Community Care: The Effects of Low Levels of Service Use

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Foreword

In an era in which all public services are facing increasing financial pressures, community support services concerned with providing support in their own homes to older people and people with a disability face a particularly difficult task. Just as they are confronted with increasing levels of demand for care at home arising from constraints on the availability of residential care, so must they adjust to the rising level of expectations associated with the ageing of the population and the increased incidence of disability amongst younger people living at home. These same services are also under increasing pressure to identify the outcomes of government funding and to demonstrate their cost-effectiveness compared to other services and programs, including service providers from the private sector.

In these circumstances, it is not surprising that one of the most common responses has been to attempt to target assistance to those with the greatest need. In many cases this has meant that those who required only small amounts of basic help have been forced to do without. But this raises important questions for policy and for service providers. Who are those with the greatest need? What happens to those who are denied assistance? Would it be more effective to provide help in a preventative manner to the large number of those who only required small amounts of help, rather than focusing all effort on those few who need much more substantial amounts of assistance?

To help address these and a number of related issues, the Commonwealth Department of Health and Family Services, as part of its 1995 Portfolio Research Program, commissioned the Social Policy Research Centre to undertake a study of the effectiveness of low levels of service. Researchers from the Centre worked closely with the Home Care Service of New South Wales, first to develop an appropriate methodology with which to examine the issue, and later in the conduct of the study. The results are a unique and important study that is bound to inform the future development of community care in Australia and contribute much to the debate on the value and relative effectiveness of the public provision of small amounts of assistance.

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1 Introduction: Low Level Services and the Targeting of Community Care

Since the introduction of the Home and Community Care Program (HACC) in 1985, the provision of formal, publicly supported assistance to those people in need of care who remain at home has grown considerably in Australia. The demand for assistance from services, however, has continued to exceed supply. Under the *Home and Community Care Act, 1985* (Paragraph 5 (1)(a)), services are required to direct assistance to clients with the greatest relative need. The interpretation and implementation of this provision, however, appears to differ considerably between services and across regions, States and Territories. In the absence of guidelines from government, most service providers have had to develop their own strategies for resource allocation.

It is possible to identify two quite different sorts of strategies that have been employed by service providers (Fine, Graham and Webb, 1991; Fine and Thomson, 1995a). The first strategy is to target assistance in an intensive way, assigning those who have the greatest and most complex care needs the highest priority for service. Given finite resources, in order to meet demands for intensive provisions for a relatively small number of people, it is argued that it may be necessary to deny assistance to a much larger number of people with lower or less complex needs. Targeting services in this way thus requires those with fewer formal care needs to be denied access to formal assistance.

The second strategy, an extensive pattern of service allocation, is an alternative approach used by many other services. This involves attempting to assist as many applicants as possible by spreading resources around, limiting the amount of assistance that any one individual may receive in order that the maximum number of people can receive some help. Proponents of this strategy argue that providing help to as many people as possible is more equitable and effective than a highly selective approach. Because the wider coverage of assistance enhances the capacity for early intervention, it is also claimed that the approach serves a preventative as well as a supportive function. Critics, however, argue that very small amounts of assistance are simply not effective in preventing inappropriate or premature admissions to residential care. Moreover, the use of resources in this way prevents services providing the extra support that more high need clients require.

1.1 The Need for Research

As a result of the adoption of such different strategies, service coverage under the HACC Program can vary greatly between services, regions and states (Healy, 1994; DHSH, 1995). Potential consumers, whose access to assistance depends very much on where they live, remain uncertain of eligibility criteria for services, and must face doubts about their rights to receive help provided by different agencies. Those consumers who currently receive support must also adapt to the lack of security that accompanies shifts in service allocation strategies as individual services attempt to adjust to the pressures of increasing demand. However, the lack of detailed evidence on the cost-effectiveness and outcomes of services in meeting different levels and types of needs makes the adjudication of any disputes difficult. Predicting the outcomes of different levels and mixes of care at home remains an elusive goal of research and practice in this field (Fine and Thomson, 1995b).

To address one of the most pressing of these concerns, the Social Policy Research Centre was commissioned by the Commonwealth Department of Health and Family Services in 1995 to undertake an investigation of the impact of community support services for frail aged people who receive only a small amount of formal assistance from publicly supported agencies. The study was intended to document the outcomes of providing small amounts of basic help with housekeeping tasks amongst a group of frail older clients who wished to remain in their own home. The research relied on a retrospective methodology which enabled a comparison to be made of the outcomes of support for those people with low level service needs who had received assistance from formal community services with a similar group of elderly people who do not receive such assistance.

