidies	83.5	4.7	202.2	9.0	142.2
Special services	.6	*	19.0	0.9	n.a
User rights and training	-	*	2.8	*	n.a
Total recurrent	1513.4	85.8	1776.2	79.0	17.4
Capital	65.8	3.7	129.6	5.8	96.8
HACC	142.8	8.1	282.9	12.6	98.1
DNCB	36.0	2.0	33.5	1.5	-6.8
Geriatric Assessment	5.6	0.3	25.7	1.1	355.4
TOTAL	1764.2	100.0	2247.9	100.0	27.4

Note: All figures are in 1991 dollars

Source: DCSH, 1991:16

The Aims and Objectives of the HACC Program

The objectives of the HACC program and the nature and size of the 'client group' eligible to receive the services included in the program have been clearly influenced by the history of its development. The client group of the HACC program is identified in this way in the **National Guidelines** published in 1988, as follows:

> *the aim of the HACC program is to enhance the independence, security and quality of life of frail aged and younger people with disabilities through avoiding inappropriate admission to long term residential accommodation by facilitating and promoting the development of cost effective community care alternatives appropriate to, and according to, need.* (DCSH, 1988: 2)

The **National Guidelines** attempt to be more explicit in identifying what it calls the 'Target Population' of the program:

> *The program is directed towards assisting those persons living in the community who, in the absence of basic maintenance and support services provided under the HACC program, are at risk of inappropriate admission to long term residential care, including -*
>
> - *frail or at risk aged persons, being elderly persons with moderate or severe disabilities,*
> - *younger disabled persons, being persons with moderate or severe disabilities,*
> - *such other classes of persons which are agreed upon by the Commonwealth Minister and State Minister; and*
> - *the carers of those persons*
>
> *A person is considered to have a moderate or severe disability who has been assessed as having difficulty in performing any of the tasks of daily living, such as dressing, preparing meals, house cleaning, home maintenance or using public transport, without personal assistance or supervision.* (DCSH, 1988: 4)

The Guidelines continue by identifying people from non-English speaking backgrounds, Aboriginal people, persons suffering from Altzheimer's Disease or other related disorders, financially disadvantaged persons and those living in remote or isolated areas as groups for whom particular attention needs to paid to ensure equitable access to HACC funded services.

The identification of the program's target group appears at first to be straightforward, as the population of 'frail aged and younger people with disabilities' and their carers is explicitly nominated. Experience has shown, however, that this has not been so easy. When, for example, does an aged person become a frail aged person, and at what point does a chronic illness or impairment result in a moderate or severe disability? How are different disabilities affecting different people to be compared and scaled? Who are those at high risk of institutionalisation? As it is not possible to provide assistance to every potential applicant it is necessary for service providers in the field to adjudicate and rank competing claims in order of priority. Difficult and contentious decisions must be made, such as whether services should be concentrated on those who face an immediate risk of admission to institutional care and are likely to require extensive amounts of assistance, or whether they should be spread more widely, to those whose quality of life would be enhanced by the availability of regular support provided in their own home. Should those who are less at risk to be given a lower priority, or are they regarded as having an equal need? Should the program service all 'younger people with disabilities', or is it intended only to assist a discrete sub-group, such as those who would otherwise require nursing home care?

Specific terms used in defining the program's aims add to these difficulties. The phrases 'inappropriate admission to long term residential accommodation', and (service provision) 'appropriate to, and according to, need' have proved difficult to employ in allocating services. This is partly because they are difficult to operationalise. Similarly, the designation of carers as part of the target population adds to the dilemmas facing service co-ordinators trying to decide which clients should receive priority. Should, for example, socially isolated applicants, unable to support themselves

and without informal support receive priority over applicants with a co-residential carer? Or should carers, designated as eligible for HACC funded services, receive priority?

3. PLANNING THE HACC PROGRAM: THE EXISTING APPROACH

Under the HACC Agreements, discussed earlier in this chapter, decisions concerning the allocation of resources to service agencies are taken at the State level, with final approval required from both the State and Commonwealth ministers responsible for the program. Funding is reviewed annually, with the Commonwealth matching State increases in expenditure on a dollar for dollar basis, up to an agreed maximum, set by the Commonwealth, of fifteen per cent above the level of the previous year (HACC Review, 1989). Although there is no single approach to resource allocation under the program some details of the process followed in each State are set out in the annual State Strategic Plans.

The objectives or philosophy of planning in the last few years of the program has been expressed as a set of priorities which underpinned the systems' expansion. Common to each State, the planning priorities were spelt out in the New South Wales State Strategic Plan for 1989/90 as follows:

1. *To complete gaps in service provision and ensure that 'each service type is represented in each service area';*

2. *'To ensure that resources are equitably distributed through sub-regional areas'; and*

3. *'To ensure that the level of service provision in each sub-region is adequate to meet the needs of each target group'.* (N.S.W. HACC, 1989: 12)

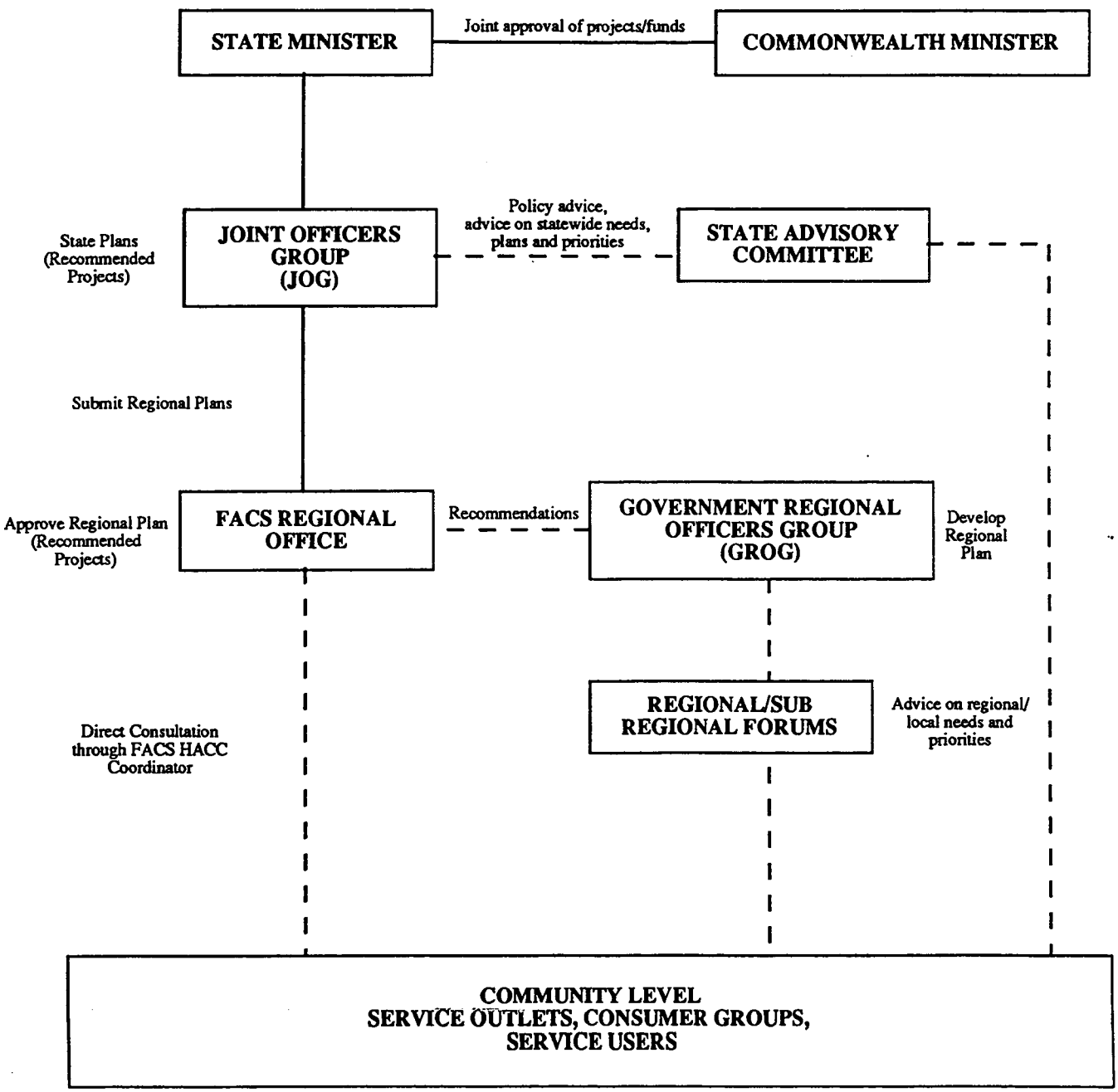
The first two objectives had been largely achieved in New South Wales by 1991, according to senior officials from FACS. Efforts towards meeting the third objective, achieving adequate levels of service, are tied to the development of 'benchmarks of minimum service levels that will establish a total picture in regard to the need for HACC services' (N.S.W. HACC, 1989: 12).

Each State Strategic Plan identifies the full amount of funding available for a given year. To date this has comprised of two components: recurrent funding, that is an amount to be provided to maintain the existing level of services; and growth funding, an additional amount for growth in services. Each of these figures is affected by a complex range of factors but, for clarity, these may be simplified a little as follows. The full amount is basically the funding for the previous year supplemented by amounts which are added by the State and Commonwealth governments. This additional amount is the amount to which the State government is prepared to commit itself, which is matched by the Commonwealth. In addition some unmatched Commonwealth monies for innovative projects and training may be allocated. Recurrent funding for existing services consists of agreed costs of maintaining the previous year's provision plus a cost supplementation factor based largely on compensation for agreed cost increases such as inflation and national wage increases. Additional or growth funding is that amount of total funding which remains after these decisions have been taken.

Systematic attempts at planning the system of HACC services in each State are, in the main, restricted to the allocation of growth funding. In this way the practical steps of planning have been directly tied to increased funding for the program. To date there has been little evidence of planning which involves the redeployment of existing or previously committed resources, although a considerable amount of such activity might have been expected in the early years of a new program such as HACC.

Typically, growth or additional funding is distributed between the different potential claimants according to a system of priorities developed as part of the consultative and decision making process undertaken in each State. Particular priorities, such as an expansion of respite care or extra services for dementia sufferers, are agreed upon in accordance with the recommendations of the State Advisory Committee and the advice of State and Commonwealth officials. A concern for ensuring that there is an equitable distribution of services between the different regions is apparent in each State. In some cases, notably New South Wales and South Australia, a formula based on 'needs indicators' derived from population statistics is also employed.

FIGURE 3.1: HACC. OVERVIEW OF ADMINISTRATIVE ARRANGEMENTS For Planning and Consultation in New South Wales



Key: ___ **Consultation**
___ **Administrative Lines (Planning)**

Adapted from 'Home Care's Future Directions' Home Care NSW, 1988

In New South Wales, the Department of Family and Community Services has utilised such a system for the funding of HACC services in each of its administrative Regions, using an index of need which is based on estimates of the proportion of elderly people and younger people with disabilities in the local population. Funding is then allocated between the Regions based on the index. The indicator used is deliberately simple in an attempt to overcome some of the criticisms that had been levelled at the previous more complex formula used to produce an index of the comparative needs of each Region[1] (Staden, 1987).

As in other States, a complicated consultative and advisory process (see figure 3.1) is used in New South Wales as part of the planning process. This involves inputs from local agencies and consumers through the use of local Regional and Sub-regional HACC Forums as well as by direct submission. In addition there are a series of planning steps involving regionally based Community Project Officers, meetings of GROG, the Government Regional Officers Group, and JOG, the Joint Officers Group involving senior officials from the State and Commonwealth Governments, the advice of the State Advisory Committee and finally the agreement of the ministers from the State and Commonwealth governments.

Despite the elaborate mechanisms for consultation with field staff and consumers, the program in recent years has been increasingly characterised by a 'top down' approach to resource allocation. In the first three or four years of the program, regional and sub-regional 'HACC Forums', in which service providers and consumers from a neighbouring local government areas participated, emerged as significant contributors to the HACC planning process in New South Wales. More recently, however, the decision making process has relied much less on recommendations from HACC Forums, and instead has deployed State wide planning procedures which have reversed the earlier emphasis placed on local participation in the planning process.

4. SPECIFIC DIFFICULTIES OF PLANNING AND ADMINISTERING THE HACC PROGRAM IN AUSTRALIA

Constitutional Divisions Between the Commonwealth and State Governments

The complex arrangements required under the Home and Community Care Act (1985) ensure that, although the Commonwealth government does not directly provide services, it is responsible for their development and administration in co-operation with each of the State governments, with whom separate Agreements has been signed (Auditor-General, 1988). For this reason, the division of responsibilities between the Commonwealth and State governments is of fundamental importance to the implementation of the HACC program. Under the Australian Constitution, State governments are responsible for the provision of health and social services. Even though the Commonwealth, through its taxation powers, has considerable control over the national purse strings and has assumed sole responsibility for the subsidy of nursing homes and hostels and, subsequently, for part of the costs of community support services, these services must be licensed to operate under State legislation (Sax, 1984; Grant and Lapsley, 1986). Introducing national standards for the allocation of resources to services is, in this situation, difficult as it is possible that such a move would meet considerable opposition from State and locally based planners and policy makers.

It could, however, be argued that it is precisely because of the relatively direct involvement of central government (ie the Commonwealth) in the provision of HACC services in Australia that national measures for the planning and administration of the program are required. However resources are divided between the States, some form of allocative mechanism is involved. A mechanism which systematically ties the allocation procedure to the need for

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1 Until 1990 other factors such as the presence of specific high needs and at risk groups, including the number of age and invalid pensioners who live alone, the number of pensioners from non-English speaking backgrounds, the number of pensioners who live alone, the number who do not own their own house and the number of people in receipt of the Domiciliary Nursing Care Benefit were also measured in the index, with each factor given a relative weighting based on a complex formula (Chan, 1987).

assistance and which would encourage forward planning would indeed appear preferable to an ad hoc system which relies simply on responses to local or State initiatives.

Funding and Organisational Problems

On top of these constitutional foundations, the HACC program has tended to utilise the existing local service infrastructure as the framework for the further development of a national system of community support services. This has meant that many of the problems existing in the system of community services prior to the HACC program have continued to affect the organisation and delivery of services. There is, for example, no mechanism for removing the long-standing local rivalries between particular services which have developed over time, nor any systematic approach developed to deal with organisations that strive, above all else, to maintain their autonomy. Nor is there a body representing the community service sector at a national, or even State level. In essence, these problems can be traced to the community services strategy followed in Australia, whereby the Federal government is not in general a direct service provider, but must rely upon a wide range of semi-autonomous organisations who receive funding from an often surprising range of governmental programs as well as other sources.

Support Needs and Eligibility for HACC Services

Because questions of eligibility for HACC funded services are important for resolving day-to-day service provision dilemmas as well as for longer term service development and planning, they received considerable attention in the first Triennial Review of the HACC program, conducted in 1988. It was noted that it was often difficult for service providers to establish the eligibility of particular clients, or in some cases, particular client groups, such as younger developmentally delayed clients, AIDS sufferers, the terminally ill, people discharged from hospital requiring a period of convalescence, those with chronic psychiatric disabilities, or those who needed assistance as a result of their social vulnerability. In certain cases in which services funded by the HACC program were going to clients who were not part of the HACC target population, so called 'No Growth' areas have been designated (HACC Review, 1989). This provision is intended to allocate a quota of services for particular users which will not receive increased funding from the HACC program in future. A danger of such a specification, however, is that it is likely to aggravate the existing fragmentation of community services by stimulating the development of new programs to provide the same services as the HACC program for another set of client groups (Davies, 1990). Alternatively the 'No Growth' provision may create a new set of social problems based upon those excluded from the receipt of services under this provision.

State and Regional Differences in Service Provision

For a number of reasons the implementation of the HACC program varies considerably between States, as well as between different regions within States. In South Australia, multi-disciplinary regional service teams (the Domiciliary Care teams) have been established by the State government to provide, within one organisation, an extensive range of HACC services. In New South Wales, in contrast, a range of separate organisations are each responsible for a particular specialised service. In Victoria, local government has a major role in the organisation of services within a local region, whilst in Queensland, Community Health Centres have been designated with the role of organising local services. Even at the most aggregate levels of spending, the HACC program varies considerably between the different States. In 1988, for example, Queensland, accounted for only 10.9% of estimated total national expenditure although it had 16.6% of the estimated target population. In the same year Victoria, with 25.9% of the estimated national target population, accounted for almost thirty percent of expenditure (Auditor-General, 1988; Howe, 1987). The scope of the differences in provisions between the States in three key service types, home help, home nursing and delivered meals, is illustrated in table 3.6 (below), although again caution must be advised in interpreting these figures due to the lack of reliable data on actual service use.

TABLE 3.6: STATE VARIATIONS IN HACC SERVICE PROVISION

Home Help, Home Nursing and Home Delivered Meals.
November 1988

	N.S.W.	Vic	Qld	S.A.	W.A.	Tas.	ACT.	NT.	AUST (Average)
HOME HELP									
Per cent population aged 65+ assisted	7.15	8.4	4.03	4.17	7.53	8.59	8.4.	11.13	6.78
Av Hours /week	1.5	1.7	1.3	n.a.	n.a.	1.0	1.1	n.a.	1.5
Av Occasions/week	n.a.	n.a.	n.a.	1.2	0.7	n.a.	n.a.	1.2	0.9
HOME NURSING									
Per cent population aged 65+ assisted	1.03	1.67	4.43	3.40	5.39	8.88	0.08	0.07	2.53
Av Hours/week	n.a.	n.a.	n.a.	n.a.	n.a.	0.9	4.9	n.a.	0.9
Av Occasions/week	1.4	1.4	2.3	1.8	1.8	n.a.	n.a.	2.9	1.8
HOME MEALS									
Per cent population aged 65+ assisted	2.28	3.38	3.06	2.85	3.25	4.10	2.51	5.60	3.01
Av Meals/week	4.5	3.6	4.2	4.6	4.4	4.2	3.8	4.0	4.1

Note: It is noted in the source that these figures are not very reliable due to a number of problems encountered in their collection. Caution should be exercised in interpreting them.

Source: Home and Community Care Program (1990) **Services Provision Data Collection No. 1, August 1990**; ABS, **Projections of the Populations of Australia, States and Territories 1984-2021**, Catalogue No. 3222.0.

Differences in service provision are also evident at what might be considered the micro-level of service organisation. Despite emphasis on the multi-disciplinary nature of the work involved, there has been a tendency in most States for relatively specialised services to be established. Just as home nursing services, meals-on-wheels and home care services were established and then funded as separate organisations under the four Acts which preceded the HACC program, so too have many innovative services been established on a specialised basis with HACC funding. Hence in some States, services such as community transport, day care, dementia day care, home maintenance and modification, and so forth, have been established as separate entities, and an extraordinarily complex network of direct service providing organisations subsidised to deliver them. The administrative and organisational problems resulting from these arrangements is likely to add to the difficulties already inherent in the development of a co-ordinated and well planned system of community support services. The large, multidisciplinary Domiciliary Care Services developed in South Australia are an important exception to this general principle of specialisation, although even there the tendency is for some services, such as nursing and community options, to remain autonomous (Mykita, 1988; Yeatman, 1989).

Resource Allocation and Data Collection

Planning requires data. More importantly, the effective allocation of resources to develop an equitable and effective system of home support services requires well developed and regularly updated data bases. Planning is unlikely to be successful if the measures are plucked from the air for want of detailed, relevant and up-to-date information on key variables as progress cannot be monitored without an adequate flow of appropriate data. In the long run, therefore, planning is directly related to the quality of the data bases.

The data required take two primary forms: routinely collected statistics and purpose-specific social research. The quality of the former will in part determine the extent of dependence on the latter, but some planning will almost inevitably rest in part on specific social research. In particular, much need can only be gauged in very general terms (using proxy measures) through the use of routine statistics, and the same is true for measures of effectiveness and therefore cost effectiveness.

Unfortunately, there is a sad history of problems with data in the Australian context. Although it is almost a forgone conclusion that each Enquiry into the provision of community assistance in Australia will deplore the amount and quality of the data available, the problems continue. Currently, all organisations receiving recurrent funding under the HACC program are required to provide information for the HACC national data collection. This collection is comprised of four parts: the service provision data collection; the service users characteristics data collection; the service characteristics data collection; and the 'no-growth' data collection. However a considerable number of problems have been experienced in establishing the data collection processes, with the result that the best available data, published in late 1990, covered only 71 per cent of service agencies, and included information from only the first of these four collections (HACC, 1990). Program administrators point to problems of field compliance with the collection methods. Field staff, in their turn, complain of endless hours completing statistical collection forms without ever seeing any results. Whatever planning strategy is adopted in Australia, or in each State, it is clear that far greater attention needs to be paid to the collection of data and particularly the use of data already collected.

5. GENERIC DIFFICULTIES IN PLANNING DOMICILIARY AND COMMUNITY SUPPORT

A number of fundamental complications affect the planning and provision of ongoing domiciliary support to people with disabilities which must be recognised in any attempt to examine the feasibility of benchmarks for such services. Such issues may be considered 'generic' to the field because they affect not only the HACC program in Australia but also similar arrangements for service provision in other countries.

Planning Health Services

A fundamental premise in planning health services is that the development of service capacity should be closely related to a particular goal. Evaluating the project's success, subsequently, relies upon the measurement of differences or improvements amongst the recipients of assistance, resulting from the actual intervention made (Hyman, 1982). For most acute disease states the stipulation of outcome measures suitable for use as both planning goals and monitoring standards are relatively straightforward, being based upon the prevention, cure or, in certain cases, limitation of damage resulting from a particular disease or condition. However, as Woods points out in the Introduction to the World Health Organisation's **International Classification of Impairments, Disabilities and Handicaps**, the determination of appropriate outcome goals is considerably more complex when the problems are associated with chronic illness and disability (Woods, 1980). These complexities are associated with the stipulation of service provision outcomes, with the measurement of service need associated with the extent or prevalence of particular conditions, and with the recognition of the types of interventions likely to prove most effective.

Outcomes and Outcome Measures

The identification of service outcomes is, for this reason, widely accepted as central to the tasks of planning, administration and evaluation of health and social services (Hyman, 1982). In their application to the general field of health care services they are often precisely defined and permit direct measurement of the effectiveness of particular actions. So, for example, Sax defines an outcome of medical care as:

> *some measurable aspect of health status which is influenced by a particular unit of care. The focus is on the effects of that care on the patient, such as recovery from illness, restoration of function or survival.* (Sax, 1990: 120)

Examples of outcome measures recommended by the Commonwealth Department of Health (1981) for the evaluation of hospitals include infection rates, occurrence of complications of treatment, the extent of recovery of normal function, length of absence from work or school, case fatality rates and readmission rates. However the use of the concept of outcomes in the field of community support services is often imprecise and controversial because a cure or significant recovery is not possible in most cases associated with significant functional impairments or chronic conditions.

For the purposes of planning, administering or evaluating community support services for people with disabilities, an outcome may be thought of simply as an end result or consequence of a particular medical or social intervention. In evaluative practice, a wide range of outcome measures are used, but clearly many of the outcomes of community support, such as the psychological well-being of the recipients, are often difficult to quantify (Davies and Challis, 1986; Goldberg and Connelly, 1982). The problems associated with the identification of the outcomes of community support services are not, however, simply questions of developing a consensus of standards by which the achievements of particular interventions can be measured. Important dilemmas also arise over the very way in which outcome goals are set. Should the outcome of support be restricted to the maintenance of life, assistance being provided to prolong life and ameliorate pain and suffering associated with the disabilities experienced by clients, or should the outcome be a more ambitious one of providing an enabling form of support, extending the goals to enable the participation of those directly affected in the life of the community to which they belong? Clearly such questions as these have considerable significance for the subsequent allocation of resources intended to achieve these outcomes.

The Determination of the Needs for Support

Identification of the extent to which support services are required by people with disabilities living, or wishing to live, in their own homes is a matter closely tied to the adoption of particular outcome standards. The extensive literature on the definition and measurement of need bears witness to the difficulties inherent in the subject. As noted in Chapter 2, statements of the need for services tend initially to be made in very general, broad and absolute terms, but when operationalised and made the basis for service provision, the concept of need is refined in such a way as to take account of the effectiveness of known interventions and the resources available to deal with them. How then is need to be measured in such cases?

Detailed measures of the need for support are usually given either in terms of the requirement for a particular already existing service (such as a need for home nursing, or for dementia day care), according to a systematic classificatory scheme (as in an epidemiological study of the prevalence of particular conditions), or as the extent of deficits in the achievement of a particular series of activities of daily living (Dooghe et al., 1988: 7-8). However as Woods points out, the extent of the need for support cannot be expressed reliably as the prevalence rates of certain medical conditions or impairments because a variety of material and social considerations affect the nature of the disabilities arising from this, as well as the amount and type of support required (Woods, 1980).

Hence, in addition to questions concerning the availability of resources and the effectiveness of particular interventions, determination of the need for community support services involves problems with the interaction of three conceptually distinct but in practice closely related phenomena. The first of these is the measurement of personal functional deficits and the development of reliable estimates of the extent of their prevalence and incidence in a given population. The second concerns the actual social conditions encountered (in the absence of a formal intervention) by those affected by these functional deficits, as social conditions directly determine the extent of disability arising from any personal functional deficit. The third is involved with the extent of interaction between needs, demands and actual service provision, as it is widely recognised that manifest needs for assistance generally increase following the introduction of a successful service into any community.

6. DISCUSSION

The focus of this chapter on the difficulties faced in planning the program should not obscure the fact that, by and large, the HACC program has also met with considerable success. In its first three years, despite fairly formidable circumstances, the program did 'get off the ground', setting up a national system of services encompassing a wide

range of a organisations and service types, and provided the system with a coherent philosophy expressed in a single set of objectives. It enabled a significant increase in funding to be provided to services which were already operating to maintain vulnerable and dependent people in their own homes, and in addition expanded the range of assistance available and enabled it to be provided throughout the country (Auditor General, 1989; HACC Review, 1989).

While pointing to these successes, the Triennial Review (1989: 50) argued:

> *There is an urgent need to develop an approach to establishing simple indicators of demand which will help establish a view both on the adequacy of the level of resources and the equity of their distribution.*

Subsequently the Review recommended

> *the analysis of information on services and populations within regions is the first step in the development of planning benchmarks for the HACC program and establishing a link between planning benchmarks and funding levels in the program by the end of 1990* (Recommendation 33.3, HACC Review, 1989: 50)

Given the achievements of the program it is important to ask what the value would be of changing the existing planning mechanisms to one in which the equity and adequacy of resource distribution is tied to a system of national benchmarks. Would such a system of national standards contribute to the future development of the services, or would it be more likely to reduce the existing flexibility in service provision and lead to unproductive conflict?

This chapter has reviewed the development of the HACC program and drawn attention to a number of fundamental problems affecting the planning and resource distribution procedures of the program. Difficulties in determining an appropriate type and level of community support services for people with disabilities are encountered in a number of different forms. Complications concerning the determination of appropriate service outcomes, the extent of service needs, and the identification of what constitutes the most effective form of service provision and how these can be best allocated to individual clients appear to be generic problems encountered internationally. In addition, a series of problems peculiar to the Australian context have been identified. These include problems of the constitutional division of responsibilities between Commonwealth and State governments, problems of funding and organisation associated with the widespread reliance upon non-government organisations for the implementation of the HACC program, difficulties of defining and thus restricting eligibility for HACC services to the existing target group, and State and regional variations in service organisation.

Planning benchmarks are frequently described in the HACC program as a measure expressing an adequate level of a particular type of service per 1000 potential users. Such standards would be likely to have an appeal as a means of overcoming the sorts of problems described in this chapter as unique to the Australian context of the HACC program. It is not, however, clear whether in fact these sorts of difficulties, which are in many senses political difficulties, would in fact be overcome by introducing a technical measure of service provision. Problems of the HACC program identified in this chapter being generic to the field of community service provision would not, however, be likely to be overcome by such a measure. Instead, the international experience with benchmark-type measures presented in Chapter 4 indicates that such an approach is unlikely to prove successful as a longer term mechanism for planning and administering a national system of services.

CHAPTER 4

THE CONTEXT AND TECHNIQUES OF PLANNING: THE OVERSEAS EXPERIENCE

This chapter reviews documentation from overseas on the planning and provision of community and domiciliary services and on the use of benchmarks or planning formulae developed in this process. It draws out the major themes to emerge from this review. These illustrate the problems, many of which appear to be virtually universal, involved in planning domiciliary services for people with disabilities.

1. INTRODUCTION: AN OVERVIEW OF THE USE OF BENCHMARKS OVERSEAS

Our review of the literature from 22 countries revealed barely any evidence of clearly articulated planning formulae or service provision benchmarks. The Netherlands is the only country in which benchmarks of this kind can confidently be said to exist, and even there current provision does not match the prescribed levels (Kastelein, et al., 1989). In New Zealand, benchmarks, stipulating target levels of community service for specified populations, were developed in the mid-1970s. These appear to have been made irrelevant by other policy developments in more recent years (Koopman-Boyden, 1988). Planning norms were also introduced in Britain in the early 1970s but they were not revised in such a way as to maintain their relevance in changed circumstances. They have not been formally abandoned, but have largely ceased to be meaningful, in part because they became redundant when the first Thatcher administration came to office espousing decentralisation. They have been replaced by a reliance on local planning and by an emphasis on performance and cost containment rather than on centrally determined output or resource input targets.

A more common method by which services are matched to need is through the use of eligibility criteria based on formal assessment by agency staff. In some cases, the criteria of eligibility are spelt out at the national level. In other cases, local or organisational rules determine eligibility. But whatever the case, eligibility for a single service inevitably rests in part on the personal judgement of the assessor. These eligibility criteria do not of themselves constitute service benchmarks because they do not imply the need of a given population for a particular level of services. Unlike service provision benchmarks, they are not primarily tools of planning but a mechanism for allocating services to individuals. Other approaches used in planning services are discussed in the Chapter 5.

2. THE APPROACH ADOPTED IN THIS CHAPTER

Matching resources to need is a fundamental goal of social policy, and the development of long term benchmarks governing levels of service provision would appear to represent an obvious and logical means to this end. We were therefore surprised to find so little evidence of this mechanism being used in the field of community services. Unfortunately policy makers and researchers in other countries did not provide a detailed rationale as to why there was so little evidence of this approach, so we can only speculate as to the reasons for this.

One possible explanation could lie in the nature of the material at our disposal. Though this is certainly extensive, it is possible that staffing norms and service coverage ratios are set out in more detailed regulations and administrative documentation which were not forwarded to us. However, this would hardly account for the total absence of references to fixed service provision measures at the national level. A more likely explanation seems to be that, in the field of home support services for elderly people and people with disabilities at least, such benchmarks simply do not exist. In some instances, which we examine later in this chapter, there is evidence that they have been used, but have since been abandoned. More commonly, however, other approaches to resource allocation have been used which would make such a centrally determined standard of service provision unnecessary.

To account for their absence one can contrast the organisational context of community services with that of the more orderly and institutionalised arrangements in connection with the planning of schools, the hospital system or the nursing home sector, where planning norms seem to be almost universal. In each of these instances, planning concerns a physical entity with finite places (beds, desks etc), well defined goals and a long history of establishment. The establishment and maintenance of such facilities is also capital intensive, with planning administered by one governmental department, with a single administrative structure. The provision of community support lacks all of these features, both in Australia and internationally.

Thus, although the development of long term service provision norms or benchmarks does not present insurmountable technical problems, by which we mean problems of measurement, community services have developed in a way which we believe is antithetical to their use. The implementation of benchmarks entails the imposition of a centralised, rational and bureaucratic regulatory device on an essentially disorganised, flexible and locally variable system. To explore the implications of this it is necessary to distinguish the technical aspects of the development of planning procedures and benchmarks, the political and administrative framework around the planning mechanism and the socio-economic context in which services are provided.

It is perhaps worth clarifying the distinction between these features. The technical aspects of a planning and resource allocation mechanism relate to such questions as the identification of need, the calculation of appropriate levels of service provision, the determination of service size and the nature of the services required by a given population. The socio-economic context includes all the historical, cultural, demographic and economic circumstances in which services have developed. The political and administrative sphere is concerned with the organisational structures through which these goals are realised. Although it is possible to produce technical calculations based on national standards, we have come to the conclusion that such an approach is unlikely to be successful unless due consideration is paid to the full range of contextual factors. In this chapter, much of the discussion therefore focuses upon those contextual factors which constrain and direct the development of community support services overseas. The next chapter builds on this material and focuses on more technical aspects of planning.

We present three detailed case studies of the implementation of benchmarks, from Britain, the Netherlands and New Zealand in the next part of this chapter, section 3. Following this, in section 4 we review the demographic, social, and political and economic factors which form the context of community service development and shape planning and resource distribution mechanisms. In the final two parts of this chapter we turn to a discussion of factors directly associated with the mechanisms of service organisation and delivery. In section 5 we examine the organisational factors that influence the parameters of service provision and in section 6, we return to a discussion of the issues which receive the greatest emphasis in the planning literature. The most significant of these are: (i) the criteria for service eligibility and allocation; (ii) the substitution of community for residential care and the targeting of services; (iii) the role of informal care; (iv) the division of responsibility for service provision between central government and local service providers; and (v) public programs for people with disabilities and the frail elderly which interact with and directly influence community service systems. In this context we draw attention briefly to the significance of income and housing in determining the nature and viability of support systems.

3. CASE STUDIES: SERVICE PROVISION BENCHMARKS IN OPERATION

1. Merits and Demerits: A Cautionary Tale from British Experience

During the early nineteen seventies the British central government introduced a common planning cycle to the National Health Service, centrally controlled through a decentralised administrative structure, and the Personal Social Services, provided locally by 118 autonomous local authorities but within a national framework of legislation and policies. The object, in particular, was to prevent unnecessary hospitalisation and to de-hospitalise long term patients wherever possible by promoting community services provided by the local authorities. Accordingly, benchmarks were established for the National Health Service which prescribed a progressive reduction of long-stay beds; benchmarks for the Personal Social Services were designed to foster expansion of community provision **within a projected expenditure growth rate of 10%** (in real terms) per annum.

These latter benchmarks were quite detailed. They specified targets for residential and day care places, for numbers of home helps and meals on wheels per thousand of the relevant population etc. They were advocated and elaborated upon in various documents but were primarily consolidated within planning guidance issued in 1972 (Webb and Wistow, 1986). Although intended as flexible and transient benchmarks, they remained largely unchanged after 1972 and were never formally abandoned, though they gradually became increasingly irrelevant as circumstances changed - and especially when 'supply side controls' replaced 'needs-related planning' in the late seventies and eighties.

The merits of this approach in the British case were that the benchmarks provided a starting point for local discussions about how to co-ordinate changes in health and personal social service provision. They also precipitated local authorities into formal, systematic planning. Some authorities criticised the benchmarks (see below), but these were

generally those authorities which had already developed a reasonable planning capacity. In most cases the benchmarks provided a framework within which local planning systems, skill and agendas could be developed. They were a catalyst to thinking and to the development of processes.

These merits were real, but so were the demerits. Although the benchmarks were characterised as **indicative**, they were initially seen by local authorities as rather more authoritative - but it was not clear whether they should be treated as authoritative maxima or minima. In practice, low spending local authorities tended to see them as maxima and high spending authorities treated them as minima. But in both cases the benchmark failed to carry weight at the extremes of the range. They were also discredited over time as resource constraints became ever more oppressive. More importantly, however, they came to be seen as a statement of the **'preferred service mix'**. The individual benchmarks for each type of service had been developed independently, by extrapolating from research on need and from average levels of existing provision. The benchmarks therefore did **not** represent a view of the most suitable or cost effective mix of service provisions, but they **implied** just such a centrally preferred or authorised mix of service provision. The inevitable consequence was that those local authorities which were least planning literate accepted the benchmarks as a desirable service mix: the benchmarks became a **substitute** for local policy analysis in precisely those places where most work was needed to improve planning processes.

The more sophisticated local authorities avoided this error and recognised that they could and should make their own decisions about the substitutability of services (e.g. the extent to which residential care targets could be reduced by increasing day care and support services), as well as about absolute levels of provision. Nonetheless the benchmarks could also prove deleterious for such authorities. Other agencies, most notably the NHS, were absolutely determined, on occasions, to treat the benchmarks as an official 'statement of service mix and level' which was set in concrete. They used the benchmarks to castigate neighbouring local authorities which fell short in any area of provision, even where this was a deliberate policy involving 'overprovision' of complimentary or substitute forms of service. In short, the very benchmarks which were designed to facilitate inter-organisational planning at the local level generated inter-organisational and inter-professional **conflict** in some cases. The merits of the benchmarks were real, but their unforeseen disadvantages were as important - and they became more so as time elapsed and the original standards remained unmodified, despite a harsher resource climate.

The British experience of using benchmarks in service planning is by no means unique. Similar problems have also been encountered in the Netherlands and New Zealand where they have been deployed, as is detailed in the following sections.

2. The Netherlands

The system of community service provision in the Netherlands is similar in a number of respects to the system in Australia. Services are provided by a wide range of non-profit agencies, the majority of which either have a religious (in the Dutch sense, 'confessional') background or are associated directly with local government. The Provinces, together with local government, are involved in the planning of service provision in each region. There are also significant points of difference from the Australian system, however. One of the most noticeable concerns financing arrangements. Long term care is, for a large part, financed through the a national long term care insurance fund (the AWBZ or Exceptional Medical Expenses Act), originally set up to finance nursing home and psychiatric institution use but extended in the early 1980s to cover home support services. Further financial support for home services comes from membership fees for the 'Cross Associations', from means-tested fees levied on users and from subsidies paid from general taxation. Other differences can be inferred from the order of magnitude of the Dutch system. Not only are there more residential facilities, but far more emphasis is placed on home support services and on housing than is the case in Australia.[1]

Domiciliary services in the Netherlands form part of what is referred to as the primary care system.(Kastelein, et al., 1989). This system includes general practitioners, home nursing and home help services. Consumers have direct access to the primary care system. Hospital and residential services provided in nursing homes and homes for the aged, referred to as the secondary care system, require referral from the primary care system and are considered appropriate only if primary care services are inadequate.

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1. Other aspects of the Dutch system are discussed in section 4.ii of this chapter (p. 45).

Service Provision Norms in the Netherlands

Benchmarks for community services in the Netherlands are part of a system of national service provision norms or 'capacity standards' which set out the levels of provision for almost every possible type of assistance available in that country. In addition to the capacity standards for nursing homes (12 somatic beds and 12.5 psycho-geriatric beds per 1000 people aged 65 or over, plus 0.035 somatic beds per 1000 of the general population) and for homes for the aged (70 beds per 1000 people aged 65 or over), capacity standards also exist for general hospitals (3.7 beds per 1000 people) psychiatric hospitals (1.9 beds per 1000), general practitioners (0.4 per 1000) and general social workers (0.154 per 1000 of the general population). Capacity standards for the major domiciliary services are presented in Table 4.1 below. Such provision norms were not found for other domiciliary services, such as meals on wheels, day care centres and so on.

TABLE 4.1 OFFICIAL CAPACITY STANDARDS, CURRENT LEVELS OF PROVISION AND USAGE OF MAJOR DOMICILIARY SERVICES IN THE NETHERLANDS.

Service	Formal Standard	Actual Volume	% 65+ who use service	65+ as % of all users
Home Help[a] Service	25.7 hrs per person aged 65+	18.0 hrs p.a. per person aged 65+	12%	64%
District Nursing	0.4 per 1000 gen.pop	0.3 hrs per person per year (Annual use)	5-8%	55-80%
Community Mental Health Care Service	No fixed norms. Budget sets capacity	1986 approx 400 services with 4877 staff in total	1.4 - 1.8%	19.1%
General Practitioners	0.4 per 1000 gen pop.	4.8 contacts per person per year	75%+	17%

Note: a. The formal standard for Home Help is not an official Capacity Standard, but a measure, widely referred to, detailed in an official report in 1984. (Kastelein, et al., 1989: 40)

Source: Kastelein, et al., 1989. Table 7.1, 8.1: 46-67

We have attempted to establish how these service benchmarks were developed and what has been the effect of their implementation but unfortunately neither topic is covered extensively in the available literature.

Kastelein, et al., (1989: 78) note:

> *Since most community care services started from local private initiatives [i.e. Voluntary Non Government Organisations], hardly any legislative control system developed in the nineteen sixties. Instead, most services are covered by government regulations and administrative regulations. ... In the period of expansion [mainly the late 1960s and 1970s] the central government was found willing to contribute to the costs of each professional community care system, in particular if supported by the municipal authorities. Standards for allowances were established concerning the necessary training and education at a medium level. Supply levels were established in bargaining processes between the central government and each distinct care service in a municipality.*

In an attempt to develop a comprehensive framework for the planning and co-ordination of all community services a major restructuring program was commenced in the late 1970s. Planning and direct funding responsibilities were delegated to the Local Government Authorities and, as part of that process, national standards were established in which the number of professional staff were related to the size of local populations. Municipal budgets for social services and community care were subsequently cut by central government (Kastelein, et al., 1989: 79).

In more recent years there has been criticism, often of a political nature, of the 'inflexibilities' in the system, some of which are said to result from the application of official capacity standards. Problems with regional inequalities resulting from the application of uniform formulae have also received significant attention. Proposals have therefore been made to introduce some form of flexibility into the system, including market-based competition and increased direct consumer payment for services. Other problems are evident in the continued failure of services to achieve the targets identified, even after more than ten years. There is said to be considerable frustration amongst service providers at these failures. Others have, apparently, attacked the arbitrary levels of adequacy implied by the capacity norms. However, there still appears to be widespread popular support for the existing system which is seen as ensuring the population's right of access to these services.

The Formulation of Standards

No information was available in the documentation from the Netherlands as to the way in which formal service provision norms were determined. In response to a direct request for information on the subject, the Director of the Institute of Preventative Health Care (NIPG-TNO) in Leiden, De Heer Kastelein, provided the following information:

> *Originally capacity standards were non-existent. In the 1970s, however, a need was felt to establish such standards in order to control the fast expanding numbers of care providers and resulting increasing costs of the system of care. The supply of services - in particular the number of professional care providers - is seen as an important motor behind this expansion. In order to control this supply it was chosen to establish legal capacity standards/norms per capita for many distinct services. Yet some kinds of services are still lacking formal supply standards (for instance Home Help Services). Moreover, the lack of differentiation for regional demographic variations causes a specific problem for several services* (Kastelein, 1990, personal correspondence).

According to Kastelein, three distinct stages can be distinguished in the development of such national standards. First, the process of developing supply standards starts with a formal political decision, taken by the national government, to establish a committee, to develop proposals for the supply of particular services, within certain restrictions, such as financial or policy targets. Sometimes professional interest groups are the driving force behind such a decision. Second, a report containing conclusions and recommendations is prepared by the committee. Generally a broad variety of parties participate in such a task including interest groups, experts, governmental representatives and representatives of the health insurance companies. Finally, within the government, proposals are made based on these recommendations. These are then the subject of further negotiations with other governmental departments and interest groups, and of political debate. At a certain point, the negotiations reach a form of consensus and the final proposals are formally established by the Minister in a so called General Measure of Administration (AMvB). The resulting standards are widely understood as representing considerations concerning the availability and commitment of resources, rather than as final indicators of the need for services, or the actual task performance or work loads of the services concerned (Kastelein, 1990, personal correspondence).

The Success of Benchmarks in the Netherlands

It is difficult on the basis of documents available in Australia to provide an unequivocal judgement as to the value or success of service provision benchmarks in the Netherlands . Even in that country it is clear there are disputes as to their value. The case study makes it clear, however, that the benchmarks for community services, whatever their achievements or failings, are part of a systematic approach to social provisions in the Netherlands where 'top down planning', associated with corporatist political institutions, small geographic scale and marked social cohesion is the norm rather than the exception. It is also notable that the official norm for home nursing remains well above the actual levels of provision, as does the unofficial standard for the provision of home help. Although they have, no doubt,

provided a guide to the equity of national policy, such capacity standards have had only a limited influence on the actual processes of planning and resource allocation.

3. New Zealand

The provision of health and social services in New Zealand has, in many ways, followed a pattern which closely resembles that of Australia. The State governments of Australia, however, have no New Zealand counterparts. Instead, since 1885 the provision of local services has been the responsibility of elected Hospital Management Boards (later known as Area Health Boards) in co-operation with the central government. (New Zealand Dept of Health, 1974; Reinken, 1988).

Non-government welfare and religious organisations such as the Aged People's Welfare Council, the Nurse Maude District Nursing Association (Christchurch) and Presbyterian Support Services either operate or co-ordinate many of the community services provided. Other services have been provided directly through the government owned hospital board services. These services include district nurses, home help, laundry services (absent in most other countries), day care, respite care and paramedical services such as podiatry, physiotherapy and occupational therapy. In general services have been provided to those assessed by service providers as requiring it. In some cases, such as meals-on-wheels, charges are levied (Koopman-Boyden, 1988).

The Development of Service Provision Benchmarks in 1976

On the basis of a survey conducted in 1973/74 by the Department of Health of the incidence of disability amongst elderly people, benchmarks establishing 'essential' or minimal levels of service provision were established in 1976 (Salmond, 1976; Hospital Board Planning Guidelines, 1986 cited in Koopman-Boyden, 1988). These 'Guidelines', as they were termed, are set out below in Table 4.2 together with alternative estimates of the 'ideal' level of services (according to Campbell, 1981), and the actual levels of provision in Canterbury and Wellington areas. The methodology used in extrapolating service requirements from the needs survey is discussed in chapter 5.

TABLE 4.2: NEW ZEALAND GUIDELINES FOR COMMUNITY SERVICES FOR THE ELDERLY. ESSENTIAL (OFFICIAL), IDEAL (UNOFFICIAL) AND ACTUAL LEVELS OF PROVISION

Services per week per 1000 people aged 65+

Guidelines and Levels of Provision:	(Official) Essential	Ideal[a]	Actual 1981[b]	1986[b]	1985[c]
District Nursing (Visits per week)	21	159	96	71	75
Home Help (Hours per week)	60	192	40	35	78
Meal on Wheels (Meals per week)	72	152	89	89	116
Laundry Services (Visits per week)	13	8	6	4	18

Notes: a. Based on alternative estimates of services needed according to Campbell, 1981.
b. Figures from the Canterbury Hospital Board Area, 1981, 1986.
c. Figures from the Wellington Hospital Board Area, 1985.

Source: Koopman-Boyden, 1988: 667-668.

Despite the effort that accompanied the development and implementation of the Guidelines, there appears from the start to have been two main sorts of difficulties associated with their establishment and operation. The first was that both local service providers and consumers criticized the service levels as inadequate, later urging the adoption of levels set at Campbell's 1981 'ideal' standards. As can be seen from the table, the ideal standards are approximately eight times the level of the essential standards set by the Guidelines for home nursing, three times the level for home help and twice that of meals on wheels. It is also apparent that, at least in some areas, adhering to the Guidelines would have meant a significant reduction in the services actually being provided. The continued variation between regions as well as between the Guidelines and the level of services actually provided suggests that over a ten year period they did not prove to be a very successful instrument for achieving either inter-regional equity or accepted standards of service adequacy.

The second difficulty had to do with the practical implementation of the standards. Their use was associated with a centralised form of Departmental administration. Changes that came about in the relationship between the Ministry of Health in Wellington and local Area Health Boards as the result of a major shift in policy in the mid-1980s subsequently made the Guidelines redundant. In the words of the 1988 Social Policy Commission, the role of the central agency came to be, 'to influence rather than to direct and control'. Under the new approach it is no longer policy to

> *earmark funds for any aspect of service ... there are few minimum standards of care which Boards are expected to provide* (Reinken, 1988: 48).

Direct enquiries to the new Board of Health in Wellington have confirmed that policy has now shifted from the use of centrally imposed service norms. We were told that resource allocation had indeed moved a long way from the Salmond model of the 1970s, and minimum service levels are no longer stipulated. Resource constraints have affected provision quite drastically but with the policy of local community control over health and community services Wellington no longer tries to tell each different Area how they should spend their money. Planning is currently a responsibility of each local area, not a question of national standards (personal communication, October 1990).

4. THE CONTEXT: EXTERNAL FACTORS AFFECTING THE PLANNING OF COMMUNITY AND DOMICILIARY SERVICES

Throughout the developed world the issue of the support of the growing number of aged people, rendered vulnerable on account of their ill health, disabilities and dependent economic and social position, is being addressed by the development of community care policies. Throughout these countries, community care is undoubtedly being adopted as the preferred model, although the place of residential care in the total system of long term care shows very interesting variability between countries. In Sweden, for example, although community care is the preferred option wherever feasible, the literature suggests that residential care for highly vulnerable people can be provided more appropriately and with greater dignity in institutions than at home. In Sweden, institutions do not seem to be viewed with the fear or abhorrence that they arouse in some other countries. It is the quality of the institution that is a matter of concern (Sundström, 1987, p. 35).

Scrutiny of the international literature reveals that there are a number of common concerns about the social context which are seen as affecting the need for and the development and organisation of community services. These concerns, discussed briefly below, focus on three main issues: demographic trends, social patterns and political and economic factors.

a. Demographic issues

Table 4.3, below, illustrates the growth in the elderly population in selected countries belonging to the OECD. The figures illustrate the differences in the current and projected proportions of elderly people in the population. In this context Australia is currently relatively well placed, with a lower proportion of the population aged at present, though with relatively high projected rates of growth in higher age groups in the coming decades. Many countries already have a proportion of elderly people in their populations which Australia does not expect to achieve for another 30 years. For this reason, it is worth examining the issues that are now faced by these countries in the delivery of their services.

TABLE 4.3: DEMOGRAPHIC TRENDS IN SELECTED COUNTRIES OF THE OECD, 1980-2030.