1.2 Overview of The Report

This report presents the results of this research. In the following section, Section Two, the background to the study is reviewed and the key research questions underlying the study are identified. Section Three sets out the research methodology, presenting details of the selection of the sample for the intervention and control groups, and discussing the compilation of the research instruments, the conduct of telephone interviews and details of the coding and analysis of the results.

A brief report on inter-branch variations in the patterns of the allocation of assistance is presented in Section Four. This is followed in Sections Five and Six with a review of the results of study, in which the outcomes of the receipt of services amongst the intervention and control groups are presented and discussed.

The results also document other differences between the two groups including patterns of residence and the use of other forms of assistance over time, the extent of disability and the need for help, and the financial circumstances of the individuals concerned.

The final section of the report, Section Seven, summarises the main findings of the study and considers their implications for future policy development in the Home and Community Care Program.

2 Background to the Research

2.1 Concerns about Targeting

This research grew out of a general concern with the need to develop program guidelines for the determination of the need for services provided under the Home and Community Care Program. Improved targeting of HACC services has also been proposed as a strategy to enable services to be utilised in the most cost-effective way, to ensure optimal benefits for the maximum number of consumers. In addition, the development of eligibility criteria have also been recommended as a means of planning services and matching provision to need (Fine, Graham and Webb, 1991; Morris, 1994). Targeting on the basis of income is already an integral element of many other areas of Australian social policy, most notably the social security system (Saunders, 1992). To ensure that the strategy could be successfully implemented in the field of community care, it needs to take account of the consumer's need for support at home and be based on reliable evidence of the outcomes of intervention at different points and levels of support.

Low Level Services

One issue that has been of particular and immediate concern is that of the allocation of basic household support services to frail older people. The Inquiry into the Home and Community Care Program, conducted by the House of Representatives Standing Committee on Community Affairs in 1994, reported that problems associated with the withdrawal of basic or low levels of service provision was a common concern across Australia, particularly in New South Wales. The Inquiry noted that:

> The difficulties encountered in relation to the focus on high level needs, while not confined to NSW, are clearly illustrated by the Home Care Service of New South Wales (HCS). The Committee heard consistently of problems arising from the policy of the HCS, the major service provider in the State, whereby preference is given to those consumers who require personal care services (such as bathing and dressing) over consumers with lower level needs. The consumers in the latter group are generally those who require assistance with what have been called the 'traditional' services of the HCS, including housework, shopping and gardening. (Morris, 1994: 36)

In contrast, the Committee also noted concerns about instances in which providers had attempted to assist larger numbers of consumers by limiting the amount of assistance allocated to each. In many of these instances, the Committee observed, the amount of service was so low 'that the effect of providing the service is doubtful'. Home Help in Tasmania, where one submission reported that 'more than half the consumers received half an hour a week at most' was one example given, although the Committee reported that similar concerns were expressed in all States and Territories (Morris, 1994: 37).

The Morris Committee therefore recommended that work be undertaken which would include 'an investigation of the impact of the unavailability or withdrawal of services on individuals with lower needs and on their carers and families' (Morris, 1994: 38). This study was commissioned by the Department of Health and Family Services as work towards achieving this goal.

A Generic, International Issue

It would, however, be wrong to conceive of the problems of maintaining basic or low level services to older people as resulting from incompetent local management or as being somehow unique to Australia. Similar problems and uncertainties about the rationing of community care are being encountered in many comparable countries, as a recent international literature review revealed (Fine and Thomson, 1995b). As community care has become increasingly important, often substituting for, rather than merely being complementary to, residential care, dilemmas similar to that now being encountered in Australia have also been manifested in many comparable countries. Bebbington and Davies (1993), writing on the situation in the UK, for example, review research indicating the importance of increasing the intensity of provision for higher need users of home help services, but express concern at the likely consequences for those with lower level needs.

> To provide substantial services to some would be at the cost of the loss of services to many others. ... How many of those denied service will thereby deteriorate and subsequently require services which are more costly to the public purse, or suffer ill effects which are unacceptable to public opinion? (Bebbington and Davies, 1993: 374)

Bebbington and Davies point to the need for research on the outcomes and cost-effectiveness of low level services. In this they are not alone.

2.2 Previous Research

As reported in a recent review of the literature on the effectiveness of community support services (Fine and Thomson, 1995b), there has been relatively little research published which deals with the effects of low level service use for frail aged people. There are, however, some studies which are of relevance to this topic. These are mainly concerned with the impact of specific interventions.