Country	Age	1980	1990	2000	2010	2020	2030	Total 65+ in millions 1990	Total 65+ in millions 2030	Increase (Per cent)
Australia	% Total Pop 65+	9.6	11.1	11.7	12.6	15.4	18.2	1.9m	4.3m	126.3
	% of 65+ 65-69	37.4	34.2	29.4	33.0	32.6	29.3			
	" 70-79	45.2	46.6	47.9	42.1	46.0	45.4			
	" 80+	17.3	19.0	22.6	24.8	21.3	25.2			
Belgium	% Total Pop. 65+	14.4	14.2	14.7	15.9	17.7	20.8	1.4m	1.9m	35.7
	% of 65+ 65-69	31.7	29.1	32.9	31.5	32.8	31.9			
	" 70-79	49.3	47.6	46.4	47.0	45.3	47.5			
	" 80+	18.9	23.2	20.5	21.3	21.8	20.5			
Denmark	% Total Pop. 65+	14.4	15.3	14.9	16.7	20.1	22.6	0.8m	1.0m	25.0
	% of 65+ 65-69	33.1	31.1	29.4	36.4	31.1	31.6			
	" 70-79	47.3	46.7	47.2	42.8	50.8	45.3			
	" 80+	19.5	22.1	23.2	20.7	18.0	23.0			
Netherlands	% Total Pop. 65+	11.5	12.7	13.5	15.1	18.9	23.0	1.9m	3.3m	73.7
	% of 65+ 65-69	33.2	32.4	31.0	34.5	33.0	30.7			
	" 70-79	47.2	45.7	46.8	43.5	48.0	46.0			
	" 80+	19.5	21.8	22.0	21.9	18.8	23.1			
New Zealand	% Total Pop. 65+	9.7	10.8	11.1	12.0	15.3	19.4	0.4m	0.8m	100.0
	% of 65+ 65-69	36.6	34.1	30.4	35.5	34.9	32.8			
	" 70-79	46.7	47.3	48.3	43.2	46.9	46.7			
	" 80+	16.5	18.5	21.1	21.2	18.0	20.4			
Norway	% Total Pop. 65+	14.8	16.2	15.2	15.1	18.2	20.7	0.7m	0.9m	28.6
	% of 65+ 65-69	33.1	30.6	25.6	33.2	32.0	29.7			
	" 70-79	47.0	47.3	47.5	40.5	48.3	46.2			
	" 80+	19.8	22.0	26.7	26.1	19.6	24.0			
Sweden	% Total Pop. 65+	16.3	17.7	16.6	17.5	20.8	21.7	1.5m	1.8m	20.0
	% of 65+ 65-69	32.8	29.7	26.6	34.6	28.3	28.0			
	" 70-79	48.0	47.0	46.6	41.2	49.8	43.6			
	" 80+	19.1	23.2	26.7	24.1	21.8	28.3			
UK	% Total Pop. 65+	14.9	15.1	14.5	14.6	16.3	19.2	8.5m	11.3m	32.9
	% of 65+ 65-69	33.9	32.5	29.9	33.0	31.0	32.7			
	" 70-79	48.2	46.2	47.9	44.4	48.8	44.1			
	" 80+	17.8	21.2	22.1	22.5	20.1	23.0			
USA	% Total Pop. 65+	11.3	12.2	12.2	12.8	16.2	19.5	30.4m	58.9m	93.7
	% of 65+ 65-69	34.2	32.8	28.5	33.2	25.3	30.4			
	" 70-79	45.4	46.3	47.9	42.3	45.2	48.3			
	" 80+	20.3	20.8	23.5	24.4	19.3	21.1			

Source: OECD (1988) **Ageing Populations, Paris.**

TABLE 4.4: OLD-AGE DEPENDENCY RATIOS, MEDIUM VARIANT 1950-2025 WORLD AND MAJOR REGIONS, AND SELECTED COUNTRIES[a]

Region	Old-age dependency ratios			
	1950	1980	2000	2025
Australia	Not available	14.8	17.5	23.6[b]
USSR	9.5	15.3	18.4	23.6
United States	12.5	17.1	17.6	18.4
Austria	15.5	24.1	22.7	31.1
France	17.2	21.4	22.4	31.0
Argentina	6.4	13.2	15.5	16.9
United Kingdom	16.0	23.1	22.6	28.9
Denmark	14.1	22.0	22.4	35.1
Netherlands	12.3	17.3	20.3	36.7
Czechoslovakia	11.4	20.1	18.6	25.0
Israel	6.0	14.3	13.0	18.6
Sweden	15.5	25.2	25.6	35.9
Canada	12.2	13.1	17.3	29.1
Fed. Rep. of Germany	14.0	22.7	24.4	35.8

Notes: a Old-age dependency ratio is defined as the ratio of the population aged 65+ years to those aged 15 to 64, multiplied by 100. Medium variant-rates of population ageing were used.

b Figure for Australia is for 2020.

Source: For Australia: OECD, (1988) **Ageing Populations**, Paris.
World: United Nations, (1989) **World Population Trends, Population and Development Interrelations and Population, Policies.** Population Studies, No. 93, New York.

The composition of the elderly population itself is given considerable prominence in the literature, a dominant theme being the growth in the number of very old people, that is those aged eighty years and over. There is evidence that the so called 'old old' (variously defined as those aged 80 or 85 and older) are disproportionately heavy users of health and long term care residential facilities and of services provided in the community (Rosenwaike, 1985; Verbrugge, 1984). One important practical implication of this trend is that service development needs to be matched to the different 'age strata' within the elderly population, and not simply to the total population above retirement age, as the mix of these strata is projected to undergo change (Dooghe, 1986). One of the policy debates that we found repeated in many countries was whether services should be targeted on those with the most intense service needs, most commonly the old old (a situation that pertains in Sweden, for example, where the actual number of people receiving services has declined but more services are received by those in most need) or whether the spread of services should be extensive, also taking in those at a lower level of dependency.

Other demographic developments emphasised in the literature which are considered to affect significantly the need for services and the capacity to provide them include changing age/sex ratios, morbidity rates, geographic dispersion of the population and, of particular interest in the case of Israel and Australia, patterns of migration, both internal and external. Of these measures dependency ratios provide the most readily available and complete index for international comparisons (see Table 4.4). There are, however, a number of imponderables affecting the prediction of future developments in each of these factors.

b. Social patterns

Closely associated with demographic developments are changes in social patterns. Important amongst these are family composition and divorce rates, the residential arrangement both of the family and the wider community, the social position and role of women and the social status of the elderly and disabled. Other very broad social patterns, such as the degree of urbanisation, patterns of employment, and belief systems also condition the way in which services develop and are organised. Although it is not the place, here, to discuss each of these developments in detail nor to examine their differential impact in different societies, it is clear that one of the consequences of such social change is to reduce the stability of familial arrangements for domestic support. This is likely to have considerable ramifications for community care policies.

c. Political and economic factors

Political and economic factors further affect both the need and the social capacity for the development of formal services. These include the levels of social expenditure, the social security and income support systems, labour force participation rates, particularly of specific groups, such as middle aged women (see Table 4.5). In addition, economic growth and inflation rates affect the capacity of countries to develop services.

Political and constitutional structures are also important in determining the nature of service provision, affecting, for example the relative importance of central government and State, provincial, county and local government. So too does the relative importance of statutory, voluntary and private sectors in the provision of direct services.

The categories outlined above draw attention illustrate the range of contextual features which, through time, shape the development of the different systems of service provision found in each country. While it is not possible to spell out exactly how each of these influences affects resource allocation and service development the multiplicity of factors which have a bearing on service planning have been encapsulated in a schema (see Figure 4.1) drawn from Morginstin (1989: 127) which we can do no better than reproduce. These demographic, social, political and economic aspects of the planning context find expression in the unique ways in which services are actually provided and needs are met. For example, the role of informal care, the significance of nursing homes, whether services are means tested or not, the eligibility criteria for the receipt of services, and so on are all matters which are deeply rooted in the history of national and local service provision. This variability underlies the difficulties of developing any formula or technical approach which is universally applicable to the calculation of service requirements for any particular population.

TABLE 4.5: LABOUR FORCE PARTICIPATION RATES IN SELECTED COUNTRIES, BY SEX AND AGE GROUP, 1965 AND 1985

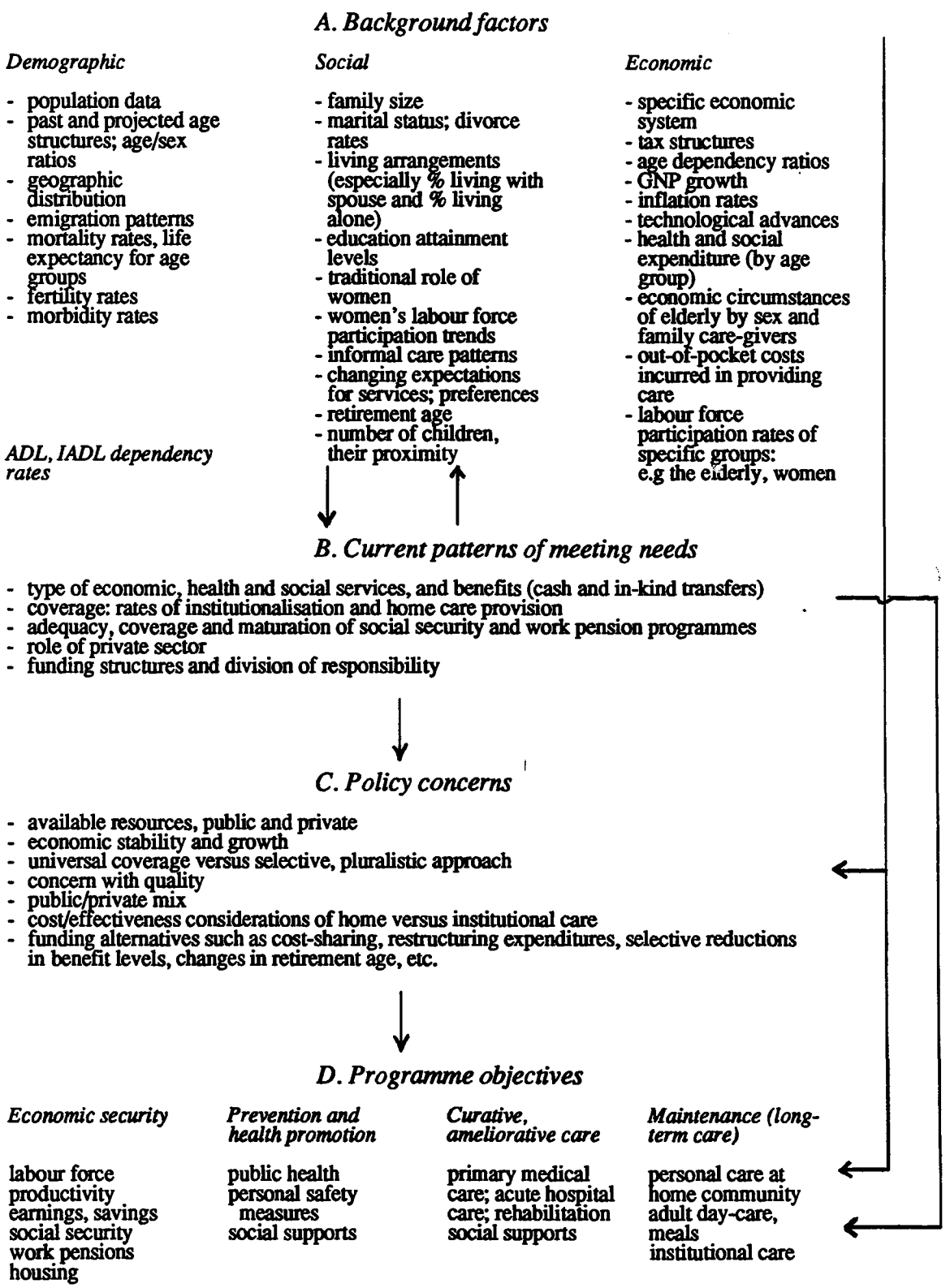
All persons in the labour force, as per cent of given age group

Country	Males						Females					
	55-64			65+			55-64			65+		
	1965	1985	Change	1965	1985	Change	1965	1985	Change	1965	1985	Change
Australia[a]	85.8	68.8	-17.0	23.3	11.1	-12.2	21.0	22.0	1.0	4.4	2.9	-1.5
United States	82.9	59.7	-23.2	26.6	10.3	-16.3	40.3	41.7	1.4	9.4	6.8	-2.6
Canada	86.4	70.2	-16.2	26.3	12.3	-14.0	27.0	33.8	6.8	6.0	4.2	-1.8
Japan	86.7	83.0	-3.7	56.3	37.0	-19.3	45.3	45.3	0	21.6	15.5	-6.1
Fed. Rep. of Germany	84.6	57.5	-27.1	24.0	5.2	-18.8	30.2	23.9	-6.3	7.8	2.5	-5.3
United Kingdom	92.7	66.4	-26.3	23.7	7.6	-16.1	35.6	34.1	-1.5	6.5	3.2	-3.3
Italy[b]	54.8	38.2	-16.6	18.4	8.9	-9.5	14.3	10.5	-3.8	4.7	2.1	-2.6
Sweden	88.3	76.0	-12.3	37.7	11.0	-26.7	39.2	59.9	20.7	11.6	3.2	-8.4
Israel[c]	84.6	82.4	-2.2	35.4	27.9	-7.5	17.9	26.0	8.1	6.1	6.6	0.5
Finland	81.5	57.8	-23.7	18.0	10.6	-7.4	54.9	52.9	-2.0	3.8	4.8	1.0
Netherlands[d]	80.3	53.8	-27.0	11.4	4.0	-7.4	14.9	14.5	-0.4	2.3	0.7	-1.6
Spain	84.2	66.3	-17.9	25.9	5.9	-20.0	22.0	20.0	-2.0	7.7	2.1	-5.6

Notes: (a) 1966 and 1980 respectively.
(b) 60 to 64 age group was used for Italy.
(c) For 1960 and 1980 respectively.
(d) Netherlands data are for 1970 instead of 1965.

Sources: OECD, **Ageing populations**, Paris, 1988.
The Labour Force Australia: Historical Summary 1966-84, ABS Catalogue No. 6204.0.

FIGURE 4.1: FACTORS AFFECTING NEEDS AND PROGRAMS FOR THE ELDERLY



Source: Morginstin, 1989: 127.

5. ORGANISATIONAL ISSUES IN THE PLANNING OF SERVICES

In Australia one of the most frequently encountered criticisms of the HACC service system is the degree of fragmentation and regional inequality associated with divisions of responsibility at various levels of service provision. This phenomenon and the concern it causes, however, is by no means restricted to Australia. Fragmentation, in which different components of the system act in an uncoordinated and often independent way, and the unequal provision of services between regions, where formal resources are provided at different rates for comparable populations, appear to affect service provision in virtually every country for which we have information. This includes compact unitary states, for example, the United Kingdom, where such problems ought, in principle, to be more easily avoided.

Three major features of the organisation of community services may readily be identified as underlying such problems of fragmentation and unequal provision. These are:

a. the **division of responsibility** between central authorities responsible for financing and regulating the services, and regional or local bodies which provide and deliver them and in most cases furnish supplementary funding;

b. the **sponsorship arrangements** (often termed the auspice or management system) in particular the mix of public, voluntary and private sponsors associated with service provision; and

c. the **divisions between service delivery organisations at the local level**, reflecting task specialisation and often professional boundaries.

Each of these structural features has significant implications for service delivery and affects the feasibility of the development and implementation of national service planning benchmarks. However, we could not obtain information which would have permitted an exhaustive comparison between countries on each of these dimensions. Discussion of their implications for planning community service provision must therefore remain somewhat tentative.

The Central/Local Dichotomy

One of the dimensions on which community service provision differs from country to country is that of the relationship between central government and local authorities. Commonly a division exists between central government, which has responsibility for taxation and hence much of the overall funding of social expenditures, and local service-providing organisations, which may or may not be governmental and which actually organise and directly control the resources required at the local level. In Britain and the Scandinavia, such divisions predominantly involve central government and local municipal authorities. In Israel and New Zealand the relationships have tended to be between central government and local public as well as non-government service providers. In other cases, as in Australia, the divisions of responsibility are further complicated by the intermediary roles of State or Provincial government. The United States, Canada, the Netherlands, Belgium and the Federal Republic of Germany all provide examples of such overlapping Federal-State responsibilities. In each of these countries State or Provincial governments are important in determining planning. These relations are further complicated by factors such as the regionalisation of major government functions, as is the case with health services in New Zealand and Britain, and by major cultural and linguistic differences within countries, as in the case of Belgium and Canada.

In only one country on which we have information were community services directly provided by a federal agency, with minimal participation by State or local government. This country was Argentina. In Italy, the reverse situation is found. There, all legislation and provision concerning community services (and residential care) is the responsibility of the regions. In Canada, a Federal model of the type often proposed for Australia is encountered. Community services and health care are the responsibility of the Provinces, so that once grants have been made by the Federal government for community services, the Federal government is not directly involved in service organisation. Considerable differences exist as a result between different Canadian Provinces (Monk and Cox, 1989; Amann, 1980; Kane and Kane, 1985; Reinken 1988; Henwood, 1990; Hardy, Wistow and Rhodes, 1990).

Building on the ideas developed by Webb and Wistow (1982, 1985 and 1986) Hardy, Wistow and Rhodes (1990) present a useful discussion of the problems associated with the division of responsibilities in their examination of the extent and causes of the 'implementation gap' for community services for people with mental handicaps in the UK

over the past 20 years. They argue that local community services have not developed in accordance with the Guidelines set out by central government, despite a number of measures such as the introduction of national planning standards in 1972 and the 'joint planning strategy' to facilitate co-operative planning between central and local government. Suspicion and resistance to national initiatives often develop as a result of the fact that although responsibility for service provision is taken at the local level, financial power is located for a large part at the centre. Despite central funding, significant resource inputs are still made by local services (e.g. by local government, by voluntary organisations' fund raising, etc.) and these serve to bolster resistance to central government domination of the local service development agenda (Hardy, Wistow and Rhodes, 1990).

Several specific reasons are advanced by the authors for such inter-governmental and inter-organisational problems. First, it is hard for central government to specify service outputs as the resources and information required to affect outputs are controlled by organisations at local and 'sub-central' level. Second, it has been difficult to initiate and implement coherent policies because of organisational problems, especially the gap between the centrally controlled health department and local government. Third, governmental policies emerge independently and are often not co-ordinated. In many cases these policies 'contradict and compete with each other'. Fourth, the very attempts made by central government to generate local policy environments have served to create hostility.

A study by Alter in the USA (1988) also found a range of contradictory effects resulting from the imposition of centrally imposed bureaucratic standards on local community service systems. As local services become increasingly dependent on government funding and accountable to State and Federal bureaucracies, the 'organic system' of local services which had grown from local initiatives is replaced by a 'second generation' administrative system. Service efficiency improves according to many measures, but staff morale deteriorates. Alter concludes that to achieve a balance of central control with the energy and flexibility of local initiative

> *planners should sort out the decisions which must be made at the state level from those which should be made by participating community agencies and then allow community systems to operate with as much flexibility and autonomy as possible. ... Effectiveness ... of the system will be improved when there is firm vertical control coexisting with horizontal autonomy, and coordination that encourages flexibility and innovation.* (Alter, 1988: 97-98)

In Australia the central/local dichotomy is manifested at both a Federal and a State level. The Commonwealth's role in the HACC program sees overlapping responsibility for planning the program by the Commonwealth and States. In turn the State administrations are dependent on a wide range of locally controlled organisations to implement their policies. This dual division of responsibility was discussed in some detail in Chapter 3.

Sponsorship

Closely associated with the overlapping responsibility for finance and planning are the sponsorship or auspice arrangements for services at the local level. In Manitoba, Canada, community services are provided almost exclusively by public agencies, operating through a series of regional offices and district agencies established by the provincial government. Even in this case, however, there are exceptions. For example, in Winnipeg, a voluntary non-profit organisation, the Victorian Organisation of Nurses (VON) has been allocated specific responsibilities in the provision of home support services. In British Columbia, in contrast, services are generally contracted out by the provincial government, with formal quality assurance programs instituted in areas such as homemaking to ensure adherence to high public standards (Kane and Kane, 1985). In Japan, the UK and the Scandinavian countries, domiciliary services are typically the final responsibility of local government, with subsidies from central government. In Sweden, for example, these subsidies (about one third of the costs of provision) are tied to conditions which require adherence to national standards and provision Guidelines (Monk and Cox, 1989; Japanese Ministry of Health and Welfare, 1990).

In the Netherlands, Belgium, the Federal Republic of Germany, a number of Canadian provinces and New Zealand, community services are provided, as in Australia, by a range of different bodies, including public statutory organisations, local government and non-profit voluntary organisations (Dieke and Steinack, 1987; Koopman-Boyden, 1988; Dooghe, 1986; Kane and Kane, 1985). Such a system in which the direct provision of services is the

responsibility of a mixture of government run services together with a range of semi-autonomous, non-government organisations, is often called 'welfare pluralism'.

In the Netherlands community support services for the elderly and people with disabilities are organised and delivered at a local level by a range of voluntary organisations (the majority of them with a religious or 'confessional' background) and by local Government. The policy of regionalisation ensures that provincial government is responsible for aspects of regional planning whilst Local Government Authorities are responsible for administration, funding and co-ordination of home help and certain other services provided. Provincial 'Cross Associations' co-ordinate regional and local Cross Associations which are responsible for Home Nursing. 'Cross Associations' are voluntary organisations generally organised on a confessional basis to which members pay a small annual subscription.

National regulation in the Netherlands provides a detailed legal and financial structure within which regional and local control is exercised. At national level, community support services are administered by the Ministry of Welfare, Health and Cultural Affairs, although a number of other departments (the Ministry of Employment and Social Security, the Ministry of Housing, Planning and the Environment, the Ministry of Finance, the Ministry of Home Affairs and the Ministry of Science and Education) are also concerned with aspects of the service provision. An interdepartmental steering committee exists to co-ordinate their actions with regard to services for the elderly. There are, however, still a number of problems of service fragmentation and co-ordination consequent on its history of growth, and a number of attempts have been made in the late 1970s and the 1980s to improve the co-ordination of health and social services provision. For example, national benchmarks, discussed earlier in this chapter, were introduced in the late 1970s in part to assist in overcoming differences in the levels of provision as between regions, and local service co-ordinators were introduced to improve co-operation between services. In this respect they appear not to have met with success, as there are still considerable differences from region to region in the rates of provision. Problems of co-ordination likewise also remain considerable (Kastelein, et al., 1989; Kastelein, 1990; Mastenburg, 1986; Tweede Kamer, 1982; Braam et al., 1981).

It is interesting that even the Netherlands, which is usually noted for its planning and systematic organisation, provides a useful case study of problems arising from the reliance of government upon non-government agencies to implement a community services program. In the United States, where private 'proprietary' profit making services operate in many states, alongside voluntary and even public bodies, problems of fragmentation and unequal provision appear far greater (Estes, 1979; Harrington, et al., 1985).

It is sometimes argued that a system of welfare pluralism enjoys virtues of flexibility and dynamism which flow from initiatives taken by 'community based' organisations (Lipsky and Smith, 1990). From this perspective the attempt to impose direct control by central government would be seen risking the increasing bureaucratisation and rigidification of the non-government organisation for little benefit. Just as the Commonwealth government does not set provision norms for the Salvation Army services or require performance indicators to be met in return for subsidies made to the Sydney City Mission, so, it could be argued, have other governments been reluctant to establish service provision benchmarks affecting community support services provided by a heterogeneous array of non-government agencies.

In short, benchmarks appear most suitable to be applied to statutory provision. This raises important issues in a pluralist welfare system. The presence of a large non-statutory sector may make it difficult to achieve equity or preferred patterns of service by the publication of benchmarks. Indeed, benchmarks which apply to statutory provision alone could even reduce the overall quality of the pluralist sector if the significance of non-statutory provision varied greatly from area to area. However, these problems of pluralism are minimised if the national or local state has a strong role in planning the system as a whole and in funding nearly all non-statutory provision by such means as the use of direct purchase of service contracts or direct payments for service. Arguably, however, such a system is pluralist in name only and is, in effect, a statutory system which happens to use non-statutory agencies to deliver closely prescribed components of service. The Netherlands illustrates some features of such a system and recent changes in British policies could point in this direction.

Service Specialisation

The third and final structural feature of community support services associated with fragmentation and unequal provision is the model of service specialisation which exists at the local level. This model is well evidenced in most Australian States where, despite the introduction of the HACC program in 1985 unifying existing legislation on community services, separate agencies operate in most localities, each specialising in the provision of just one of the many separate services available. Not surprisingly, this task specialisation, which tends neatly to coincide with professional boundaries, is also found in most overseas countries.

There are also, however, considerable differences between countries in the types of service provided. Community transport, well recognised in Australia, is not encountered in the Netherlands, nor is the laundry service of New Zealand widely replicated. More significant differences also exist with regard to differences in the actual services provided by each organisation, both in Australia and internationally. In some cases, personal care is provided only by home nurses, in others only by home care services. Meals may or may not be prepared by home help, or be the exclusive province of another specialised service such as a Meals on Wheels service.

This pattern of variability between, and within, countries, makes the specification and comparison of service provision benchmarks a particularly difficult and sensitive issue. It is possible that their implementation as long term measures would be likely to lead to the entrenchment of existing patterns of service provision. The probability of this occurring seems greater the more such benchmarks function as measures tied to service growth. In essence, service provision benchmarks set out a preferred service model which, deliberately or not, may well inhibit future changes in emphasis and direction by funding authorities. Changes in service provision, such as those evidenced in Australia with the widespread introduction of Community Options, or those seen in Norway and Japan, where some home care workers and home nursing staff now work together, could be resisted as a result of rigidification following the establishment of benchmarks. For this reason it is important to consider how such problems could be avoided in Australia were benchmarks were to be introduced in the HACC program at national or State level.

6. IDENTIFYING THE POPULATION FOR SERVICES: SOME SPECIFIC PLANNING ISSUES

To determine the quantity of community services required we need first to establish clearly the goals of these services and the resources required to achieve them. The crucial questions are: who should be eligible for services and how should this be determined?

What are the goals of community support for elderly people and those with disabilities? As noted in chapter 3 the goals of the Australian HACC program are to provide a comprehensive and integrated range of basic maintenance and support services for frail aged people, younger people with disabilities, and their carers, in order to prevent their premature or inappropriate admission to long term care and to enhance their independence at home and in the community. Community care is therefore seen as **a substitute for institutional care** for a certain section of the population, over an indeterminate period. In Australia, the expenditure on community care is justified, as elsewhere, partly on humanitarian grounds but also as a means of reducing expenditure on the supposedly more expensive care provided in residential settings, such as nursing homes and hostels (HACC Triennial Review, 1989; Monk and Cox 1989).

Substitution

What is the evidence from the research literature on substitution, that is the extent to which community services can provide a substitute for residential care? It is by no means unequivocal. Berg, et al, (1988) have characterised the disabled population as comprising three groupings:

> *those who are better served only by institutional care, those who could be well served by either type of care and those who are better served only by home help. In this context, better served or well served imply criteria of cost efficiency and appropriateness of support. The first and third group would not be subject to any form of substitution, no*

> *matter how well intended or ideologically pushed. Some people need to be in institutions for humane and efficient care; some people should stay at home with home help for humane and efficient care. Still others can be helped by either form of care and it is for these people that policies of substitution can be directed.* (Berg, et al, 1988: 828)

Berg, et al, go on to say that their view does **not** accord with the prevailing notions of appropriate care in Sweden where the population of long term clients is regarded as essentially 'homogeneous', without any underlying differences affecting their need for specific types of care. These two apparently conflicting views seem to us to encapsulate two very important premises upon which community support services may be developed. The intensity of the level of service provision and consequent staffing required and hence the cost structure, will to a large extent be determined by the populations that the program is intended to serve. This will be a matter of judgement and of program philosophy.

However, in the real world of allocating services, substitution is seldom the major consideration. Rather, services tend to be allocated to people who are believed to be likely to benefit from them in their own home life. In real life there is often a tension between program aims and the actions of those responsible for the delivery of services and the well being of clients (Seidl, et al., 1983). Services have therefore tended to be allocated to a far larger group of people than may ever have been anticipated by those who saw services as a substitute for residential care.

One useful source of evidence on the question of the effectiveness of community support services as a substitute for institutional care is provided by the evaluation literature from the United States. In a review of their extensive literature on the evaluation of long term community based care (in which over 700 citations were examined, from which the 31 most rigourous and generalisable studies were selected for intensive study) Weissert, Mathews, Cready and Pawelak (1988) concluded that the community support provided did not, by and large, provide a substitute for nursing home care. Instead of reducing expenditure through substitutions, such services in practice actually increased the overall costs of providing long term care. Hospital and medical costs for those receiving home support were in many cases considerable, well in excess of those in control groups who were not receiving such support. Community support services tended to improve the living conditions of those people who were maintained at home and delayed the institutionalisation of others, although their use was also associated with an increasing loss of independence amongst the recipients in comparison to the matched control groups. They did not finally provide a reliable or cost effective substitute for institutional services for the majority of participants. This literature also draws attention to a peripheral, but closely related issue. The programs which were most cost effective were those which were prepared to admit people requiring intensive support to nursing homes. The authors draw the conclusion that nursing homes are substituting for expensive health care which would otherwise be provided in hospitals.

In the Netherlands four major relationships between community services, institutional accommodation and the health system have been identified and used in a wide variety of research. These relationships are integration, overlap, complementarity and substitution. Although community support services, on the whole, have been shown not to provide a substitute for residential care, it is recognised that it is possible to optimise some components of each of the identified effects to achieve social and budgetary objectives in the provision of ongoing care (van Santvoort, 1984). The policy of substitution, has recently been the subject of considerable attention, and a major report based on a review of all previous studies published by the Department of Welfare, National Health and Culture (WVC, 1990). Its conclusion is worth consideration:

> *Although substitution [of community care for residential care] and the financial advantages deriving from it appear to be possible in theory, in practice these have not been, or have only been partially, achievable.* (WVC, 1990: 128)

The study identified three general points that are of practical importance for actually achieving a substitution policy. First, alternative community based provisions must be available, of the correct type and with adequate immediate capacity for potential users. Second, a certain overcapacity of institutional beds appears important as a means of reassuring potential applicants that a viable alternative to home support is readily at hand, should they ever require it. This overcapacity can, in part, be used for temporary respite accommodation. Third, the potential users of community services (including those requiring round the clock help seven days a week) need to have the certainty that the help can continue indefinitely, preventing a premature application for admission to institutional care (WVC, 1990).

Debate associated with the substitutability of institutional care by community support services is also reflected in a publication of the Swedish Institute on old age care in Sweden. After noting that approximately the same percentage of the elderly are supported in institutions in Sweden, the United States and in other western countries, despite the considerable expansion of home helper services and other supports for independent living in Sweden, Sundstrom suggests that

> *one interpretation of this might be that non-institutional old age care has not yet significantly increased the number of elderly people who remain in their own homes, but instead has improved their living conditions while they still live at home.* (Sundstrom, 1987: 49)

The issue of substitutability has also received attention in Israel. In one study (Factor and Habib, 1986), it was concluded that many of those awaiting placement in institutions applied because of the unavailability of adequate community services. Three key informants - the elderly people themselves, their families and professional case managers - were asked to assess whether the elderly people could remain in their own homes, and if they could, what level of support they would require. Even amongst the most severely disabled (the 'mentally frail' and those severely disabled in the Activities of Daily Living (ADL)), a majority of cases were thought by the formal providers to be capable of remaining in their own homes, in most cases at a cost lower than that of institutional care. Informal care givers were not as optimistic and only a minority, albeit a large minority, thought that the elderly person could remain at home. It is perhaps worth noting that in those cases where they were asked (those who were 'semi-independent' and 'moderately disabled in ADL') the elderly people themselves were less optimistic than formal service providers, although more positive than informal caregivers, about their capacity to remain at home with support (See Figure 4.2) (Factor, 1986).

After reviewing the research literature on welfare provision for the elderly, Sinclair and Williams concluded that it is unlikely that domiciliary services in the UK, at least, prevent or delay admission to residential care (Sinclair and Williams, 1989a: 116). They indicate that one factor responsible for this is that 'the packages of services available have not typically been intensive enough or covered a wide enough range of needs to be plausible alternatives to residential care'. Whereas apparently housebound elderly people have themselves regarded home help as essential to their being able to live at home, the authors note that research evidence has not shown that such people are less likely to be admitted to care than they would have been without the service.

On the other hand, the evidence from Denmark, where community support services are very highly developed and are intermeshed with a range of specialised non-institutional accommodation options and security systems, suggests that low rates of institutionalisation are matched by high quality well-targeted services in the community (Levin and Frehbohm, 1989).

For the demonstration projects (similar in nature to the Community Options program) investigated by researchers at the Personal Social Services Research Unit at the University of Kent, substitutability has been a central issue. The two major findings have been: firstly, that the standard provision of community support does not substitute for residential care. Secondly, intensive and individualised packages of care were shown to provide an adequate substitute for residential care. However, to achieve such outcomes cost savings were not achieved (Davies and Challis, 1986). Given the rather unique conditions under which these projects functioned, commentators have been wary of the generalisability of findings from demonstration or 'state of the art' projects such as these, to more ordinary conditions (Sinclair and Williams, 1989a).

Although in demonstration projects favourable outcomes tended to be achieved, outside of these the evidence appears less favourable. It is interesting to note that in Sweden, where elderly people receive on average 3-4 hours of home help per week, at the time of admission to residential care, they have been receiving on average 3 hours per day. As Sundstrom notes:

> *in most cases it would have been difficult for these people to remain at home, even with a substantial increase in help, and some of them actually wanted to move. In practice, it is extremely difficult to determine whether letting the person remain at home and receive a lot of help and other support in that setting would be more dignified in an old age care institution. This is a topic of continuous discussion among researchers, politicians and the general public in Sweden.* (Sundstrom, 1987: 35)

Thus, the evidence on substitutability is at best equivocal. It is clear that one cannot be overly optimistic about the economic feasibility, or even desirability, of substituting long term care in the home for such care provided in residential institutions. On the other hand, there appears to be a group of people for whom home support does represent a real, albeit high-cost, alternative. There is ample evidence that community care is not a cheap option for high dependency clients, and it might even be more expensive (Doty, 1989). There is clear evidence, however, that community services enhance the living conditions of those who do remain in their own homes. Whether, and how far this has a long term preventative function, is not at present clear.

Eligibility

One might suggest that one of the major successes of long term care policy in Australia has been the recent introduction of eligibility criteria for admission to nursing homes, together with mechanisms for enforcing these (DCSH, 1991). It is therefore surprising that so little attention has been given in Australia to the question of eligibility criteria for community support services. This contrasts sharply with the attention paid to this question in much of the overseas material. Here it seems clear that eligibility criteria are one of the central mechanisms by which services are matched to need.

In this connection the case of Israel is worth looking at in some detail. Like Australia, Israel has been faced in recent years with an accelerating growth of its aged population which has quite alarming cost implications. In the last decade it has introduced a Community Long Term Care Insurance Law (CLTCI) whereby support services are financed from the contributions of the working population. In an effort to minimise the costs and maximise the effectiveness of this provision, very strict conditions of eligibility apply. Services are universally available, with a legal entitlement to services only to those who are deficient in two or more activities of daily living (ADLs), for example, feeding and dressing. Eligibility is determined by a specialist nurse assessor and, in some cases, a social worker, rather than by the direct service providers, whom it is considered would have a clear conflict of interest. A standardised assessment scale is used to assess eligibility. Services are also available, but on a more discretionary basis, for people who have lesser levels of disability. For these people, personal resources and the availability of an informal carer play a much more important part.

Morginstin (1989) has pointed to some of the implications of this system. One of these is that in budgetary terms the costs are determined by the number of eligible users and not by expenditure limits imposed by government. In this way the support system resembles a social security measure rather than a social service which attracts a block grant. There are even appeal tribunals for those who believe that they have a legal entitlement and feel that they have not been treated fairly. As Factor, et al, note:

> *in contrast to a budgeted program in which the adjustment can simply take place in the form of an increase in uncovered needs, growing waiting lists and discouraged applicants ... an entitlement program forces the issue of the growth of needs and how it must be addressed in terms of financing and coverage.* (Factor, et al, 1989: 38).

Perhaps the Israelis have some confidence in this system because of the considerable effort that they have put into the determination of need (see chapter 5).

It will be observed, in Table 4.6, below, that the supply of services increased considerably after the introduction of the CLTCI Law. Factor, et al, suggest a number of possible explanations for this. First, before the introduction of the Law, applicants were subtly discouraged from applying for services so that the demand did not accurately reflect the underlying need for services. The authors further suggest that a system in which eligibility is based on entitlement has a considerable impact on increasing demand by uncovering hidden needs and that less stigma is attached to a system where the right to assistance is based on past contributions.

The German situation contrasts with that in Israel. According to Diecke and Steinacke (1987), community services in the Federal Republic are provided by a number of nationally organised voluntary bodies, many of which have a religious base. The services, for which users are charged, are provided from community health centres. To offset the costs, users may apply for a social security-type of 'emergency' assistance. However, there is considerable scrutiny of

TABLE 4.6: ISRAEL: EXTENT OF PERSONAL-CARE, HOMEMAKING AND PREPARED MEALS SERVICES 1981-1989

			CLTCI 1988-89	
	1981	1984	First Stage	Full Implementation Stage
Personal Care				
Number of Recipients[1]	3,043	4,874	7,444	16,246
Percentage of Recipients of Total Population Aged 65+ in the Community	0.9	1.4	2.0	4.2
Average Weekly Hours per Recipient	4.2	5.6	8.8	9.3
Homemaking				
Number of Recipients	8,002	10,138	10,304	7,418[2]
Percentage of Recipients of Total Population Aged 65+ in the Community	2.5	2.9	2.7	1.9
Average Weekly Hours per Recipient	..	1.0	2.5	2.8
Prepared meals[3]				
Number of recipients	3,155	3,500	3,500	3,500
Percentage of Recipients of Total Population Aged 65+ in the Community	1.0	1.0	0.9	0.9

Notes:
1. Those who receive both personal-care and homemaking services are listed here as personal-care recipients.
2. This figure is biased downward because homemaking services are provided to recipients of personal care under CLTCI who are not reported as a separate service by the National Insurance Institute and therefore could not be included in this table.
3. Prepared meals are not part of the CLTCI.

Source: Factor H, B. Morginstin and D. Naon. (1989)

the financial status of applicants and of their actual need for the service. Commentators have suggested that the effect of these rigid procedures for determining eligibility is to deflate the provision of public services to such an extent that they fall far short of meeting the need for them. This in turn has stimulated a private market in domiciliary services. Indeed, one simple measure of the extent of need left unmet by public services in Germany is the high usage of private services.

The assessment of eligibility for the receipt of services is an issue which received considerable attention in a study by Monk and Cox concerning home services for the elderly in 6 countries. In the province of Manitoba in Canada, in the Netherlands and in Argentina they found that standardised assessment instruments were used to determine eligibility. In Sweden, in Norway and in the UK, local authorities typically instituted their own methods of assessment, though they often borrowed from each other or replicated some of the more established programs. Thus, the authors suggest,

'the result is again a rather high degree of uniformity in the assessment methods they utilise' (Monk and Cox, 1989: 11). This degree of uniformity in determining eligibility for assistance contrasts quite significantly with the situation in Australia, where detailed guidance on how services should be allocated is lacking. Indeed in this country each service tends to have its own eligibility criteria and assessment procedures, often exercising considerable discretion in the allocation of services as a result.

These examples serve to illustrate the attention that is paid overseas, at the level of practice, to questions of eligibility in service provision. The issue of eligibility is linked, both conceptually and at the policy level with the question of the targeting of services.

Targeting

Much debate in the international research literature in recent years has focused on whether services should be provided on an **intensive or extensive basis. That is, should the bulk of services be concentrated on a limited and highly dependent population, or should the same resources be spread more widely serving people with varying degrees of dependency?**

One argument for providing services at an intensive level is that this is a strategy which seems likely to have the most immediate and marked effect on institutionalisation and to be the most cost effective. Whether or not this is the case in the different Australian contexts can only be established empirically by longitudinal studies. However, the alternative strategy of providing extensive services might also have potential rewards. Services provided at a low level of intensity to a wide range of applicants may function as a preventative measure, reducing subsequent demand for medical and institutional care services. Again this is a question which requires empirical investigation.

Sundstrom (1987) points to the trend towards the intensification of assistance provided in the home in Sweden, noting that fewer aged people received help in the late 1980s than previously. Many municipalities, he points out, now appear to concentrate their home help services on people with the greatest needs, providing this limited group with more in-depth services. He contrasts this to the situation in the UK, where he notes the trend has been towards giving fewer hours of help to a larger number of people. Sinclair and Williams make a similar point:

> *Domiciliary services such as home help, which have not traditionally been delivered in sufficiently intensive packages to provide a realistic alternative to residential care, have to be delivered more intensively, sometimes at unsocial hours, and in close collaboration with other services, so that key aspects of an old persons care are not left uncovered. This may mean that they have to be withdrawn from elderly recipients with a low level of need.* (Sinclair and Williams, 1989a: 95)

Recent Australian data on the subject indicates that community support services are provided at a relatively low level of intensity. In November 1988 and February 1989 the national average for the receipt of home help by each individual recipient was only 1.5 and 1.6 hours per week, respectively. Home nursing services provided for the same months were 0.9 and 0.8 hours, respectively. Expressed in another way, recipients received on average between 7 and 8 minutes a day assistance from home nursing services. Although there was some variation between States, in none was there evidence of HACC services being provided at an intense level (HACC, 1990: 6).

Any discussion of targeting services inevitably raises the question: to whom and on what basis should assistance be directed? Should social equity be the overriding consideration, or is the effectiveness of the assistance a more important consideration? Should an individual's level of service need, or the personal and domestic circumstances be accorded priority? Whatever philosophical questions are involved, and we found considerable discussion in this area, information about the outcomes associated with the targeting of specific groups is still relatively sparse. Whilst there may be information about how services are targeted, what is lacking is information about the effectiveness of doing so.

Some indication of the way different groups of clients could be identified in this way is provided by the demographic research conducted by Soldo and Manton (1985) into the service needs of the 'oldest old'. The authors describe 'four homogeneous subgroups' of service users, each with different service needs and likely to benefit from substantially different packages of service supports. These 'subgroups' are differentiated on the basis of social characteristics,

measures of functional impairment and disability, and their medical conditions. The major social characteristic identified by the authors concerns the elderly person's domestic arrangements and the availability of informal support networks. The principal dimensions of impairment and disability concern the nature and cause of morbidity and the existence of a cognitive impairment.

The four subgroups identified are as follows:

Group 1 **Minimal IADL or ADL dependency.** Relatively young, mostly married individuals (mean age approximately 73) with low levels of dependency in Instrumental Activities of Daily Living (IADL) and Activities of Daily Living (ADL). This is the least functionally dependent of the four groups and is not associated with any specific chronic disease or disease group. They are the lightest consumers of health care services with the lowest risk of nursing home placement.

Group 2 **Substantial IADL dependency.** Members of this group tend to be very old, unmarried (including widowed) women free of ADL kinds of dependencies, but with substantial IADL needs. Although having relatively low risks of chronic disease generally, included in this group were those suffering such conditions as glaucoma and hip fracture. The authors suggest that unmeasured cognitive impairment may also be present in many cases as this group is associated with a high level of 'senility'. The risk of admission to residential care amongst members of this group is greater than any other. This may largely be a result of the fact that most members of this category are widowed and lack adequate co-residential support.

Group 3 **ADL problems, limited mobility.** Members of this group tend to be relatively young individuals, distinguished primarily in terms of their mobility limitations. Though not bedfast, people in this group were likely to be housebound to a considerable degree. Members of this group have an above average chance of having Parkinson's disease, diabetes, arteriosclerosis, permanent numbness or stiffness in limbs or circulatory disease.

Group 4 **Extreme ADL dependency.** A substantially disabled group, disproportionately married, not distinguished by age or sex, nearly totally dependent in all ADL and IADL activities. The most disabled group, this appeared to be the group with the most concentrated care needs, suggesting intensive use of informal support, and requiring assistance from more than one person to enable them to keep living at home. Members of this group also made the most intensive use of hospital and nursing home services and paid home care attendants. (Soldo and Manton, 1985: 299-301)

Note that while the degree of disability intensifies from Group 1 to Group 4, the type of service intervention likely to be most suitable differs along other dimensions, the availability of informal help and the need for specialist medical attention.

The four sub-groups proposed by Manton and Soldo are at best indicative of the sorts of categorisation that might be developed if services were to be targeted in the most effective manner. This targeting should itself be based on an appraisal of service effectiveness established by careful analysis of the characteristics of different groups in the population and the outcomes of different types of assistance at various levels of intensity. It would be valuable, for any future developments that findings from this type of research be taken into account.

Informal Support

The relationship between formal services and the informal support provided by family and in some instances friends and neighbours is one of the most crucial variables determining the level, range and mix of home support services. Unquestionably community support relies heavily on informal support, in particular family support, in virtually every country from which we have been able to obtain information. A common model of service, therefore, is for families to be accorded prime responsibility and for formal services to provide support where informal carers are not available, to supplement support provided by informal carers, to fill in gaps or to provide support when the family support network

breaks down. In Australia this would appear to be the rationale underlying the usual practice of Meals on Wheels services which will not provide meals when a relative lives nearby. It also clearly accounts for the designation of carers as a target group under the HACC program.

The role of informal care in the support system and even its 'appropriate' contribution is made quite explicit in Israel. In a study which evaluates the need for long term care services and their cost Factor, et al., noted that formal services constitute only part of the assistance and is supplemented by the family.

> *according to expert estimates in the Bnei Brak survey, families can continue to give 85 percent of the hours required for personal care, and some 74% in the sphere of homemaking, without being overwhelmed by the burden. ... We used the estimates in the survey of community service recipients which reflects a more balanced division between formal and informal assistance. For example, the expert recommendations with respect to personal care indicated that the families need to provide some 60 percent of the total assistance.* (Factor, et al., 1988: 141-142)

Perhaps more extreme than the Israeli case is the situation reported in Argentina, where a 'home hospital' program has been developed which operates from certain major hospitals. In this program, support is only provided to a person living at home if that the setting is judged viable in terms of privacy and sanitary conditions, that home care tasks are assumed by family members or neighbours, and that family members are prepared to be trained to follow an approved treatment plan (Monk and Cox, 1989).

An important alternative model to reliance on the family is found in the Scandinavian countries, in particular Denmark, where the assumption is that the community and the State have a basic responsibility to support dependent people and that any support from the family is to be regarded as additional to this rather than essential. It should be noted that in these countries the labour participation rates of women are high and the economic circumstances of elderly people are generally good. In addition to these factors, social welfare appears to reflect a commitment to social solidarity and responsibility **outside** of the family. In Sweden and in Denmark, a particularly intensive level of support from community services is provided (see Table 4.7).

A lesson to be learnt from the Danish approach and from other countries with high and often growing female labour force participation rates, particularly amongst middle aged women, is that it would be unwise in the long term to plan formal community service provision assuming current levels of informal care.

TABLE 4.7: ELDER CARE IN SCANDINAVIA, 1985

Country	No. of Long-Term Places in Institutions (Percent 65+)	Percent 65+ Receiving Home Help in Prior Week	Average Weekly Hours of Home Help Received	Percent 65+ Receiving Home Nursing in Prior Week
Denmark	5.9	19.5	4.9	5.4
Finland	7.9	10.0	3.3	5.6
Norway	6.3	13.8	3.3	5.4
Sweden	6.9	14.2	6.8	3.8

Source: Levin, R and R. Frehbom, (1989)

Whatever the moral or philosophical issues involved, a community services policy predicated simply on the supplementation of family support needs to take into account the variation in the availability of family support. This variability, already considerable, is likely to increase in the future. Demographic, economic and social trends have combined, throughout the developed world, in such a way as to ensure that the informal carers typically available in the past will become increasingly scarce. This is attributable to a number of factors: smaller family sizes which mean fewer potential carers for elderly parents; higher rates of marriage in the younger generations so that there are fewer unmarried daughters (or, for that matter, sons) to provide informal care; increased female labour force participation rates; delayed age of marriage and childbirth with the consequence that women are less available at the time parents might otherwise have called upon them, also resulting in greater age differences between generations; finally, increased rates of divorce and family breakdown which have had as yet, an uncertain impact on the future availability of informal support. As Dooghe noted in deriving estimates of the need for long term care services in Belgium:

> *on the grounds of a number of social changes ... it is less probable that the family of the old-old amongst whom an increasing amount of dementia, incontinence and terminal illness is found shall continue to find the preparedness, and the opportunities to provide the necessary help in the secure environment of their own homes. ... Of course the availability of informal care also depends upon the demands made. This means that the greater the duration of the demand for help and the more intensive the care required actually becomes, the less informal help is likely to be provided.* (Dooghe, 1987: 34)

This draws attention to the fact that, in addition to being affected by other patterns of social change, the viability of family support is closely tied to the intensity of the support that is needed. If community services are to be effective, it is to be expected that their input will increase significantly as the level of disability or medical attention required increases.

A further issue of relevance is the heterogeneity of both the recipients of care and their carers. The vast majority of personal care received by the elderly is provided by their elderly spouses, who may themselves be frail (ABS, 1990). In these cases

> *the nature of the caring relationship is likely to be based on love and mutual support over a long period of time. The elderly partners may have varying degrees of disability and, at any one time, the more able may be the primary carer, but this may shift over time and with variation in the physical health of each partner. These may be characterised as fragile caring units of mutual support.* (Arbor et al. quoted in Stevenson, 1989: 40)

A smaller proportion of elderly people are cared for by their offspring and in these cases the demographic and social factors mentioned above are likely to be particularly relevant. On the other hand, in the case of younger people with disabilities, depending on the age and type of disability of the dependant person, parents and spouses contribute a considerable amount of care (ABS, 1990).

The Impact of Housing on Community Service Systems

The capacity of frail elderly people and people with disabilities to remain in their own homes and hence to call on community and domiciliary care may be crucially affected by the suitability of their housing. Two of the most important requirements of housing are that the physical features of dwellings should not in themselves be handicapping and should provide conditions such that people can live easily in their own homes with a sense of security at all times.

On the basis of a major piece of research on innovatory housing schemes, conducted by the Department of the Environment in the UK, Tinker suggests that those in greatest need of special housing are the most physically dependent, those living alone, the over 75s and the confused. Tinker noted that if innovatory and special housing schemes are to be effective they need to be provided as part of an integrated package of support arrangements, the cornerstone of which must be home help services (Tinker, 1984: 120). As Table 4.8 (over the page) shows, a

TABLE 4.8: HOUSEHOLD COMPOSITION OF THE ELDERLY AGED 65+, BY AGE OF FAMILY HEAD (PERCENTAGES)

Household Composition	Australia		FRG		UK		Sweden		Israel		US		Canada		Norway	
	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+	65-74	75+
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Single male	9	9	7	11	11	13	18	17	7	11	9	12	11	14	14	18
Single female	29	44	44	51	31	47	37	57	26	23	31	44	29	45	35	52
Couple without children	46	33	36	33	43	25	44	26	46	47	42	30	40	28	41	25
Couple + children	1	-	1	-	1	-	1	-	2	3	2	1	2	-	6	1
One-parent family	-	-	-	-	-	-	-	-	1	-	1	1	-	-	3	3
Other + children[a]	1	-	1	-	1	-	-	-	4	2	2	-	2	1	2	1
Others[b]	14	14	11	5	13	15	-	-	14	14	13	12	16	12	-	-
Mean Household Size	1.8	1.5	1.9	1.6	2.1	1.9	1.7	1.4	3.0	2.2	2.3	1.9	2.3	1.9	2.0	1.5

Notes: a This type of family includes families with children and with additional adult persons.
b All families without children which are not included in the first three types.

Source: Achdut, L. and Y. Tamir (1986), **Retirement and well-being among the elderly,** National Insurance Institute, Jerusalem; ABS, **Income Distribution Survey 1986,** Unit Record file.

significant proportion of older people both in Australia and elsewhere are either on their own or live with a spouse. The proportion living on their own increases with age, a tendency which particularly affects older women. Suitable housing, which does not require a large amount of maintenance, is an important requirement for this group.

The principle that elderly people and people with disabilities should be able to stay in their own homes for as long as possible presupposes the need for dwellings that can continue to be used as the need for care increases. This may involve modification of the existing home or a move to a more suitable one. Whether or not this will be possible will depend on housing tenure and the availability of grants and loans for such purposes.

In Denmark, it would appear that housing especially designed to meet the needs of frail and disabled people is one of the keystones of social policies for elderly people. The 1987 Danish Housing for the Elderly Act places the responsibility for such housing on Danish Local authorities or municipalities. The Act recognises that elderly and handicapped people will often need specially designed houses and that this can be achieved either by building new units or by converting old ones. In either case the Act specifies the required size of units and stipulates that they should have no institutional features. Alarm systems are required in the new units so that help may be called at short notice in the event of sickness or accidents. The calls go to an alarm service exchange in the settlement or in the neighbourhood or they may go through a computerised exchange directly to the nursing staff working in the area. Some of the new or adapted autonomous dwelling units form part of the general housing stock, and some are provided in individual units which are part of special housing schemes and usually have additional social and medical amenities attached to them.

In respect of their housing policies there seem to be parallels between Denmark and the Netherlands. The Netherlands also places a great deal of emphasis on housing. There 'adapted housing' (small, purpose built units) according to some Dutch authorities need to be regarded as one of the main primary health care services providing support for people in their own homes (Kruit and Kruizenga, 1987: 169). 'Adapted' dwellings, which in 1987 accommodated over 200,000 aged people or 11% of the total, provide specialised domestic accommodation without any formal domestic staff. Adapted dwellings are provided in a range of forms, from small motel-like units found in most neighbourhoods, to independent living units situated alongside homes for the aged and nursing homes.

Though we have not come across studies which have measured the impact of special housing on moves to residential care, in Denmark it is considered self evident that this will be considerable. Table 4.9 (next page) indicates that the number of nursing home places is expected to decline while there is likely to be an increase in the number of other types of dwellings. Indeed, one of the elements of the Act is that local authorities may no longer build nursing homes or sheltered flats.

The Economic Circumstances of Users of Support Services

One might suppose a relationship between the capacity of people to live independently and at home and the extent of their economic resources. Indeed this has one of the assumptions of 'needs based planning' employed by the HACC program in Australia, where areas with a high proportion of socially and economically disadvantaged people have been regarded as having special needs.

Morginstin suggests that:

> *... an important factor influencing the way we define needs, demands and utilisation of public and private services is the economic resources available to current and future cohorts of elderly. ... Policy and planning should take into consideration the changing economic circumstances of ageing cohorts, especially in terms of work, retirement and earning patterns, capital income, cash and in-kind transfers and occupational incomes. One would expect, for example, the relative proportion of public and private expenditure on care, the emphasis on public or private service development to be related to the income available to groups of elderly upon retirement and as they age.* (Morginstin, 1989: 142)

TABLE 4.9: NUMBER OF PLACES FOR ELDERLY BY TYPE OF ACCOMMODATION IN DENMARK

	Total resources 1986	Budget estimate 1987	Planning period 1988	1991	Changes 1986-91 abs.	%
Nursing homes	49,088	48,650	47,190	46,140	-2,510	-5
Sheltered housing						
Number of dwellings	6,577	6,780	7,040	7,240	460	7
Number of residents	7,277	8,330	8,690	8,910	580	7
Commune-type dwellings						
Number of dwellings	3,356	5,720	6,470	7,130	1,410	25
Number of residents	n.a.	7,270	8,260	9,060	1,790	25
Other housing[1]						
Number of dwellings	n.a.	34,300	35,610	39,040	4,740	14
Number of residents	n.a.	37,310	38,650	42,550	5,240	14
Day-care centres	12,783	13,480	13,920	15,250	1,770	13
Day-care homes/centres	10,965	11,090	11,560	12,190	1,100	10

Notes: 1 Dwellings for retired persons, non-profit dwellings and private estates in which the municipality can allot flats to the elderly.
Developments in the housing sector: The downward trend of recent years in the number of nursing home places will continue in the years ahead. Municipal housing plans for 1987-91 envisage a decline in the number of nursing home places amounting to 2,510, a drop of 5%.

Source: The Danish Cultural Institute, 1989.

The economic circumstances of the elderly, both in terms of age cohorts and as individuals, may influence the level of need as well as how needs are defined in policy. Put simply, where service systems are poorly developed and there is a heavy reliance on private services, the more affluent are more likely than the less affluent to be able to remain independent (Estes, 1979; Butler, 1975). Further, such considerations are also likely to influence the response of health and welfare services to those needs. One response is to limit services to the poorer sections of the community and to allow market forces to provide for the remainder as for example occurs in the USA with the Medicaid system, and with the system in the Federal German Republic. In this situation eligibility for public services is determined on the basis of the financial means of the applicant. Another response is to means test payment for publicly provided services and to give people a choice as to whether they use public or private services. This is the basic system encountered in the Netherlands and in Scandinavia. In this context, the wealthy subsidise the less well to do, but are assured, as indeed are the poor, of access to high quality and regulated services. Yet another response is to provide services free of charge regardless of the client's income, or to levy a standard charge in the same way. This is the case with many community services in Australia. If there are inadequate services in this situation, rationing, in the form of waiting lists, becomes necessary with more detrimental consequences for those without private means than for those who are able to purchase private services. Each of these responses has crucial implications for the level of publicly provided services.

Our reading of the documentation has suggested that considerable variation exists with regard to such practices, both between countries and, as in the case of HACC services in Australia, between different regions and types of services within countries. This is clearly a very important area in any consideration of benchmarks. The literature received is only indicative, and suggests that those countries which have a very well developed system of home support services, such as the Netherlands and Denmark, lean towards universal access to public services with means tested charges. Countries with less well developed public services, such as the US with its Medicaid support of the indigent, will intervene in situations of acute need but otherwise allow private provision to dominate. The literature did not provide us, however, with sufficient detailed information to make any conclusive statements about these relationships. In future investigations of benchmarks and the provision of services in the HACC program, this topic will require further attention.

7. CONCLUSION

In this chapter we have examined the evidence concerning the actual operation of community support service programs overseas. Evidence of official service provision benchmarks was encountered in only three countries. In two of the countries, New Zealand and the U.K., their use has been abandoned, and it is only in the Netherlands that such benchmarks remain an important part of the national system of service administration. This absence of benchmarks can not, we believe, be attributed simply to difficulties in estimating the service needs of a population. Our reading of the relevant literature leads us to conclude that, instead, the structure of community service provisions and the socio-economic contexts which have shaped their operation have, in most countries, mitigated against their use.

In the relatively recent history of their development, the size, form and structure that formalised public systems of community services have assumed has varied considerably. Throughout the world it is clear that community services are still very much in a process of expansion, a process accompanied by considerable ferment and change. Their development is, in one sense, a response to demographic and social changes which have seen an increase in the numbers of people with disabilities, especially older people, who require assistance to remain in their own home. However this response is not simply an automatic or uniform reaction, but one which is conditional upon a range of contextual and operational factors. Because its growth and continued operation depends upon social, political and economic factors, both the size and structure of the emerging system of services and the resource allocation system which underlies it continue to vary between different countries. In turn, there often appears to be considerable variation tolerated, and in some cases even promoted, between the different States, or provinces, as well as regions and localities, in virtually every country for which we have information.

Many aspects of service provision associated with what might be thought of as the mechanics or internal dynamics of service provision have also proven significant determinants of their operation and clearly influence the types of planning measures most suitable to be deployed. The structure of the service system, with its multiple auspice arrangements, the combination of localised responsibility for agencies with centralised policy making and funding arrangements, and the specialised division of labour between different community service agencies has ensured that community service provisions are qualitatively different from that of most other large social programs. As a more sophisticated understanding of the operation and effectiveness of such a system is emerging it is likely that services will be targeted more selectively, and that assessments and questions concerning the eligibility for assistance will be emphasised more. Under such conditions processes of adjustment and change are likely to continue, if not accelerate. Consideration of the effectiveness of different types of assistance, and of different modes of organising this assistance, is, in this way, likely to have considerable impact on the types of community service systems that operate in the future.

Many of the same sort of issues facing Australia's HACC program are exercising planners, administrators and academics overseas. It would appear, however, that their approach in most cases is to conduct their planning activity at a local level, although Israel is a noteworthy exception in this regard. Rather than by using benchmarks, comparable countries overseas have attempted to reconcile the judicious use of financial resources with a concern for social equity in several different ways which we have sought to document in this chapter. Some examples are worthy of much more intense examination than we have been able to undertake here. We would particularly draw attention to the Netherlands, the Province of Manitoba, in Canada, Israel and Denmark.

CHAPTER 5

PRACTICAL APPROACHES TO THE PLANNING OF COMMUNITY AND DOMICILIARY SERVICES

The Triennial Review of the Home and Community Care program (1989) noted the absence of the development of centrally determined 'indicators of minimum or desirable levels of service provision' explicitly linked to a given population for use as a planning mechanism. However, service provision benchmarks of the sort envisaged have not been widely used as a planning mechanism for HACC-type services overseas. As we have noted in Chapter 4, services overseas have tended to develop in response to immediate local conditions resulting in somewhat ad hoc incremental growth and levels of service provision vary considerably between and within countries, (see Table 5.1). Despite this, we could find little evidence that centrally determined standardised levels of provision were thought to be either desirable or achievable. The lack of reference to them in the literature suggests that they do not play a major part in the planning culture.

TABLE 5.1: VARIATIONS IN EXTENT OF COVERAGE PROVIDED BY HOME HELP AND HOME NURSING SERVICES IN SEVEN COUNTRIES (1985-1988)

	Australia	New Zealand	Sweden	Denmark	UK	Belgium	Netherlands
Home Help							
Per cent 65+ receiving help	6.7	n.a.	21.3	17	9	9(a)	12
Hours help per week per 1000 65+	89	78					
1-6 hours per week	n.a.	n.a.	n.a.	84	94	n.a.	72
7+ hours per week	n.a.	n.a.	n.a.	16	5	n.a.	27
Home Nursing							
Per cent 65+ receiving help	2.5	n.a	3.18	12 per yr	5	6	5-8
Visits per week per 1000 65+	83	75					

Note: (a) 6% receive home help, only 3% also receive personal care.

Source: Figures or calculations based on information provided on the following sources:

Australia: HACC, 1990. Data for November 1988. ABS Population Projections 1988.
New Zealand: Koopman - Boyden 1988. Figures for Wellington 1986.
Sweden: Calculated from National Board of Health and Welfare, Sweden, 1989. Figures 1986-87, Swedish Institute 1988.
Denmark: Jamieson 1990.
UK: Jamieson 1990.
Belgium: Dooghe 1987, Dooghe and Vanden Boer 1986.
Netherlands: Jamieson 1990, Kastelein et al., 1989.

The development of measures of minimum or desirable service levels is nevertheless technically feasible. In Section 2 of this chapter we examine some of the more interesting practical approaches to this problem encountered in our examination of the literature, which suggest a range of ways in which the need for assistance can be measured and

service provision made to meet these. Building on this, we outline in Section 3 a suggested prototype or schema for the development of measures of minimum or desirable service measures and for the application of these as a method of resource allocation. In the final chapter we consider the relevance of alternative approaches for Australia.

2. SOME CASE STUDIES IN THE DETERMINATION OF SERVICE NEEDS

The case studies that we present in Section 2 of this chapter represent a range of methodologies and illustrate some of the ways in which information on service needs can be used both to arrive at judgements as to minimum or desirable service levels and to develop mechanisms which will regulate the allocation of resources for community support services. We have described the approaches used in Israel and Manitoba first because these were found to be particularly interesting. Other approaches used in a number of other countries have also have useful lessons for Australia. As will be apparent, these approaches have been developed under different circumstances or planning climates and at different stages in the development of service systems.

ISRAEL - PLANNING AND IMPLEMENTING A NEW SERVICE SYSTEM

Faced like other countries with an increase in the number of elderly people and a change in the composition of the elderly population, in particular with a growth in the old-old population, Israel has put considerable thought and effort into working out the implications of demographic change for service needs and more generally into the planning of community services for elderly people.

In 1980 the Israeli Parliament passed legislation which established a community services financing branch within the National Insurance Scheme and set up a public commission to recommend the specific form that the new scheme would take. In order to cost alternative service options, the commission required basic information regarding both existing services and service needs. The Government's National Insurance Institute and the JDC-Brookdale Institute of Gerontology collaborated in developing the necessary data base. A preliminary task was to map comprehensively community services for elderly people with disabilities and to obtain detailed information about these. This information was then used to calculate utilisation rates both nationally and by specific geographic areas.

Methodology

To estimate service needs within the context of the existing provision and hence to be in a position to cost service options, answers were thought to be needed to the following questions:

> *'What is the gap between needs and services?*
>
> *In what services is this gap most acute?*
>
> *How will the needs for services grow and which needs will grow the fastest?*
>
> *Is the relative division between formal and informal sources of care likely to change?*
>
> *What are the cost implications of the growth in needs?*
>
> *What are the relative needs in different regions of the country?'* (Factor, 1988: 62-63)

In order to answer these questions a complex long term research program was set up. Factor describes the components of this program. These represent the steps taken to estimate current and projected need for services.

The steps were:

1. **A community-wide survey of disability.** The information collected was based both on self reported disability and on assessment by teams of professionals;

2. **The translation of disability levels indicated in this survey into units of care needed.** This was based on the views of 3 types of key informants- professionals, the family and the elderly person and involved the preparation of a care plan based on the assumption that needs were to be fully met. Functional disabilities were translated into hours of required assistance in personal care and homemaking.

3. **The division of required hours between formal and informal providers and thereby the determination of units of need for formal services.** This information was based on the judgements of 3 types of key informants, as above. The assessment teams recommended an 'optimal division of labour' between the family and formal providers of care, paying due regard to excessive burden of care.

4. **An estimation of the links between demographic traits in the population and the need for formal services.** This involved the development of a model to predict disability and service needs on the basis of demographic characteristics.

5. **An estimation made from census data of the links between demographic traits and institutionalisation.** National population census data was used to calculate specific institutionalisation rates by type of bed, and demographic characteristics.

6. **Projection of the elderly population by major demographic characteristics at the national and regional levels.** The model referred to in 4. above was used to estimate service needs in other regions.

7. **Projection of the numbers of disabled people and service needs by area or, at various points in time, based on projection model and demographic composition.** Demographic variables such as age, sex, family status, ethnic background and living arrangements were found to be significantly related to functional status and service needs. In addition, the relationship was found to differ between service types, indicating the importance of examining each service-type separately (Factor, et al., 1984 and Habib, et al., 1987).

8. **Evaluation of the community services required to prevent institutionalisation and an assessment of the degree to which institutionalisation can be prevented based on key informants evaluations of elderly people awaiting institutional placement** (substitution rate parameters).

9. **Application of substitution rate paramenters to alternative assumptions about increases in institutional beds.** This analysis showed that waiting lists indicate both insufficient institutional services and community services.

On the basis of this information the Community Long Term Care Insurance Law (CLTCI) was implemented in 1986. This Law provides a universal personal entitlement to personal services and care benefits in a social insurance program which is paid for by contributions from the working population. The aim of the personal benefit is to enable dependent people to remain at home for as long as possible and to help family caregivers by providing support services. The benefits or services are not intended to replace or undermine family care but, where it is available, to complement it. Commentators suggest that the CLTCI Law has provided a much needed impetus to the growth of community and domiciliary services in Israel. Tables 5.2 and 5.3 below, show that the implementation of the Law has had a considerable impact on the provision and receipt of services, particularly in the area of personal care.

Under the Law an individual's eligibility for services is defined in terms of the extent of their functional disability. The eligible population is confined to people with very severe disabilities, broadly defined as those who need assistance in at least 2 of the Activities of Daily Living (ADLs), for example, mobility and personal care. Level of dependency is determined using an assessment instrument administered by a public health nurse. Each person

TABLE 5.2: ISRAEL: COMPARISON BETWEEN NEEDS AND EXISTING PERSONAL-CARE SERVICES FOR 1980-88, PRIOR TO THE IMPLEMENTATION OF CLTCI LAW

	1980		1983		1988[5]	
	Thousands	%[1]	Thousands	%[1]	Thousands	%[1]
Total Disabled in ADL in the community[2]	25.6	7.8	28.4	8.1	33.6	8.8
Disabled in the community: require formal services[3]	10.8	3.3	11.9	3.4	14.4	3.8
Recipients of formal services[4]	3.3	1.0	5.1	1.5	9.1	2.4
Percent coverage of unmet needs for formal services		31		43		63
Percentage of recipients out of total disabled population		13		18		27

Notes:
1. Percentages of aged 65+ in the community.
2. Including persons requiring assistance with at least one of the following basic ADL functions: bathing, eating, dressing, continence control.
3. Including persons requiring at least one hour per week of assistance in basic household tasks and there is no other person in the household able to perform these tasks.
4. Recipients of formal services include elderly referred by public agencies and self-referrals to Matav Association.
5. Although during two years prior to complete implementation of CLTCI, funds were transferred under CLTCI to the Ministry of Health and Social Affairs and to the General Sick Fund in order to expand the network of services until final implementaiton of personal benefits in April 1988. Thus comparison of coverage before and after CLTCI should be made with 1983.

Source: Factor, H., B. Morginstin and D. Naon (1989), **Cross-National Analysis of Home Help Services: Development of Home Help Services in Israel**, JDC-Brookdale Institute of Gerontology and the National Insurance Institute, Jerusalem.

TABLE 5.3: ISRAEL: COMPARISON BETWEEN NEEDS AND EXISTING PERSONAL-CARE SERVICES AFTER THE FULL IMPLEMENTATION OF THE CLTCI LAW, 1989

	Thousands	Percentage[1]
Total disabled in ADL in the community	**34.5**	**8.9%**
Total Recipients	**17.1**	**4.4%**
Financed by the National Insurance Institute	13.7	3.5%
Financed by Others	3.4	0.9%
Percentage of recipients among the total disabled population	-	50%

Note: 1. Percentage of the population aged 65+ living in the community.

Source: Factor, H., B. Morginstin and D. Naon (1989), **Cross-National Analysis of Home Help Services: Development of Home Help Services in Israel**, JDC-Brookdale Institute of Gerontology and the National Insurance Institute, Jerusalem.

receives a dependency score and additional points may be awarded on the basis of other personal circumstances, for example, living alone. There are two levels of benefit which are allocated on the basis of assessed need. At the lower level the benefit is worth about 11 hours of personal care per week. At the higher level of dependency the benefit is worth about 17 hours of care per week. The basic entitlement is for 'service in kind'. However, where services are unavailable the eligible person is entitled to a cash benefit with which may be used either to purchase services or to support caring family members until services become available. Services are means tested but the rules governing payment for services are such that, in fact, few people pay for the services they receive. The kinds of service which are included under CLTCI are delineated in a 'basket of services' which are closely related to direct caring functions. Service providing agencies (be they public or private) are reimbursed directly from the insurance fund.

Thus, benefits within the framework of the CLTCI Law are provided on the basis of universal entitlement, according to strict criteria of eligibility. Eligibility is primarily dependent upon the assessed level of functional disability and there is a clear attempt to minimise service providers' discretion in determining eligibility within the framework of the Law. However, it should be noted that Israel has a dual system. Whilst services provided under the Law are targetted at those with the severest levels of disability, those with a lesser disability may still receive services. In these cases there is no automatic entitlement. Services are provided in this case on a discretionary basis. Further, the CLTCI covers only a limited range of services, not the wide range of service types included in the HACC program in Australia.

Because services under the Law are provided on the basis of entitlement and not limited by budgetary considerations, in setting up this new insurance scheme it was particularly important to be able to predict the cost implications of meeting needs at various levels and to taking into account the means and domestic circumstances of the dependent population. A great deal of importance was therefore attached to the quality of the data base used to cost the various options. In personal communication, Brenda Morginstin of the National Insurance Institute indicated that, despite the rigour with which the research was undertaken, the studies tended to underestimate the demand for services. This is not surprising as it is common experience that knowledge of the availability of a service stimulates the demand for it.

Although Israel does not have centrally determined benchmarks (in the narrow sense of the term), it certainly uses centrally determined eligibility criteria which enable services to be developed in such a way that provision is matched closely to need. We are not, however, in a position to comment on the outcomes either in terms of the sufficiency or quality of services provided to clients or as to the cost implications of the Israeli system. We have described this in some detail because it illustrates the use of a systematic approach, along the lines recommended earlier, to determine the need for services and to cost them. It is an approach which Australian authorities, at both the Commonwealth and State levels, might wish to scrutinise more closely.

MANITOBA - UTILISING DATA FROM ASSESSMENTS, SERVICE USE AND SURVEYS

The methodology used in Israel, like those of New Zealand and Belgium described later in this chapter, required a major survey (or surveys) of need to be undertaken. Research predicting the use of home support services conducted in Manitoba, in contrast, demonstrates the effectiveness and simplicity of an alternative strategy which utilises existing statistics on service use together with data collected as part of the centralised assessment of clients. Rather than producing an estimate of need from survey results and then attempting to extrapolate service provision from this, the Manitoba approach is able to provide an extremely accurate estimate of the actual rates of service usage together with a wealth of detail concerning the characteristics of those people who apply for and receive assistance.

As discussed in the previous chapter, the Manitoba approach to community support services utilises a case management approach to community services. An assessment system serves as a single point of entry for all institutional and domiciliary care. Because eligibility for services is determined on the basis of the assessment, the eligibility criteria employed identify the minumum level of need for those entering the program. Payments to service agencies are made simply on the basis of the reimbursement of agreed costs. This approach is similar to the mode of operation of the Australian Community Options projects, with the exception that there is no ceiling imposed on either the total number of clients or the total expenditure for the home support program. Instead, the maximum spending limit is determined for each client as the cost of nursing home subsidies, at which point the cost effectiveness of community support is no longer apparent.

On the basis of assessment data and subsequent service records for Manitoba in 1976, Shapiro (1986) estimates that between 5 and 6 per cent of all elderly people in Manitoba are likely to be 'admitted to service' each year. Many of these will require support for a limited time only as they benefit from support during a period of recovery, or cease to use services for other reasons, such as death or admission to a nursing home. Others, however, are likely to require assistance for a prolonged period. Hence, during any one year, approximately 10 per cent of the population aged 65 and over will require such assistance. Details of average costs and service usage are also referred to in the study.

By combining data derived from service records and from the Manitoba Longitudinal Study on Ageing (Mossey, et al., 1981), Shapiro is able to demonstrate that higher usage rates of 'home care' are required with increases in the age of applicants and with increases in disability. Other factors affecting usage include domestic circumstances and self-rated health. Hence, she argues, provision rates for services need to be based not simply on a crude index such as the number of people aged over 65, but on estimates of usage by distinct user groups. (See Table 5.4)

TABLE 5.4: MANITOBA: AGE-SEX DISTRIBUTION OF NEW ADMISSIONS TO HOME CARE, IN MANITOBA[a]. ALL HOME CARE ENROLLEES AND COMMUNITY ELDERLY NOT USING HOME CARE IN 1976

		Total Sample N = 2770[b]	New Admissions N = 125	All Home Care Recipients N = 273[b]	Non-users in Community N = 2497[b]
Pct Age 70-74	M	18.0	4.8	4.4	19.5
	F	18.4	8.8	11.4	19.1
Pct Age 75-84	M	24.1	24.0	19.0	24.7
	F	26.0	35.2	34.1	25.2
Pct Age 85+	M	6.3	12.0	13.2	5.5
	F	7.2	15.2	17.9	6.0
TOTAL PERCENT		100.0	100.0	100.0	100.0

Notes: a. In Manitoba the Home Care Program includes all HACC-type services.
b. One Person is missing in these tallies because information on his or age age was unavailable.
Source: Shapiro, 1986: 33.

The concluding paragraphs of her study of 'patterns and predicters of home care use by the elderly' show the approach to be one which could be of particular interest for the HACC program.

> *The study indicates that a home care program [i.e. HACC like services] based solely on professionally-assessed need admits only a small minority of elderly. ... The actual number of home care admissions and lengths of stay [i.e. the amount of time individuals receive assistance] can be expected to increase with the growth in the population over age 75 and especially over age 85 but concerns about uncontrollable demand if nonrestrictive policies in the provision of service (or payment) are implemented appear to be unjustified.* (Shapiro, 1986: 43)

Shapiro is thus able to claim with some confidence that service provision would not need to escalate in an 'uncontrollable' manner if services are provided solely on the basis of the assessed need of individual applicants.

Shapiro's account clearly demonstrates the value of this approach for determining the extent of requirements for home support services. Full details of the research method were not available to us, however. Although it was published in 1986, data presented in the study relate to 1976. A more up to date analysis based on a similar methodology but using more recent data would, we believe, be of considerable interest. A comparative investigation in the Australian context, for example, one comparing data from a Geriatric Assessment Team with census data, could also prove a valuable tool in estimating the likely need for and take up of community services under certain conditions.

NEW ZEALAND - DETERMINING THE ACCOMMODATION AND SERVICE NEEDS OF THE ELDERLY

The application and subsequent lapse of service provision benchmarks for home support services in New Zealand has been detailed in Chapter 4. For present purposes, however, we are less concerned with the implementation of these benchmarks than with the methodology used to develop them. This methodology remains worthy of study many years after it was first carried out not only because of its pioneering approach and the international recognition it has received (Little, 1982; Dooghe, et al., 1988) but for its simple yet direct approach to the estimation of the need for assistance, and for the innovative way in which the need for assistance was translated into direct measures of service provision. There were, however, a number of problems and limitations inherent in the method which also deserve attention.

Methodology

The New Zealand methodology, modelled on the standard research techniques of a survey based needs analysis for a population, was developed and adapted specifically by the Management Services and Research Unit of the Department of Health, in Wellington, in the period of the early to mid-1970's. A representative sample of 5000 people aged 65 and over was selected from the Department of Social Welfare's list of universal superannuants, age beneficiaries and holders of war veterans allowances. This sample was supplemented by a smaller number of people resident in psychiatric hospitals, and prisons. Interviews were then carried out in three stages. In the first, a 'screening' stage which involved the entire sample, basic demographic data and some information about health, housing and disability was obtained. In the second stage, more detailed questions, including those about the capacities of respondents in ADL and their use of services were asked using what the researchers called a 'control group' of one in five of those originally surveyed. The third and final stage of the survey involved a medical assessment. All respondents who were disabled or in institutional care were examined by a medical assessor. Recommendations were subsequently made concerning the assessed need for services and accommodation (Salmond, 1976).

Guidelines setting out the standardised service needs of people with particular levels of disability were determined prior to and in the course of the conduct of a survey, so that field staff conducting the research could readily estimate the type and amount of services individuals would require. Interviewers (experienced public health nurses) and medical assessors (three senior medical practitioners) classified the service requirements of each respondent according to the specific guidelines and their professional judgement of need. The researchers subsequently tabulated the extent of 'essential need' for specialised services and forms of accommodation as part of the collection of reseach data.

Because estimates of the extent of service provision required were derived from the assessors' recommendations, the criteria used in formulating recommendations were of crucial importance. These criteria, or 'guidelines to recommendations' were developed on the basis of discussions conducted by the research team. Although developing recommendations concerning the service needs of most of the sample does not appear to have been difficult, the researchers note the range of factors which needed to be taken into account in making recommendations for the services needed by some individuals. These included questions of health and disability as well as the type, size and location of accommodation, the availability of informal support, the adequacy of income and the personality of the individual. Given the complexity of such factors in making judgements about required services the report observed that:

> *Good practical guidelines and effective supervision will reduce bias attributable to individual assessors but the fact of the matter is that in a well controlled survey need* ***cannot be assessed with scientific precision. Professional judgement is required.*** (Salmond, 1976: 15, our emphasis)

The guidelines to assessors were thus formulated in a fairly general manner, leaving considerable scope for individual assessors to exercise discretion. According to the report, the specific guidelines which should be taken into account when recommending services were as follows: (Only the key sections of the guidelines for residential care and hospital care have been included here)

> *'Recommend for care in a residential home only those people who need help with bathing, dressing, toilet and meals ... and those with temporary or continuing confusion of mind but who do not need psychiatric nursing care.*
>
> *...As a general rule if a person can walk independently he should not require hospital care. ...*
>
> *The following guidelines were suggested in recommending services.*
>
> 1. *Services may be provided to help an elderly person (often living alone) to cope with the activities of daily living, such as bathing, washing, cooking, cleaning.*
>
> 2. *Services may be provided to deal with specific medical, nursing or paramedical problems; services such as district nursing, domiciliary oxygen, chiropody, domiciliary physiotherapy or occupational therapy.*
>
> 3. *Services may be provided to give physical support to those caring for an elderly patient at home, i.e. a district nursing service, a laundry service or home help.*
>
> 4. *Services may be provided to give social support to an elderly person or to the people who care for the elderly, i.e. a social work service, a home visiting service.*
>
> *In all cases recommended services must be related to recommended accommodation.*
>
> *When making recommendations assessors were asked to keep the guidelines in mind but* ***in the last analysis each decision had to stand on its own as an independent professional assessment.'*** (Salmond, 1976: 16, our emphasis)

The emphasis, therefore, appears to be on a professional and somewhat discretionary approach to the assessment of need, rather than upon a standardised and objective approach as employed in the Israeli case cited above. However, it is interesting to note that both systems rely upon professional judgement, albeit in different ways.

In this respect, the research seems at some stages to have had difficulty in determining an appropriate level of services which could be judged adequate. To cite once again the original report:

> *Need for services was assesed at two levels, an essential level and a desirable level. 'Essential' services were those deemed essential to maintain an elderly person in the accommodation recommended. The concept of 'essential' services applies to the four main domiciliary services - nursing care, meals-on-wheels, laundry service and home aid. Services recommended at the 'desirable' level could be thought of as preventative maintenance services ... thought necessary for physical fitness and morale. What is reported here is need assessed at the 'essential' level. Need at the desirable level turned out to be a hopelessly unrealistic concept given the resources we can reasonably hope to command in the foreseeable future.* (Salmond, 1976: 39)

No data on 'desirable' service levels was included in the final report. While this is unfortunate in some respects, it does appear to be an illustration of the process outlined in chapter two, by which needs tend to redefined in terms of the resources available to deal with them. Once again, we note the similarity with the Israeli system which distinguishes between essential and discretionary services.

The report's main conclusions regarding the provision of home support services are summarised in Table 5.5 (next page). This shows an index of the adequacy of current provision as a guide as to the extent of additional services required to meet the 'minimal standards' determined by the research team.

TABLE 5.5: NEW ZEALAND 1976: ASSESSED ESSENTIAL NEED FOR AND CURRENT PROVISION OF DOMICILIARY AND OTHER SOCIAL SERVICES FOR THE POPULATION AGED 65 AND OVER

Services	Assessed need per 1,000 65+ at home	Assessed need per 1,000 population 65+	Percent need currently met at home.
	No.	No.	%
Domiciliary nursing*	21	25	100
Meals-on-wheels*	18	27	40
Laundry services*	13	20	20
Home aid**	20	28	10
Occupational therapy	18	18	10
Physiotherapy	29	27	70
Chiropody	116	115	75
Social day care	16	17	20
Day ward care	4	4	10

Notes: * Services needed at least weekly
** Services needed at least once every two weeks.

Source: Salmond, 1976: 40, 86.

A comparison of Table 5.5 with the New Zealand benchmarks presented in chapter 4 shows that, by and large, these recommended levels of service were adopted by the New Zealand government as service provison guidelines, following some slight modification which allowed service provison to be expressed as an appropriate figure, for example based on the number of hours service per week, or nursing visits, or meals, per thousand people aged 65+. However, as discussed in Chaper 4, the Guidelines are no longer in use, having since been replaced by a different approach to service planning and resource allocation.

It is notable that the New Zealand methodology combined the collection of primary data about the levels of disability and health problems with Guidelines on the level of assistance needed in a single survey. This approach initially tended to disguise the level of discretionary judgement involved in producing estimates of the need for particular services, as the estimates were presented as the result of technical research, and not as professional judgements. Subsequently, however, the measures were widely criticised for having underestimated the amount of services required. One of the lessons which might be learnt from this experience is that the different steps used in producing estimates of the service requirements of a large population need to be made explicit and, as far as possible, kept distinct from any initial data collection exercise.

BELGIUM - TWO APPROACHES TO THE DETERMINATION OF THE NEED FOR SERVICES IN THE FLEMISH SPEAKING COMMUNITY

In Belgium, community services for the two major linguistic and cultural 'communities' are organised separately under the Ministry for the French Speaking Community and the Ministry for the Flemish Speaking Community. Each of the community ministries works under the same national legislation in respect of community support services for aged people and people with disabilities, and administers a system of services which is in accord with the national legislation. Detailed information on estimates of the need for services amongst the elderly was forwarded to us from the Ministry of the Flemish Speaking Community, in particular from the Centrum voor Bevolkings en Gezinsstudien (the Centre for Population and Family Studies) in Brussels.

Two distinct but closely related methodologies used in determining the future requirements for community support services for this group are of interest: the projection of existing patterns of service usage; and a population survey of need. Each of these is summarised below. It should be noted, however, that although the research was conducted by a government based research institute, it is not known to what extent the estimates provided by the research have been endorsed by government as a measure for determining future levels of provision.

Estimating Required Services by the Projection of Existing Provisions

In a major report for the Office of the Ministry of Family and Welfare Services, Dooghe provides estimates for short-term developments in the major institutional and home support services required by elderly people in Flanders, based on adjusted projections of current provision, and population projections. 'Short term' developments, he explains, refers to the fifteen year period 1985-2000.

In conducting this study a number of basic parameters held to affect the need for 'non-profit services' are spelt out as the basis on which more detailed estimates can be made. These parameters include:

a. the **non-market characteristics** of a welfare policy for elderly people, requiring government intervention and planning;

b. the assumption of the continuation of the existing **pluralistic provision of services**, whereby non-profit government, local government, voluntary organisations based service, supplemented by the contributions of volunteers will continue;

c. the importance of **facilitating family assistance**, by a careful recognition of both the strengths and the limitations of support provided by such informal carers;

d. a recognition of **the limits of government finance**, and the importance, therefore, of achieving both efficency and equity in supporting such services. The slogan to be used in planning, Dooghe notes, needs to be 'to do more and better with just as much';

e. a plea for more research into factors which determine the **actual use of services** provided, as patterns of need and actual service use do not correspond; and

f. an examination of **social factors** which directly affect the need for home support. Those analysed in detail include demographic developments, changes in the health of the population and in the provision of health services, accommodation and changes in the pattern of housing and home ownership, questions of income adequacy and income support, the impact of social changes such as the increases in divorce rate, declining marriage rates, the increasing labour force participation of women, smaller family sizes, and higher education levels, and the shift in service provision to a community services model.

Factors listed above as a.-e. affect the need for and type of future service planning to be undertaken, Dooghe claims. The factors listed in f. influence the extent of service need and should therefore be reflected in the extent of service provision. Where possible such factors were taken directly into account in the calculations of services required. Of particular note here was the association between services provided in residential institutions and the home. Dooghe

took pains to point out that a reduction in the level of institutional facilities would require a massive expansion in home support, well beyond the levels projected in his report.

Projections of the future levels of services required were derived by a careful consideration of evidence from a variety of sources, including official reports, evidence of waiting lists, parliamentary debates and academic research, as to the adequacy of existing provision and the features presently associated with service use. Adjustments of various types were made when evidence warranted this (for example, where there was clear evidence of continuing waiting lists despite apparently accurate assessment of existing users and of those waiting) and estimates of an adequate level of service produced. Using population projections, estimates of future requirements and their resource implications were then produced. The figures set out in Table 5.6 below summarise the rates used for determining the main projections.

TABLE 5.6: PROPOSED FUTURE LEVELS OF PROVISION FOR DOMICILIARY SERVICES IN FLANDERS, BASED ON AMENDED EXTRAPOLATION OF EXISTING PROVISIONS.

Service	Level of provision
Home Help	
Minimal estimate	1014 hrs p.a. for each 100 people aged 60+[a]
Higher estimate	1109 hr p.a. for each 100 people aged 60+[b]
(Higher estimate based on projections using data from the Netherlands)	
The Provision of Warm Meals	
Minimal estimate	258 meals/week for each 100 people aged 65+
(Based on current level of provision)	
Higher estimate	395 meals/week for each 100 people aged 65+
(Based on levels of recognised need for such services and projections from some areas of high provision.)	
Home Nursing[c]	
Current rates used as basis for projection	0.3 nurse per thousand gen pop. (i.e. 2.1 per thousand 65+)

Notes:
a. Figure calculated from estimate of 301 hrs p.a. for 3.37% of the population aged 60+
b. Figure calculated from estimate of 329 hrs p.a. for 3.37% of the population aged 60+
c. Home nursing appears to be outside the jurisdiction of the Office of the Community Minister for Family and Welfare Services. Projections for home nursing were not presented in the report.

Source: Dooghe, 1987; Dooghe and Vanden Boer, 1986

Developments in other community services are also discussed, but numerical projections of future requirements are not made.

Estimates of the Need for Services Based on a Survey of a Representative Sample of Elderly People

A second Flemish example of a technique for estimating the extent of need for formal services amongst the elderly is provided by the survey method. Information concerning the lives of the elderly in Flanders was obtained from a large scale survey of a representative sample of approximately 1,500 people aged 65 and over living outside residential institutions in Flanders in 1984-85. Analysis of the data permited the identification of sub-groups with particular characteristics, patterns of the use and non-use of formal services, the availability of alternative forms of support, and,

consequently, the measurement of what the authors term 'unmet need'. (Dooghe, et al., 1988.) All information used was provided by the respondents in an interview. Separate medical assessments were not made. Considerable attention was given to the preparation of the survey, and the development of appropriate and reliable survey instruments. Details of this preparation and the analysis applied to the results are contained in the report. Some of the most relevant and interesting results of the survey are summarised below. The method is similar to that employed by the Australian Bureau of Statistics in the **Surveys of Disability and Handicap** and by surveys of the needs of older people previously conducted in Australia (ABS, 1981, 1990; Howe, 1989). What is particularly notable about the Flemish survey is the systematic way in which the study was set up as research. This involved a comprehensive review of a wide range of alternative approaches to the study of service needs, the employment of definitions of crucial terms (such as disability, ADL and so forth) in an internationally standardised way, where possible, and a critical perspective on the survey's results and their application to the planning of services.

Tables 5.7 and 5.8 (next page) show the extent to which elderly people receive assistance with personal care, mobility and a wide range of household tasks. Although the level of assistance appears to be considerable, much is provided within the household, usually by a spouse. The authors comment that it is often not possible to distinguish between assistance received on the basis of incapacity or assistance received as part of a person's role in the home.

TABLE 5.7: FLANDERS: PERCENT OF THE AGED POPULATION RECEIVING HELP WITH HOUSEHOLD ACTIVITIES (N = 1478)

	Prepare warm meal	Make coffee or tea	Light house-work	Heavy house-work	Laundry	Garbage	Small Repairs
Self-care	52	79	67	34	35	60	45
Dependent on help all sources:(1)	48	21	33	65	65	38	51
- Spouse/partner	30	15	21	23	23	16	13
- Children	11	5	8	21	22	15	23
- Other family	3	1	2	4	4	3	5
- Friend, neighbour	2	1	1	2	1	4	4
Total informal care(2)	46	22	32	50	50	38	45
Home help, meals on wheels	4	-	1	8	1	1	*
- Home nursing	*	-	*	-	-	-	-
- Private service	1	*	1	9	16	2	9
Formal care(3)	5	*	2	17	17	3	10
TOTAL	100	100	100	100	100	100	100

Notes: * Less than 1 %

The total of (2) and (3) is, in most cases greater than (1) as multiple sources of support were often encountered.

Source: Dooghe, et al, 1988: 253.

TABLE 5.8: FLANDERS: AGED PERSONS RECEIVING HELP WITH MOBILITY AND PERSONAL CARE, IN PERCENT (N = 1478)

	Garden	Neigh-bourhood	Beyond Neigh-bourhood	Climb Stairs	Move around home	Step in or out of bed	Dress	Foot care	Daily wash	Use toilet	Take shower or bath	Eat or drink
Self-care	86	71	57	84	98	97	94	73	95	98	68	99
Dependent on help, provded by:(1)	12	28	33	4	2	3	6	26	5	2	9	1
- Spouse/partner	4	9	8	2	1	2	3	5	2	1	4	*
- Children	6	14	21	3	1	1	2	5	1	1	3	1
- Other family	1	3	4	1	*	*	*	1	*	*	*	-
- Friend, neighbour	1	3	3	*	*	*	*	1	*	-	*	-
Total informal care(2)	12	29	36	6	3	4	6	12	4	2	8	1
Home help, meals on wheels	*	*	*	*	-	-	*	1	*	-	1	-
- Home nursing	-	-	-	-	-	*	1	2	1	-	1	-
- Private service	-	*	*	-	*	*	*	12	*	*	*	*
Formal care(3)	*	1	1	*	*	1	2	15	2	*	2	*

Note: * Less than 1%
The Total of (2) and (3) is, in most cases greater than (1) as multiple sources of support were often encountered.

Source: Dooghe, et al., 1988: 252

The extent of the use of formal community support services by those in differing domestic circumstances is shown in Table 5.9. Patterns of use vary considerably. The self-identified need for services also varies according to the type of service, but in almost all cases is between 1 and 5 per cent of those surveyed.

TABLE 5.9: FLANDERS: THE USE OF SERVICES, AND EXPRESSED NEED FOR SERVICES, ACCORDING TO DOMESTIC CIRCUMSTANCES, IN PERCENT

Domestic Circumstances	Service used	Service not used but needed	No service or need	No service: service unknown or no answer
1. Personal care				
- Lives alone	4	3	89	4
- With others	2	3	92	3
- Total	3	3	91	3
2. Cleaning service (Polishing service)				
- Lives alone	12	5	79	4
- With others	3	5	88	4
- Total	6	5	85	4
3. Home nursing				
- Lives alone	6	*	92	2
- With others	6	1	92	1
- Total	6	1	92	1
4. Home maintenance				
- Lives alone	1	4	86	9
- With others	1	2	91	6
- Total	1	2	90	7
5. Warm meals				
- Lives alone	6	3	90	1
- With others	1	1	96	2
- Total	3	2	94	1
6. Social service (Social worker?)				
- Lives alone	5	1	91	3
- With others	3	1	93	3
- Total	4	1	92	3
7. Service centre				
- Lives alone	2	1	81	16
- With others	1	*	83	15
- Total	2	*	82	16

Note: * Less than 1%

Source: Dooghe, et al., 1988: 268.

The use of three core services, personal care, cleaning and home nursing, is documented in Table 5.10. The authors comment that the figures show the relatively low intensity of service use amongst the sample. Further, although service use tends to increase with increases in disability, there is not a uniform tendency for use of all home support services to increase to the same extent with increases in disability. A detailed comparison of these results with a similar survey in Australia would be likely to be provide interesting results.

TABLE 5.10: FLANDERS: THE FREQUENCY OF ASSISTANCE FOR THOSE WHO USE PERSONAL CARE, HOME CLEANING OR NURSING, IN PERCENT

No. of hours help/work	Personal Care	Cleaning Service	Frequency	Home Nursing
1	2	26	Several x per day	9
4	28	57	1 x per day	33
5	7	9	Several x per week	17
8	37	5	1 x per week	26
8	26	3	Less than 1 x per week	15
n(100 %) =	43	82	n(100 %) =	90

Source: Dooghe, et al., 1988: 271.

The extent of 'unmet needs' encountered in the sample is presented in Table 5.11 (next page). The difference between the 'objective' and 'subjective' measures is worthy of note. The large differences between self-reported or subjective need for services and the researcher or objectively identified need may help explain why demand for services tends to increase significantly once provision is expanded. The existing levels of provision plus additional services to meet existing subjective levels of need could, for this reason, prove a useful initial planning guideline. Later developments would be likely to see demand increase towards the level of objectively identified need, and service provision could be increased accordingly.

To our knowledge the data obtained in the needs survey have not, as yet, been used to develop accurate estimates of the level of service provision required to meet the needs identified. Interestingly, the authors refer favourably to the New Zealand research outlined earlier in this chapter, and point to the determination of service levels in an analagous way in Flanders as one of the possible applications to which their data could be put. However, the problems with cross-sectional research are noted and it is pointed out that for reliable predictions of service provision a longer term profile of the development and change in patterns of need and support is required. This can only come, they suggest, from longitudinal studies. Such studies, to supplement a large national survey, can confidently be undertaken on a local basis with a smaller number of participants (see also Croes, 1987).

A further difficulty in using such survey data to plan services, as the report notes, is that, in addition to the differences already noted between the levels of 'objective' and 'subjective need', a considerable difference is observable between the levels of need for assistance, and the levels of actual service use. This leaves a considerable margin for error or disputation in the application of such methods for service planning.

TABLE 5.11: FLANDERS: UNMET NEEDS: SUBJECTIVE AND OBJECTIVE MEASUREMENTS

Per cent of total sample

Activity	Objective[a]			Subjective[b]		
	Living Alone	**With Others**	**Total (n=1478)**	**Living Alone**	**With Others**	**Total**
Mobility						
Garden	13	7	9	2	1	1
Neighbourhood	8	5	6	3	1	2
Use stairs	22	21	22	1	1	1
Move around home	15	10	11	1	1	1
Step in or out of bed	17	11	13	1	2	1
Personal Care						
Dressing (both clothes and shoes)	18	10	12	1	1	1
Foot care	13	7	9	3	2	2
Daily wash	14	8	10	2	1	1
Use toilet	11	8	9	*	*	*
Take shower or bath	10	6	7	2	*	1
Eating or drinking	8	5	6	1	*	*
Household Activities						
Prepare warm meal	8	2	4	3	1	2
Make coffe or tea	9	3	5	*	*	*
Light housework	11	5	6	1	1	1
Heavy housework	9	4	6	3	2	3
Wash and/or iron	6	4	5	1	*	1
Put garbage out	12	4	7	2	1	1
Small repairs	5	5	5	2	1	1

Notes: * Less than 1% of total.

a. The aged person is partly or totally incapable of the activity, but receives no help. He or she is therefore **objectively assessed by the researchers** as requiring assistance.

b. The aged person, although, partly or totally incapable of the activity, copes without assistance at present. **He or she, subjectively,** identifies a need to receive help.

Source: Dooghe, et al., 1988: 275.

GREAT BRITAIN - BALANCE OF CARE

The Balance of Care Model, which was developed in Britain by the Operational Research Section (ORS) of the Department of Health and Social Security in the 1970s represents another and rather different approach from those we have so far described. Its main objective was 'to assist local health authorities and social service authorities to achieve a balance between institutional and community services on the one hand and between health and local authority funded services on the other.' Another key objective was to provide local planners with a knowledge of the resource implications of altering the balance between these different sectors of care (McClenahan, et. al, 1987).

There are many alternative ways of providing care for elderly dependent people (and indeed other client groups). Different care options require inputs from different sources and have different resource implications. Using a microcomputer system, the Balance of Care Model provides a method of assessing the resource implications of providing care in one way rather than another for a given population with given care needs.

The model is based on the assumption that a system of care has a number of component parts which can be combined in an almost infinite number of ways, each of which will have measurable resource implications. A description of the components of the model may serve to clarify how it works.

The components of the model are as follows:

- **client groups.** This is the group of people for whom a range of services is being planned, for example, elderly people or people with a mental illness;

- **classification factors.** This term is used to divide the client group into smaller sub categories with similar needs for care. These factors include physical disability, mental disability, incontinence, level of informal support, housing conditions;

- **categories.** These are comprised of subgroups of people defined by combinations of classification factors judged to have similar needs for care, for example, elderly people, with cognitive or behavioural problems, who are incontinent and living with their daughter;

- **resources.** These are defined as services allocated and/or managed by a single relatively autonomous group of (often professional) staff. They include hospital beds in a long stay ward, a place in a nursing home, a hostel place, a place in a day centre, home help, respite care, meals on wheels and so on;

- **care settings.** This is the predominant location of the type of care provided, for example, hospital, residential home, day hospital, client's home.

- **methods of care** These are combinations of resources available to provide care to a category of people. There may be several methods of care judged suitable for any particular category. Each combination of resources constitutes a different method of care which can be grouped into care settings. For example, domiciliary care can involve the visit of a domiciliary nurse only, or a domiciliary nurse and meals on wheels, or a home help and meals on wheels.

The Balance of Care model assumes that:

a. the number of people within a given locality with specific care needs is known;

b. it is possible to cost the components of a care package;

c. it is possible to specify on whom the cost falls;

d. it is possible to arrive at some sort of consensus as to the most appropriate packages of care for people with similar care needs.

On the assumption that these conditions are met, the model provides a very powerful planning tool because it can assess the resource implications of providing care in a specific way to a given population and inform planners of the impact of decisions made to alter the way in which that care is provided. For example, on the assumption that resources are fixed, the Balance of Care model enables planners to cost a decision to provide care at home rather than in a residential facility for people with high care needs, and to calculate the impact of this decision on people with lower care needs.

In practice, the application of the Balance of Care model emphasises flexibility in local planning rather than the administration of centrally determined planning guidelines. The Department of Health and Social Security distributed the software and operational manuals free of charge to any health or social service authority wishing to employ this planning tool, and the take-up has been considerable. The Department also provides personal advice and training courses in the use of the technology. However, its implementation does not appear to have been an unqualified success. In December 1987, using a mailed questionnaire, the ORS surveyed authorities who had received the microcomputer system since it became available in May 1987. Approximately two thirds of those who responded to the questionnaire had not made use of the system, the main reasons being lack of time to learn the technology, other priorities, staff shortages and staff changes. Amongst users there were some technical difficulties, for example, microcomputers with insufficient memory (Jones, 1988).

In personal communication with policy makers and academics other problematic issues emerged. These relate to some of the assumptions, mentioned earlier, on which the viability of the model is based. Perhaps the most important of these concerns the cost of service inputs. In Britain, as elsewhere, it is extraordinarily difficult to cost services with any precision, and even more difficult to establish on whom the cost actually falls. Yet this sort of information is crucial to the viability of the Balance of Care model. Another problem mentioned was that the demographic information required is not necessarily available in sufficient detail for planning areas, and most planning authorities do not have the time or resources to obtain profiles of their population. A further difficulty is that the successful operation of the model requires that the traditional barriers between health authorities and social service departments are broken down. The building of structures to enable this to take place has rarely occurred. As well as this, the resistance to technology, particularly in the social service departments, appears to have created problems.

Despite these negative features we were told that the existence of this model has encouraged professionals to reflect critically on the judgements they make about appropriate models of care for clients with particular care needs and to think more painstakingly about their resource implications. **The Balance of Care model does not ensure that resources are matched to needs for care. It may however assist in informing local judgements about the most effective use of available resources.**

UNITED STATES - FUNDING FORMULAE: AN ALTERNATIVE MATHEMATICAL APPROACH

The simplest approach to forcasting the volume of services required for home health care services that we encountered is, without a doubt, the mathematical approach outlined by Sharma. With this approach local data are incorporated into simple mathematical formulae to give numerical measures of the extent of services that will be required. Certain assumptions about the conditions applying to each of the formulae need to be made explicit, but, it could be argued that within the limits of these assumptions, the estimates are quite reliable. As each of the four approaches outlined by Sharma has been drawn from practical applications in health services planning, another strength of the formulae is that they have actually been applied and tested in practice, permitting, presumably, a practical evaluation of their impact.

Sharma contrasts three different mathematical formulae used to determine the need for services with an approach deriving estimates for demand from current service utilisation rates. In making this contrast she derives estimates for service provision in Allegheny County in Pennsylvania, the results of which are summarised in Table 5.12 below. In the first and second models (the HSA/SP model and the Florida model) estimates of the need for services was derived from census data using assumptions about the percentage of the elderly population requiring assistance. The Rhode Island model, like the first two models, is also a 'needs based' approach. The model is based on information about the prevalence of a particular type of disability (which remains unnamed) in the population and is thus considerably more restrictive than the first two models. The final model, the fixed utilisation rate model, is based on the projection of

TABLE 5.12: FORM COMPARISON OF ESTIMATES FOR HOME HEALTH SERVICES IN ALLEGHENY COUNTY PENNSYLVANIA ACCORDING TO DIFFERENT MATHEMATICAL FORMULAE. (1980-1985)

Method	Estimated population requiring services.
Need based approaches	
- HSA/SP model	52,090
- Florida model	54,355
- Rhode Island model	34,436
Demand/Utilisation model	
- Fixed utilisation rate method	23,758

Note: The population of Allegheny County was projected to be approximately 1.38m in 1985.

Source: Sharma, 1980.

existing levels of service utilisation. The exercise is instructive in that it allows direct comparisons of two approaches to service volume estimation (the need and demand/utilisation approaches) as well as making explicit some of the problems likely to be encountered in estimating service requirements.

The formulae are, themselves, quite simple. For example the Rhode Island model, which Sharma considers to be the most sophisticated of the needs based formulae, is as follows:

$$A_{i+j}^{t+n} = P_i^{t+n} \times a_{i+j}^{t}$$

Where: A_{i+j} = forecasted population in age group i with disability type j.

Pi = Population in age group i.
a_{i+j} = percentage of population in age group i with disability type j
t = base period
t+n = forecast target date.

(Sharma, 1980: 576)

Essentially, the formula approach outlined by Sharma represents one step in the process of forecasting the requirements for service provisions, formalising a series of calculations that, in various ways, are likely to be involved in any planning exercise. Details of the types and amounts of service various individuals should receive cannot be obtained from such a calculation. The advantages of using such an approach however, should not be overlooked. It uses data which are often readily obtainable, such as population projections, estimates of the prevalence of disability and data on hospital discharges, and it permits planning to be carried out within any region for which such data are available, such as a nation, a state, a region or a local government area. Further, the ease with which calculations can be made and checked enables people with a wide range of backgrounds to carry out the work and would allow planning on this basis to commence very rapidly.

The limitations and disavantages of such a system should also, however, be borne in mind. The types and amounts of assistance required by the population identified according to this method are not in any way specified. Furthermore, the results derived from the different formulae vary widely, and choice or compromise would be needed in deciding which method, if any, to employ. Most seriously, however, none of the methods, or the results obtained, are in fact of value unless the assumptions underlying the models are valid. For example, in deriving the estimate of 34,436 people requiring home health services, based on the Rhode Island method outlined above, Sharma assumes that all people with a particular disability type will require assistance and, equally, that all others with disability types not included in the calculation will not require assistance. In calculating provision based on current utilisation rates it is necessary to make the assumption that current utilisation is at the correct level, or that future utilisation will increase or decrease by some known factor. These assumptions require either great faith in decisions made by planners about the system or naivety about the system's operation. Indeed questions concerning the number of people with a particular disability who actually require assistance and the adequacy of the current level of provision must underlie any systematic attempt at planning which aims to maximise both the equity of provision and the effectiveness and efficiency of resources deployed. These questions should not, in our view, be avoided by making them into assumptions hidden in planning formulae.

In summary, **the mathematical formulae would appear to be most valuable if used as only part of a larger process of planning.** Used on their own they offer a simple but, to our mind, unreliable and incomplete series of answers to planning questions such as those faced by the HACC program.

JAPAN - A TEN YEAR SERVICE DEVELOPMENT PLAN

In contrast to the case studies presented earlier in this chapter, Japanese efforts to develop the system of community support services in recent years have focussed on the establishment of highly specific service provision targets in a way which is distinct from any measure of the need for such assistance. This approach forms part of the 'Ten Year Strategy for Ageing Society of 21st Century', also known as the Gold Plan, a wide ranging program which aims to prepare Japan to become a 'longevity' society in the 21st century, a society in which one person in four will be aged.

The ten year strategy represents a broad strategic planning approach, within which the planning of community services takes place. Amongst the main objectives of the strategy are 'the urgent consolidation of domiciliary welfare measures in the municipalities', the development of 'the strategy for zero bedridden elderly' and the 'promotion of measures to ensure that the elderly live to some purpose' (Japan MHW, 1990: 41). Listed in this program are plans to develop public sector domiciliary services and promote private services which will operate alongside these under government control. The Annual Report on Health and Welfare described the plans as follows:

> *In aiming to build up a system where 'anybody can receive appropriate, good quality services comfortably and without anxiety at any time', 'the ten year strategy for the promotion of health and welfare for the elderly' stipulates that by 1999 there will be 100,000 home helpers, 50,000 beds for short stay, and 10,000 places for day care services. Added to which by the same year there are to be 10,000 domiciliary care support centers near at hand to coordinate consultation and guidance and other services which may not be offered by the municipalities in order to give support to the families looking after elderly relatives'.* (Japan MHW, 1990: 53)

National growth targets established for key services under the program are set out in table 5.13 below. It will be noted that the targets are expressed in round figures, a move indicating that service development questions and considerations of public relations have been central to the strategic planning process. Measurements of the need for assistance have not been a major focus of policy development.

TABLE 5.13: JAPAN: SELECTED OBJECTIVES OF THE TEN YEAR PLAN FOR THE PROMOTION OF HEALTH AND WELFARE FOR THE ELDERLY.

Type of service	Level in 1989	Target for 2000
Home helpers	31,405 staff	100,000 staff
Short stay (respite)	4,274 beds	50,000 beds
Day service centres	1,080 places	10,000 places
Domiciliary Care places Support Centres	-	110,000

Source: Japan, Ministry of Health and Welfare, 1990: 42.

In Japan community services are actually organised and provided at the local or municipal level. For most services an equal share of the cost is paid by central government, by the (regional) prefectures and by municipalities, although recent revisions have seen the central government share increase to half the funding required by each service in some programs. In some instances means tested charges are also levied on the service users. Yet despite the significant role of the central government in service funding, the concern for national equity has not been expressed as a desire for uniformity in service provision between the different locations. Rather, considerable emphasis is placed on the development of locally suitable solutions to the challenges posed by an ageing society (Japan, Ministry of Health and Welfare, 1990).

3. ISSUES RAISED BY THE CASE STUDIES

The variety of planning methods which we have described has suggested to us that there is no single made-to-measure method which which can be applied universally. Our search of the literature gives no indication that any country has adopted, in their entirety, all the elements of a system used by another.

Nevertheless, in most of the case studies, most notably those of Israel and Manitoba, common elements of a sound approach to planning were undoubtedly revealed. In the first place an identification of need forms a common starting point. Second, the process of moving from need to service provision requires the exercise of judgement. Most essential in this is the judgement of how many and what level of service a person with particular dependency and social characteristics requires. However these judgements were made by different kinds of people. There were other similarities. We saw little evidence of a critical assessment of the process, nor of how conflicts between judgements might be resolved. Further, there was evidence of a disjunction between the processes of planning and implementation.

The countries contrast in the way that information collected for planning purposes is put in place as a means of regulating the provision of services. For example, service provision guidelines as found in New Zealand function as a resource input benchmark, determining the amount of services it is appropriate to provide for any given population. This is quite distinct from the use to which the information is put in Israel or Manitoba. In these instances eligibility criteria and assessment function to regulate the allocation of services. In this way they operate as a needs input

benchmarks. In contrast the Balance of Care system in the UK is largely concerned with service mix and service output efficiency.

Our consideration of the literature has enabled us think more clearly about the components of planning and the steps that it would seem reasonable to follow in the development of national planning guidelines. In the following section we propose a schema which incorporates many of the elements we have observed. In developing this we have drawn particularly on the Israeli experience. We recognise that in its existing form it lacks the detailed elaboration which would be required before practical use but nonetheless see value in specifying these essential elements in principle.

Schema for the Development of Benchmarks in Community Services

The development of measures for the allocation of resources can be depicted as a process in which the component parts or steps are treated as conceptually separate but are nevertheless crucially interlinked. These steps, which are broadly but not completely sequential, are:

Step 1. The identification of the need for assistance;

Step 2. An estimation of the amount, range and mix of services that would be required to meet the need that has been identified;

Step 3. The setting of specific targets or goals for service provision;

Step 4. Implementation;

Step 5. Review or evaluation;

Each of the steps in this process is a distinct but complex task comprising a number of activities and requiring the skill and judgement of people with different types of expertise and with different interests or stakes in the system's operation. A more detailed description of the schema now follows.

Step 1: Identification of Need

Before it is possible to plan the appropriate provision of services it is necessary to know both the extent of existing need for support and the extent and use of existing services. In this first step the issues are defined and clarified and relevant evidence is sifted. Subsequently, data concerned with the types and amount of impairment and functional disability and other relevant information is collected and analysed. This can be undertaken at either a national or local level, or both. The collection of this information is essentially a research task but also requires input from planners and service deliverers.

The following specific activities are involved in Step 1:

a. The identification of existing national and local sources of information;

b. An assessment of the quality of these sources and of the generalisability of locally based information;

c. An assessment of the kinds of additional information which will be required. It will be necessary to decide upon the relative advantages of collecting information nationally or locally as well as the most appropriate methods of data collection, whether by way of census, surveys, case studies, analysis of service records, or careful assessments associated with model services or demonstration projects;

d. In the light of a. - c. above, further data collection exercises may be undertaken, as required.

It should be noted that there is already a considerable body of research on this topic in Australia. Five surveys of living conditions and needs conducted in Australia over the last decade are identified in a review article by Howe and Sharwood (1989). Each of these provides useful but, in some cases, dated evidence of the needs and/or service use by elderly people in particular localities (ACOTA/DCS, 1985; Kendig, et al., 1983; ABS, 1984; ABS, 1987; Hugo, Healy and Luszcz, 1987). The value of the article lies particularly in its discussion of the methodological issues involved. Howe (1987 and updated in 1990) and Sitsky, Graham and Fine (1989) have compiled directories which contain relevant research. The ABS **Surveys of Disability and Handicap** (ABS, 1981 and 1990) and the ABS **Carers of the Handicapped at Home** (ABS, 1990) all provide valuable national data but are unsuitable for small area analysis and planning. One other study of service need and provision, conducted at a local level which deserves attention is based on work in Warringah Shire by Curson and McCracken (1989).

Step 2: Estimation of the Amount, Range and Mix of Services that Would be Required to Meet the Need that has been Identified, Bearing in Mind the Present Availability of Services and Other Forms of Support

This step involves the determination of service requirements to meet the needs for support identified in the first step. It requires the involvment of people who themselves have disabilities, their advocates and informal carers and professionals such as medical practitioners, physiotherapists, nurses and social workers.

The determination of need for services based on levels of impairment and disability requires:

a. a judgement, made by clients, family, experts, and others involved in support, as to the amount and type of help required by individuals according to the type and level of their dependency; and on the basis of this

b. the determination of how much and what type of formal support is needed for a given population, paying due regard to the social circumstances of people with the disabilities.

On the basis of a systematic analysis and synthesis of these judgements it should be possible to predict the amount of service input required by individuals with different types and levels of disability in different social circumstances and, utilising good epidemiological data such as that obtained in Step 1, to extrapolate this to populations. It is clear that in some cases the need for support will be intense but temporary, for example, following hospital discharge. In some cases it will be related to sudden crises and emergencies, whereas in others there will be a progressive increase in the need for help, for example as with Alzheimer's Disease. In yet other cases early intervention or treatment may have a preventative or rehabilitative effect such that the need for support can later be reduced.

Already considerable data on this topic has been produced in Australia by the Community Options Projects and is in the process of being analysed. The work of assessment teams in determining the amount of services required to maintain people in their own homes could also be used in addressing this question. However, it needs to be recognised that in neither of these cases is data representative of community needs. Further, the judgements which are made in the current circumstances are based on available resources and therefore do not tell us about the optimal level of servicing for individuals.

Step 3: Setting Specific Targets or Goals for Service Provision

Having determined the level of services required by individuals and populations it is necessary to identify targets or goals for future service provision. As we noted in Chapter 2, the operationalisation of need for services involved in this step is most likely to succeed if it is grounded in a realistic appraisal of financial and other contraints. In particular, good studies of the cost effectiveness of services are crucial. Therefore, the setting of targets should not be an exercise undertaken in the abstract.

Step 3 lies in large measure in the political sphere. In this area, informed by knowledge obtained in the first two steps, politicians advised by public servants, community and interest groups, professional groups and trade unions will be those most critically concerned. The judgements made in the previous step need to be translated into policy statements which identify objectives and set priorities for their implementation. These objectives should be informed on the one

hand by developments in other relevant spheres, for example, in the health care system and in the nursing home sector and, on the other, by the social and economic contexts in which service delivery takes place. This may include a consideration, for example, of the importance of personal income, housing and family circumstances in determining the need for support of various types. In addition one might expect other types of knowledge to inform judgements about targets for services. These include specialist knowledge about the substitutability of community care for other forms of residential care, and, in this context, the impact of targetting on substitutability.

In setting specific targets for service provision in Australia it will be necessary for agreement to be reached between Commonwealth, State and local government, as well as representatives of non-government service providers and consumers, as to the amounts and types of services which are to be provided and the mechanism by which that agreement would implemented. Thus, in Step Three, it would be necessary to consider first whether benchmarks should be adopted and, if so, at what level they should be set. As the case studies presented earlier in the chapter illustrate, levels of service provision may also be determined in a number of other ways; for example by specifying criteria to be used in determining the eligibility for services, or by the size of block grants made to local or regional planning bodies.

Step 4: Implementation

The fourth step, which is concerned with implementation, is in a sense the most complex, and should be taken into account in undertaking the previous three steps. The **operational** success of any policy objectives that may be devised depends largely upon the phase of implementation. It is important that the sorts of measures that are developed are **capable** of implementation; that is that they are appropriate for the structure into which they have to fit. Therefore the sorts of decisions that will need to be made in the third step should be shaped by a consideration of this question. More attention will be given to the issues raised by implementation in the final chapter.

Step 5: Review and Evaluation

Unless the consequences of setting up procedures and measures for regulating service provision are reviewed the value of the entire exercise is put at risk. Most importantly the effectiveness of the measures in achieving their objectives requires evaluation. For example, have they resulted in the reduction of unmet need? Have there been unintended consequences such as a decrease in service efficiency or an increase in the rates of institutionalisation? At the very least, it is necessary to determine whether the measures have actually been implemented. The impact of other policy changes in the field also needs to be reviewed.

The review process should have a number of components. These should include:

a. the ongoing monitoring of the implementation of policy, e.g. whether services do actually achieve the size stipulated;

b. the evaluation of the effectiveness of the measures, both in achieving their goals and in affecting other aspects of the operation of the system of services; and

c. the enforcement of obligations which arise as an inevitable consequence of setting measurable and objective standards and goals. For example, are services being provided to people who are entitled to them?

In conducting an evaluation, baseline data obtained in the first two steps enable the impact of changes in service provision to be measured, and therefore programs should be set up from the commencement with review and evaluation as an integral part. In Australia, although the Triennial HACC Review process lends itself to the type and timing of systematic evaluation that is envisaged, there is no body charged with specific responsibility for this as a research exercise. The creation of such a body might well be considered.

CONCLUSION

In this chapter we have illustrated the application of a range of practical methods used in the planning of community and domiciliary services. On the basis of these examples we have suggested a schema which makes explicit the elements which we see as being involved in the planning of services. In the final chapter we review the main issues to emerge from our study and consider the relevance for Australia of some of the approaches we have identified.

CHAPTER 6

SUMMARY AND CONCLUSIONS

In this chapter we draw attention to the main issues that have emerged from our review and, in the light of these, conclude with some comments on the the feasibility of developing benchmarks for the Home and Community Care program. Although, as is well known, this program is intended for adults with disabilities of all ages, it is important to point out from the start that we found that virtually no attention had been paid in the literature to younger people with disabilities. Despite our request for information on all age groups the focus was almost entirely on the elderly. This is reflected in our report.

1. ISSUES TO EMERGE IN THE REVIEW

Our review has shown that universally the planning and provision of community and domiciliary services represents a particularly challenging and difficult field of social policy. There appear to be a number of reasons for this:

a. There are **difficulties in defining precisely the aims and purposes of community support.** Is community support intended to relieve neglect and improve the lot of people who are living at home and do not appear to require institutional care, or is it intended to replace or prevent institutional care? Linked to this question there are also dilemmas as to what sorts of support people should be receiving. One approach is to provide services on an extensive basis ensuring that the largest possible number of people receive assistance in the home. The other is to target services intensively at those who are most at risk of institutionalisation. There seems little doubt from our reading of the literature that in recent years most countries have shifted the emphasis from the first to the second course.

b. Another feature to have emerged is the **almost universal dichotomy between central and local elements of the planning and provision of community support.** The most common arrangement is for central government to play a major part in the regulation and funding of services which are then planned, allocated and provided by locally based agencies. Thereby, a good deal of support seems to be given to the notion that the planning of services must involve those who are in closest touch with local circumstances and the needs of the actual recipients of assistance.

c. The **system of planning associated with the above arrrangements is ill-suited to the setting of centrally determined targets.** We found little evidence of benchmarks in the form of centrally determined planning norms. There was some evidence that those which had been in existence had fallen into disuse.

d. Nevertheless there were a number of features of the operation of community services overseas which enabled a balance to be struck between the supply or provision of services and the need for them. The **most common means by which this balance was achieved was through the determination of eligibility and the growth of services to assist those who are eligible.**

At the beginning of our research we had anticipated discovering a quite widespread use of benchmarks and had envisaged that our report would be primarily concerned with technical issues concerned with **'establishing and costing benchmarks'** in the Australian context, as proposed in the initial DCSH tender documents. In the event, our findings were of a very different nature and consequently our attention has shifted to much broader and more fundamental questions. The cost of services inevitably depends on a range of factors, such as who services are directed towards, whether they are to be provided at an extensive or intensive level, whether an integrated model of service provision is adopted, what role informal care will play and which financing mechanisms will apply. Even supposing accurate information on the cost of services were available, it does seem to us that these fundamental issues need to be resolved before realistic costings can be attempted.

In the light of the above, what conclusions can be drawn from the review of the literature concerning the feasibility and desirability of benchmarks for the HACC program? To answer this question we first reconsider the purpose of benchmarks.

2. PURPOSES OF BENCHMARKS

The Triennial Review of the Home and Community Care program (1989: 42) noted **'the absence of a coherent strategy for needs based planning and the difficulty of achieving an equitable distribution of resources in practice, given the complexity of both the HACC program and its position in the health/welfare system'**. The Social Policy Research Centre was subsequently commissioned by the Department of Community Services and Health to investigate the feasibility of the development of benchmarks or service targets. In the tender document the term **benchmark** was never specifically defined, but in subsequent discussion it became clear that the Department was interested in the feasibility of developing formulae which could serve as national standards to be met. These would determine the level, range and mix of services required to be used in the allocation of resources.

Underlying the issues of **equity** and the **development of a coherent strategy for the allocation of resources** we see the following issues as being important:

a. ensuring that services are sufficient to meet needs - a matter essential for the Government's commitment to social justice;

b. the development of a rational planning framework and the shaping of the development of services in such a way that will better meet needs;

c. the achievement of equities in resource allocation between States, between regions within States, and between services within regions;

d. the provision of a mechanism for dealing with inter-governmental relations;

e. the prediction of expenditure on services.

These issues represent a range of financial, organisational, political and ethical problems. Benchmarks, in contrast, represent a **technical** mechanism for balancing need and resources. **The adequacy of a purely technical solution to such a wide range of problems must be doubted.** There are a number of features associated with the provision of community support services in Australia that lead us to suggest that the **implementation** of nationally standardised formulae for service provision here, would, as elsewhere, present considerable difficulties. This is because the structural features of service funding, organisation and delivery in community services implies multiple points of control and interests such as have been outlined for Australia in Chapter 3 and overseas in Chapter 4. Implementation of standard formulae is likely, for this reason, to prove difficult. In addition there are sound reasons for caution in implementing centrally determined resource input benchmarks in the long term because of the danger that they will prevent services from being as responsive to local circumstances as may be necessary. We note, too, a lack of evidence of an association between absolute service levels and service effectiveness.

3. DISCUSSION

Community services represent an area in which market forces are an inadequate distributory mechanism. This is the reason for state intervention, in varying degrees, in their financing, organisation and allocation. Given this, the question becomes: how can this intervention best be organised, especially when such a wide range of organisations and professions are involved in the direct provision of services to clients? More specifically: how many resources are needed, and of what type? How should they be distributed?

The public provision of community services has been developed for a number of complex reasons, but the formost justification is that people need help which they are not able to otherwise receive, or which would be more expensive or less suitable if provided in another way. However, it is not, in practice, an easy matter to match the supply of assistance to the need for support, although this sounds at first a straightforward task. On the one hand, the need for support is not fixed, but fairly variable. People's sense of independence or the stigma associated with some forms of assistance may limit the use of certain services, while for others the need appears to grow and change, as a result of the initial intervention exposes further need, as demographic, social and political changes effect demand, and as public expectations change. On the other hand, the supply of assistance is a process constrained by resource restrictions and

by organisational, administrative and political difficulties. It is not possible to simply continue expanding supply indefinitely. Nor is it possible to be confident, that, at any one time, the existing resources are being put to the most efficient use. Therefore, to match limited provision to need, to ensure the supply of assistance meets the demand for support, some form of rationing mechanism is required. This rationing mechanism is the basis of the public planning and resource allocation processes that lie at the heart of the development of a system of community support services.

One approoach to the problem of resource allocation essentially rations supply in accordance with estimates of likely useage, allocating resources to enable services to be provided. As the emphasis is placed on rationing the supply of services, there is no direct relationship established between actually providing the support needed and the allocation of resources. Rather, when employing the relationship between needs and resource allocation is indirect: supply-side planning, an estimate of total need is made and resources allocated to provide services, independently of any client in need actually applying for assistance. An alternative approach involves matching supply to need in a more direct manner. Instead of attempting to ration the supply of assistance, the direct approach emphasises the need for assistance, providing resources directly to service agencies to assist those individuals and households who actually apply for and receive help. To ensure that resources are only provided to applicants who have the greatest need, an eligibility procedure is commonly established. This eligibility procedure thereby serves as the key rationing mechanism with such an approach. Because it provides a measure of the amount and type of service people meeting particular criteria should be entitled to receive, it can also be used to produce estimates of the total expenditure likely to be incurred and, in turn, the criteria can be adjusted so that total expenditure remains within given limits. What is most important to note about this demand-side approach, however, is that while it ensures that the legitimated needs for support are met, final total expenditure is not precisely known until after the assistance has been provided. In comparison, final expenditure is known beforehand when rationing of the supply of services is used to determine levels of resource inputs. What is not known using the supply-side approach to needs based planning is exactly how adequate the supply of services will be in meeting need.

In this context, we see **benchmarks as regulatory mechanisms, a means by which scarce resources can be rationed and conflicting claims on them resolved.** To be successful these mechanisms should provide at one and the same time a **meeting ground** between the demand and supply sides of planning, in which a proper role is given to government, as the body responsible at the various levels for resource input, and to field staff, who are finally accountable for the direct provision of assistance and are the people who must make the final decision as to who actually receives services.

We remind readers of Figure 2.2 - 'Models of resource allocation'[1] - which illustrates the relative importance of the key 'actors' in the process of service provision. The circumstances associated with the planning and provision of community support services under the HACC program to date stands in contrast to the circumstances surrounding medical practice and also to those associated with the payment of social security benefits. In the case of medical practice, the model is a decentralised and discretionary one. Medical practitioners are entrusted with determining, in a professional manner, the servicing needs of their patients, thereby incurring costs which will be met from a variety of sources, but most particularly from government. The contrasting model is centralised and non-discretionary, as in the case of the payment of social security benefits. Here, eligibility criteria are determined by legislation, involving a centralised decision-making process which is implemented in a standardised form at the local level by departmental officers.

In the case of the organisation of community support services under the HACC program in Australia, elements of both models are combined. Some elements of policy, such as the financing and the overall profile of service provision, are centrally determined in legislation, regulations and guidelines. Other elements, particularly those involved in the allocation and delivery of services to clients, are largely discretionary and are the responsibility of locally based field staff. Adding to this complexity, in Australia to date, is the involvement of both the State and Commonwealth governments in the administration of the program, and of State government departments and statutory authorities, local government and the non-government voluntary sector in the direct delivery of services to clients.

We suggest that the most appropriate form of regulation is one which builds on, rather than opposes, these characteristics of our system. The HACC program, to achieve its national objectives of equity and effectiveness in

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1 See page 12, chapter 2.

community service provision, requires clear direction at both national and State levels. This control must, however, be sensitive to local differences and avoid unproductive threats to the local agencies responsible for the program's direct service provision. At the same time, the regulatory system should recognise the importance of fostering the most efficient use of resources in meeting the needs of clients and encourage community services to continue to develop and change as our understanding of the field grows. **The feasibility and desirability of implementing benchmarks for the HACC program depends crucially on striking the right balance between a centralised system of resource allocation and the localised implementation of the program.**

4. USING BENCHMARKS AS PART OF PLANNING

Lessons and guidelines for the use of benchmarks can be extracted from the conceptual and practical considerations noted above. They do not provide a complete blueprint for the Australian context, but they should enable us to build upon the experience and thinking of others.

Benchmarks, a term used here in the broader sense as planning measures or norms, have demerits as well as merits when used as a guide to resource allocation in community support services. **Their main value is as a catalyst - or spur - to changes in provision, to policy analysis, and to the development of planning processes and a planning culture.** However, inexpert use of benchmarks can also be an inhibiting force. In particular, the following need to be borne in mind:

a. A single benchmark for a particular service type is bound to have an uncertain impact on levels of provision if the existing range of provision is great. A benchmark has to be very carefully chosen in this situation.

b. A set of benchmarks referring to inter-related services is likely to be perceived as the officially preferred model of the service mix, even if this is not the case. If services are complementary or substitutable, the benchmarks for each must be clearly seen as variable one against the other and should preferably be presented in the form of acceptable ranges of provision.

c. Benchmarks should be presented as a basis for policy analysis and planning and not allowed to become substitutes for detailed consideration of local needs, circumstances and pre-existing service provision.

d. Need related benchmarks may sometimes take the form of rather 'utopian' goals which bear no close or direct relation to resource constraints, but they more frequently and usefully ought to represent a judgment about the balance to be struck between need and resource use (including priorities between alternative uses) in the short to medium term. Consequently, they should not be allowed to become immutable; unrealistic or increasingly irrelevant goals of an apparently absolute kind.

e. Benchmarks are essentially a mixture of political and professional/expert judgements about the balance to be struck between need and scarce resources and should not be seen or treated as a pseudo-scientific alternative to difficult policy judgements of this kind.

f. Absolute standards can have a role, but benchmarks ought usually to be normalised by reference to appropriate populations.

g. Needs-related benchmarks may in practice take the form of resource input (e.g. expenditure, or staff numbers), service output (e.g. day care places per thousand relevant population), demand regulation (e.g based on assessment procedures or eligibility criteria) or even outcome targets. This is because need is a peculiarly difficult concept which is often operationalized as a statement of desired 'solutions' rather than as a statement of the underlying social ill.

5. A WAY FORWARD

The development of benchmarks for the HACC program is technically feasible. In previous chapters we have outlined methodologies which can be used for their development and we have also provided case studies of their operation. Some of the difficulties in their development and their implementation have also been identified.

It will be noted that the benchmarks strategy is not the only means by which community service provision can be matched to needs. Two alternatives are suggested on the basis of our reading of the literature. Whilst neither is a panacea and without difficulties, each has the merit of paying considerable regard to individual need and to local circumstances.

The first, based on the approach encountered in Manitoba (see Chapter 5), is associated with centralised assessment and a community options-like case management approach to service provision. In this approach, there is an assessment of the need for services of all individuals likely to require either support in the home or admission to residential care before services of the level and type to meet these needs are arranged. The method of payment for this assistance should facilitate their implementation, as funding is brought into a direct correspondence with service provision. When conducted on a wide scale the extent to which services expand or contract to meet assessed needs serves to match service provision with need in a manner which optimises local decision making. National (or State) concerns about local service provisions are represented in the organisation of assessment and service eligibility.

A second alternative is based on the use of eligibility criteria, as occurs in Israel. In this case, established and 'objective' procedures exist whereby a specified level of need (associated with functional incapacity, medical conditions and social circumstances) forms the mechanism by which services are allocated to individuals. Services are funded for each individual eligible and paid for on a fee-for-service like basis, thereby enabling services to develop in a way that is sensitive to need.

Neither of these possibilities should be regarded as a complete equivalent to planning benchmarks, nor are the two intended to exhaust the possibilities. Indeed much could be gained by choosing a strategy which combined elements of a range of different proposals. In addition, as noted in Chapter 2, it is possible to develop benchmarks or targets which affect a wide range of the aspects of service provision. Instead of benchmarks which focus on the level or amount of a particular service available, benchmarks concerned with service efficiency or outcome, or on service mix are possible. These need not necessarily be introduced in the form of a service inputs to population ratio, but could take a number of different forms, such as service payments to agencies for each hour of assistance provided, or as a block grant paid to a regional planning body which would then decide final resource allocation on the basis of detailed knowledge of local priorities. The process by which such benchmarks could be developed is likely to resemble in some ways the schema outlined in Chapter 5, although clearly different kinds of information would be required at the different stages depending on the nature of the measure introduced.

However, it should be noted once again, that benchmarks developed for one purpose are quite likely to have a range of unintended and undesirable side effects distorting overall service provision. For example, benchmarks focussed on the levels of provision of nursing assistance and home care may have the effect of directing attention on these services at the expense of day care and respite care services. Benchmarks dealing with preferred service mix, in turn, could adversely affect aspects of service efficiency and quality of service. In each case, there is a trade off which, although anticipated to a certain degree, will remain largely unpredictable in the full extent of its effect.

In conclusion we recommend that, if it is decided to develop benchmarks for service provision, this should be done in a limited and cautious way. Whatever strategy that is decided upon it should be recognised that, to be effective, service provision benchmarks need to be modest, time limited and flexible, and subject to regular review. The Triennial HACC Review process provides an excellent basis for such a strategy.

APPENDICES

APPENDIX 1

List of Countries Invited to Participate in Survey of Home Support Services for People with Disabilities, Including Frail Elderly People

Austria

Canada

Denmark

Federal German Republic

France

Greece

Hong Kong

Hungary

Indonesia

Ireland

Israel

Italy

Japan

Netherlands

New Zealand

Norway

Poland

Singapore

Spain

Sweden

United Kingdom

United States

APPENDIX 2: INTERNATIONAL SURVEY OF COMMUNITY SERVICE PROVISIONS

To standardise and update information received as a result of the earlier requests for information, a questionnaire was sent in September 1990 to the heads of relevant central government departments of 22 countries. This sought information on the organisation and scope of their services, the existence of benchmarks or planning norms and the problems and issues associated with the planning and delivery of services in their countries. A copy of the questionnaire is included in this appendix following the tables of results.

Replies to the questionnaire covered fifteen countries, including Australia. In most instances the questionnaire was completed by a senior governmental official concerned with health and welfare service matters, but in the Australian case, answers were supplied by the Social Policy Research Centre. For Belgium and the Netherlands two replies were received from different departmental divisions: aged care, and disability services. In the tables that follow these answers have been combined as far as possible so that one set of information is provided for each of the fifteen countries.

With 14 of the 22 countries approached replying to the questionnaire, the nominal response rate for the survey was approximately 64 per cent. This level is generally considered acceptable for a postal questionnaire. However in this instance two major reservations about the use of mailed questionnaires must be expressed. First, it was clearly difficult in many cases for officials to encapsulate the complexity and variation in programs in a single answer. Second, it was clear that as well as there being considerable variation in provision between countries, variation within countries was also significant. As a result it was not always possible for the officials of central government departments to provide an account of detailed aspects of service provision which are the direct responsibility of a number of provincial or local authorities.

In short, the use of mailed questionnaires was not entirely satisfactory for our purposes. Other, more intensive methods of research are, we believe, more suitable for this sort of international comparative study. Nevertheless, although the information obtained needs to be interpreted with some caution, certain patterns are clearly discernible in the data presented in the following tables.

Table 1 focuses on the auspice arrangements for community services. It shows that community services were most commonly reported as being provided by local government and voluntary organisations in the fifteen countries for which information was provided. Direct provision by central government was found in only two countries, Israel and Indonesia. In Sweden, Denmark, England, and, to a lesser extent Norway, local government was reported as the main provider of services. However this arrangement was largely confined to these northern European countries.

Another feature to emerge from Table 1 is that community support services commonly cover a number of different specialist tasks. Those that were most widespread, and which, therefore, may be considered as the international 'core' services, are: home help and personal care; food services; day care; paramedical services and home nursing. Other services such as home maintenance, respite care and community transport were also widespread. In a few instances, generally those countries with the least developed service systems, only a few medically oriented services are available. Indonesia and Singapore were notable in this respect. The information provided by the official from Hungary indicated that community programs in that country have a distinct non-medical focus. It is unclear whether home nursing and other medical services were not reported because they do not exist, or because they are the province of other programs.

Table 2 shows the use of explicit eligibility criteria in assessing the need of individuals for formal services in most countries. In general multiple criteria are employed, assessing an applicant's need for assistance on the basis of health problems, disability, and/or social vulnerability. In several countries, notably Canada, Hungary, Israel and West Germany, financial hardship was also reported to be an important criterion. The relative lack of financial need criteria in most other countries seems to point to a vision of 'universal access' which underlies the provision of services to older people. The use of specific eligibility criteria in most countries stands in contrast to the situation in Australia. Here, although the HACC Guidelines provide some indication of the suitability of particular applicants, decisions about the eligibility of applicants are commonly left to individual service providers to determine.

As shown in Table 3, considerable variation was reported in the payment of fees by clients. Payment by clients were found in all countries in some form or other, although frequently this requirement varied considerably between services. In Canada, West Germany, and, for non-medical services, in England, some form of means testing was part

and parcel of service provision. In the Scandinavian countries, in contrast, greater variation was reported, possibly reflecting the fact that certain services are covered by forms of health insurance while others are not. Variation in the fee charging practices between services was reported to be less common in other countries than in Australia.

The outline of the main problems faced in the provision of community services, presented in Table 4, demonstrates that four sorts of problems are perceived to be common in the field of community service provision. The most frequently reported problems were:

i. Problems of service organisation, such as duplication and lack of co-ordination;

ii. Problems of inadequate services, especially with regard to the rapid ageing of the population in recent years;

iii. Insufficient trained personnel, and problems of retaining good staff due to the low pay levels in the community field;

iv. Regional issues, including regional gaps in services and regional deviation from nationally determined policy directions.

Most of these problems sound familiar to Australian ears. However the emphasis placed on the use of trained personnel in community services may serve to alert Australian planners and policy makers to the importance of the issue of education and training could assume in the near future.

Table 5 presents the responses concerning the planning of services at national or local level. The information has confirmed our view that community services are predominantly locally organised and planned. In only two countries, Indonesia and the Netherlands, did respondents indicate that community services were planned at a national level. In other cases there appears to be considerable emphasis placed on local inputs into the planning process.

TABLE 1: AUSPICE ARRANGEMENTS: DIRECT PROVISION OF PUBLIC COMMUNITY SERVICES

Services	Aust-ralia	Belgium[a]	Canada	Denmark	England[b]	Greece[c]	Hungary	Israel[d]	Indo-nesia	Nether-lands[e]	Norway	Singa-pore	Sweden	USA	West Germany
Home help	2,3,4	3,4	2,3,4,5+	3	3	4	3	1,2,3,4		4	3		3	#	3,4
Personal care	2,3,4	3,4	2,3,4,5+	3	3	4	3	1,2,3,4		4	3		3	#	3,4
Home maintenance	2,4	3,4	2,3,4,5+	3	3	-		1•		3,4•	3		3	#	
Food	3,4	3,4	2,3,4,5+	3	3	4	3	1,2,3,4		3,4•••	3	4,5+++	3	#	4
Respite care	2,4		2,3,4,5+	3	3	-		1,4••		2,4	3	4	3	#	3,4
Day care	4	2,3,4	2,3,4	3	3	4	3	1,2,3,4	1,2,3	2,3,4	3	4	3		3,4
Community transport	2,4		2,3	3	3	4				3,4				#	3,4
Community paramedical services	2	3,4	2	3	5++	4		3,4	1,2,3,4	4	3	4	2	#	4
Community domiciliary nursing	2,3,4	3,4	2,3,5+	3	5++	4		4	1,2,3,4	4	3	4	2		3,4
Other:															
Alarm system		3,4													
Aid for daily living		2													
Physician visits	1,2							4							
Medical/Rehab. equip.	2,4			3				1,4							
Neighbour program												1,4,5+++			

Notes:
(a) Services organised by private organisations are very important and they reach more people than the municipal (public) services. Both public and private services are subsidised by the government of the Flemish Community (northern part of Belgium with + 60% of population.)
(b) Local Government provide most of support services for elderly and disabled people. Some services also provided by voluntary organisations.
(c) The Ministry of Health and Social Welfare sponsors the whole program.
(d) The funds from Central Government are channelled through the District Government offices and the local authority.
(e) Services are provided by State financed non-government orgnanisations.

Key:
1. Central Government
2. State, County or Provincial Government
3. Local or Municipal Government
4. Voluntary or Charitable Organisations
5. Other

\+ Private for profit organisations. Provinces and municipalities have responsibility for provision of service.
++ Health authorities.
+++ Statutory Board under a Government Ministry.
• Home modification only.
•• Respite care only in NH.
••• No shopping service available.
\# The US Department of Health and Human Services commented that all Federal funds 'pass through' to States via the formula system. Other funds for R & D are awarded via competive grants. It is understood that programs for each service area vary significantly in different states and local government areas of the country.

TABLE 2: ELIGIBILITY FOR EACH SERVICE

Services	Aust-ralia[a]	Belgium	Canada	Denmark	England	Greece[b]	Hungary	Israel	Indo-nesia	Nether-lands	Norway[c]	Singa-pore	Sweden	West Germany
Home help	1,5	1,2,3	1,2,3,4	1,3	1	-	1,2,3,4	1,2,3,4		1,2,3	1,2,3		1,2,3	1,2,3,4
Personal care	1,5	1,2,3	1,2,3,4	1,3	1	-	1,2,3,4	1,2,3,4		1,2,3	1,2,3		1,2,3	1,2,3,4
Home maintenance	5	1,2,3	1,2,3,4	1,3	1	-		1,2,3,4•		1•	1,2,3		1,2,3	
Food	1,2,3,5	1,2,3	1,2,3,4	1,3	1	-	1,2,3,4	1,2,3		1,3,4•••	1,2,3	3,4	1,2,3	1,2,3,4
Respite care	1,3,5		1,2,3,4	1,3	1,3	-		1,2,3••		1,2,3	1,2,3	1,3,5##	1,2	1,2,3,4
Day care	1,2,3,5	1,2,3	1,2,3,4	5	1,3	-	1,2,3,4	1,2,3	1,2,3,4	1,2,3	1,2,3	1,2,3	1,2	1,2,3,4
Community transport	1,4,5		1,2,3,4	1	1	-				1,5	1,2,3		1,2	1,2,3,4
Community paramedical services	2,5	1,2	1,2	2	2	-		1,2	1,2,3,4	1,2	1,2,3	1,2,3	1,2	1,2,3,4
Community domiciliary nursing	2,5	1,2	1,2,3,4	2	2	-		1,2	1,2,3,4	1,2,3	1,2,3	1,2,3	1,2	1,2,3,4
Other:														
Alarm system		1,2,3												
Aid for daily living		1,2												
Physician visits	2							1,2						
Medical/Rehab. equip.	1,2,5			1				1,2,4						
Neighbour program												3,4,5###		

Notes:

(a) Eligibility is determined largely at descretion of individual service providing organisation. Most services would refer to HACC guidelines which stipulate reasons 1 through 4 in general terms.

(b) Assistence is given to all people without any socio-economic discrimination, provided that the area where they live is covered by our program (5 neighbourhoods of Athens).

(c) Social services vary considerably between municipalities and counties.

• Home modification only.

•• Respite care only in NH.

••• No shopping service available.

Depends on availability on vacancies.

Residence

Key:

1. Type and/or level of disability of client
2. Health needs of client
3. Family circumstances (e.g. lives alone) of client
4. Financial circumstances of client
5. Other

TABLE 3: PAYMENT FOR SERVICE BY CLIENT

Services	Aust-ralia	Belgium	Canada	Denmark	England	Greece[a]	Hungary	Israel	Indo-nesia	Nether-lands[b]	Norway[c]	Singa-pore	Sweden[d]	West Germany
Home help	4	1,3	3	2	3	2	3	5+		1,3	4		4	3
Personal care	4	1,3	3	2	3	2	3	5+		1,3	4			3
Home maintenance	3,4	1,3	3	1,2	3			3•		3,5•	4			
Food	1	1,3	3	1	3	2	3	3		1,4•••	4	3,4		3
Respite care	3,4		3	1	3			3••		1,2		1,3		3
Day care	4	1	3	1	2	2	3	3	2	1,2		3		3
Community transport	3		3	2	2	2				1,4	4			3
Community paramedical services	2,3	1	3	2	2	2		3	3,4	3	4	3		3
Communmity domiciliary nursing	1,2,3,4	1,3	3	2	2	2		2++	3,4	1		3		3
Others:														
Alarm system		1												
Aid for daily living		2												
Physician visits	3,4							2++						
Medical/Rehab. equip.	2,3			5				3						
Neighbour program												2		

Notes:
(a) Thinking about developing programs where client will pay a symbolic amount of money in order to understand that he contributes in the community program.
(b) Clients have to pay a contribution (depending on income) for home nursing.
(c) About 9% of expenses for the homehelp services are covered by the recipients themselves (higher in smaller municipalities)
(d) Every community sets all fees for home support services. The fee must never be more than the actual cost of providing the service.

Key:
1. Yes always
2. No never
3. Depends on client income
4. Varies between localities
5. Other

• Home modifications only.
•• Respite care only in NH.
••• No shopping service available.
\+ Client pays if service is not given by virtue of Nursing Insurance Law.
++ Non-profit.

TABLE 4: THE MOST IMPORTANT PROBLEMS IN SERVICE DELIVERY APART FROM FUNDING

Country	1	2	3	Comments
Australia	Providing adquate services to identified special needs groups: NESB, Aborigines, dementia sufferers & carers	Achieving inter-State and regional equity in service provision	Problems of service co-ordination	
Belgium	Increasing difficulty finding nurses and home helpers - the work is very demanding and not so well paid	More daycare centres needed for people with severe mental disabilities		
Canada	Previous lack of knowledge about needs of disabled and elderly	Geography of vast and diverse land-Remoteness of some small populations in north	Regional economic disparities	
England	Organisation/Division of responsibilities	Determining needs	Increasing demand	
Greece	Lack of personnel	Lack of means of transport, auxilliary book etc.	Bureaucracy	
Hungary	In population of 20% elderly there is a high proportion who need care	Low public utility and infrastructure	Lack of money	
Israel	Many organisational problems due to multiplicity and duplication of services	Lack of certain trained personnel	Lack of National Health Insurance scheme	
Indonesia	Improve the disabled's ability and skills	Establishing more modern facilities for disabled persons	Encouraging community participation in the disabled's problems	
Netherlands	Co-ordination of services	Lack of manpower	Not possible for client to decide amount and nature of care	24 hr in home help not available
	Expenditure control	Structure of (Health) care	Quality control	Next decade (Health) care system will be generally restructured
Norway	Lack of social service personnel	Economic situations in municipalities	Lack of institutions for increasing number of old people	
Singapore	Shortage of nurses and paramedical staff e.g. physiotherapists and occupational therapists			
Sweden	Difficulty in recruiting and keeping employees within home support service	Overlapping responsibilities: both community and county councils have responsibility for certain home support service		
West Germany	Financing	Education, training and qualifications of personnel	Community nursing not yet established	

TABLE 5: NATIONAL OR LOCAL PLANNING

Country	Decisions on level of services made by	Basis on which decisions made about level and amount of services in area
Australia	2,3	State plans reflecting population statistics and local input. State and Federal governments contribute on a dollar for dollar basis. Planning follows National Guidelines.
Belgium	2	Normally amount of services based on needs of population. For budget reasons limitations are possible.
Canada	2,3	
Denmark	2	Economic and planning considerations affect decisions.
England	2	Local needs and circumstances and available resources.
Greece	3	According to request made from Local Agencies and the community's inhabitants, the social worker conducts research to assess needs of community then Hellenic Red Cross or Government consider financing.
Israel	3	Information is gathered in several ways by Central Government, Local Authorities, National Insurance Institute and public bodies such as The Association for the Planning and Development of Services for the Aged in Israel (ESHEL) and the JDC - Brookdale Institute of Gerontology and Adult Human Development in Israel. Planning and standard-setting is usually carried out by several of these bodies functioning together.
Indonesia	1	Based on population of disabilities of an area and should be in line with government budget plan.
Netherlands	1,3	Planning criteria established at central level.
Norway	2	Access to help is according to national law. The municipalities execute duties. The recipients can claim to the county governor.
Singapore	3	Meal Service: at least one centre in each 'old' housing estate with high density of aged. Day Care Service: 1 centre per 25,000 persons aged 60 and over. Befriender Service: 1 in each constituency where needed has been established.
Sweden	2,3	
USA	(2)*	Annual Budgets at all levels of government determined service planning.
West Germany	2	Responsibility of local government.

* Information not gained from questionnaire.

Key:
1. Central Government
2. Local or Regional Government.
3. Depends on service.

SOURCES

Australia	Social Policy Research Centre
Belgium	Ministry of the Flemish Community of Belgium: Department of Social Services; and Department for Disabled Persons
Canada	Health and Welfare Canada, Social Services Programs Branch
Denmark	National Board of Social Welfare
England	Department of Health Community Services Division
Greece	Hellenic Red Cross - Social Welfare Department
Hungary	Ministry of Welfare Republic of Hungary
Israel	Ministry of Health Division of Chronic Disease and Geriatrics
Indonesia	Department of Social Affairs Republic of Indonesia
Netherlands	Ministry of Welfare Health and Culture: Directorate for the Policy on Aging; and Interministerial Steering Group on Policy for Disabled
Norway	Norwegian Ministry of Health and Social Affairs
Singapore	Ministry of Community Development - Senior Citizens Branch
Sweden	The National Board of Health and Welfare
USA	Department of Health and Human Services - Office of Human Development Services
West Germany	Ministerial Council

SOCIAL POLICY RESEARCH CENTRE

UNIVERSITY OF NEW SOUTH WALES

Dear Sir/Madam,

HOME SUPPORT SERVICES FOR PEOPLE WITH DISABILITIES, INCLUDING FRAIL ELDERLY PEOPLE

I am writing to you in your capacity as the person responsible for the administration of policies for people with disabilities, including frail elderly people. I would very much appreciate your assistance in a study I am undertaking which is funded by the Australian Department of Community Services and Health.

This study is seeking comparative information from several countries about the support services delivered to people with disabilities, including frail elderly people, who live at home and which are intended to help such people to stay in their own homes for as long as possible. The purpose of the study is to find out, cross-nationally, what services are provided for such people, who is entitled to receive them, who is responsible for providing them, what formal national standards exist for the level of provision of these services and, if possible, how these standards or norms are determined, and so on.

The study:

- includes adults of all ages. It does not include children under 16 years of age;
- is concerned with human services and not with pensions, social security payments or purely financial support;
- is concerned with publicly-funded services and/or non profit making services, not with private services.

I would be very grateful if you would answer the questionnaire attached and return it to me within two weeks. Your reply can be faxed to 010612-398-9903.

P.O. BOX 1 • KENSINGTON • NEW SOUTH WALES • AUSTRALIA • 2033 • TELEPHONE (02) 697 5145 • FAX (02) 398 9903

If your Department deals separately with younger people with disabilities and elderly people would you please send a copy of both this letter and the questionnaire to relevant colleagues, as appropriate.

I would be pleased to send you the results of this enquiry and would like to thank you very much indeed for your assistance.

Yours sincerely,

Sara Graham PhD
Senior Research Fellow

QUESTIONNAIRE

HOME SUPPORT SERVICES FOR PEOPLE WITH DISABILITIES, INCLUDING FRAIL ELDERLY PEOPLE

QUESTION 1

What is the name of your Government Department?

.....

Part I - Services for Individual Clients

QUESTION 2

Are the home support services for which you are responsible intended for:

	Tick Box
Only younger people with disabilities (aged 16-60/65 years)	☐
Only elderly people with disabilities (aged 60/65 years or over)	☐
Both of the above groups	☐

Comments (if any)

.....

.....

NOW PLEASE COMPLETE THE TABLE ON PAGE 3

QUESTION 3 (Please tick column of table on page 3)

Which of the services listed on the table are available in your country for people with disabilities who live at home? **Only include services which are publically funded. Do not include services which are entirely privately funded.**

Comments (if any)

.....

.....

QUESTION 4 (Enter number(s) in column of table for each service ticked in first column. Enter more than one number if joint provision applies.)

Is the service directly provided by:

Central Government	1
State, County or Provincial Government	2
Local or Municipal Government	3
Voluntary or charitable organisation	4
Other (write details)	5

Comments (if any)

.....

.....

QUESTION 5 (Enter number(s) in column of table for each service ticked in first column. Enter more than one number, if appropriate.)

Does getting the service depend on:

Type and/or level disability of client	1
Health needs of client	2
Family circumstances (e.g. lives alone) of client	3
Financial circumstances of client	4
Other (write details)	5

Comments (if any)

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QUESTION 6 (Enter number(s) in column of table for each service ticked in first column. Enter more than one number, if appropriate)

Is the service provided:

Day and night (on 24 hour a day basis)	1
During day only	2
During night only	3
During weekdays only	4

Comments (if any)

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.....

QUESTION 7 (Enter number(s) in column of table for each service ticked in first column)

Does the client have to pay anything for the service?

Yes, always	1
No, never	2
Depends on client's income	3
Varies between localities	4
Other (write details)	5

Comments (if any)

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.....

QUESTION 8 (Enter number(s) in column of table for each service ticked in first column)

Do you keep statistics on the use by clients of the services?

Yes	1
No	2

If yes, could you please attach national statistics for latest year available.

Comments (if any)

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TABLE

Please note this study is concerned with human services and does **not** include pensions or social security payments

Services	(tick) Question 3	Question 4	Question 5	Question 6	Question 7	Question 8
Home Help: cleaning, housework, domestic support						
Personal care: bathing and showering, toileting, dressing						
Home maintenance or home modification, gardening, etc.						
Food: meals on wheels, frozen meals, centre-based meals, shopping						
Respite Care: (temporary full-time care at home or in nursing home)						
Day care, daytime activities in centre						
Community transport						
Community paramedical services, physiotherapy, podiatry, occupational therapy						
Community domiciliary nursing						
Others (please fill in)						

QUESTION 9

Does one single body assess whether a person should receive services or is this decided for each service separately?

	Tick Box(es)
One assessment for eligibility for all services	☐
Eligibility for each service assessed separately	☐
Varies for each service	☐
Varies for locality	☐

Comments (if any)

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.....

Part II - National or Local Planning

QUESTION 10

a) Are the levels or the amount of services provided in your country decided by:

	Tick Box(es)
Central government	☐
Local government	☐
Depends on service	☐

b) On what basis are decisions made about the level and amount of services provided in an area (for example, planning formula, standards or norms). Please attach brief documentation, if possible.

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Comments (if any)

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QUESTION 11

In Australia, priority is given to people with moderate to severe disabilities, people from non-English speaking backgrounds, people who live in isolated areas etc. Are there any priority groups for services in your country? Which groups?

No priority groups 1

Priority Groups
1. .....
2. .....
3. .....
4. .....
5. .....

Comments (if any)

.....

.....

QUESTION 12

What is the **total** amount spent on home support services for elderly people **and** people with disabilities. (Please give your best estimate for most recent year available.)

Amount (in your currency)
and year for which information is provided Amount ..... Year .....
Don't know 1

Comments (if any)

.....

.....

QUESTION 13

Apart from problems of funding what do you think are the three most important problems your country has in delivering services (describe very briefly)?

1. .....

2. .....

3. .....

Comments (if any)

.....

.....

THANK YOU VERY MUCH FOR PROVIDING THIS INFORMATION

Are there any additional comments you would like to make?

.....

.....

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.....

1. Your name: .....
2. Your position in organisation: .....
3. Your address and phone number: .....

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