Research looking at home visiting programs reports mixed results. For example, Rossum et al. (1993) in an investigation of the preventative effects of home visits to elderly people, determined that such visits were only of use to those elderly people with poor health, rather than the whole population. Hendriksen, Lund and Stromgard (1989), in a three year study noted the beneficial effects of a single visit three months after discharge from hospital to people over 75 years of age. Extra visits were made if necessary. It was found that the simple intervention reduced the number of hospital admissions, especially readmissions, and the number of bed days of the experimental group.

The findings on the contribution of basic domestic support services are more consistent and point to the value of such services. Shapiro (1986), in analysing data from the Manitoba Longitudinal Study on Aging, wrote:

> Since the performance of ... tasks such as shopping, laundry and light housework is essential in meeting the day to day needs of elderly community residents who do not require medical care, a home care program in which eligibility is not restricted to those needing a medical service may be particularly well suited to helping the elderly remain at home. (Shapiro, 1986: 42)

Baume, Isaacson and Hunt (1993), in an exploratory interview-based study conducted in Western Sydney, noted that many consumers felt that simple services, such as home care and Meals on Wheels, were important in enabling them to continue living in their own homes. Without adequate levels of formal support, the survey suggested, 'many of the consumers of services would have needed residential care in a nursing home or hostel' (Baume, Isaacson and Hunt, 1993: 268). Similar findings were reported from the United States by Krivo and Chaatsmith (1990), who analysed statistics on the provision of basic services such as the provision of daily meals. The results, they argued, suggest 'that very straightforward extensions of community-based services should notably increase the ability of elderly persons to live alone' (1990: 489).

As a recent editorial article by Anna Howe (1994) reminds readers, there was also much earlier research which identified widespread evidence of neglect in the

absence of basic support services. One of the better known and most influential of these studies systematically catalogued problems amongst 'geriatric patients' in Glasgow, pointing out the cost in both human and financial terms, of the absence of any early intervention, preventative measures (Isaacs, Livingstone and Neville, 1972). Costs arising from this neglect, the researchers argued, were later borne by the hospital system.

Other research, however, provides a less optimistic picture of the value of low level services. One of the most detailed and comprehensive studies of the issue was that undertaken in the England and Wales by a research team from the Personal Social Services Research Unit (PSSRU) at the University of Kent (Davies et al., 1990). The researchers found that while service providers had chosen to maximise the coverage of home help services by allocating relatively standardised amounts of assistance to most clients, there was little evidence that small amounts of assistance had any measurable impact on objectively measurable variables such as the 'destinational outcome' of the recipient (i.e. whether the client continues to live at home) over a six month period. The researchers noted that in general, consumers expressed satisfaction with the help they received, with the least disabled consumers expressing the greatest satisfaction with receiving help. However, when asked whether the assistance provided had made a difference to their chances of remaining at home, a rather different picture emerged (see Table 2.1). The results indicated a strong relationship between the consumer's own assessment of the importance of home help and the amount of hours received. A minimum of three hours a week was found to be required to ensure 50 per cent probability of a high impact (responses 1 and 2) while seven hours were required for a similar probability that the client would regard the home help service as essential to their continued survival in the community (Davies et al., 1990: 110). Interestingly, the researchers also reported that services were of greatest value for those with higher levels of disability without other social support.[1]

The absence of evidence suggesting beneficial outcomes of relatively low levels of service provision in the home may be contrasted with warnings about the ineffectiveness of relatively large amounts of service for other clients. Victor and Vetter (1988), for example, note the lack of better outcomes when large amounts

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1   It is important to point out that the research team also points to the diminishing returns from the provision of too much help, arguing that their study and others they had reviewed indicate the importance of maintaining a spending limit (determined as a proportion of the costs of residential care) on the amount of assistance that any one individual can receive, as well as a cap on the total budget available to the service (Davies et al., 1990: 350-1).

Table 2.1: Consumer Evaluations of Significance of Home Help Services by Hours Received Each Week, UK: 1988

Consumer's Assessment of Impact	Amount of Home Help (hrs/wk)					
	2	4	6	8	10	12
	Percentage of consumers agreeing with statement					
1 Enabled client to remain at home	10	22	39	61	82	93
2 Has made a great difference	30	41	38	26	12	4
3 No apparent sign of impact	22	20	15	9	4	2
4 Little difference	23	14	7	4	2	1
5 Given up	15	3	1	0	0	0
All responses (1-5), n = 589	100	100	100	100	100	100

Source: Davies et al., 1990: 111.

of home help services were provided to people who were very disabled and discharged to 'appalling housing circumstances' (Victor and Vetter, 1988: 90-1). The client group's requirement for personal care services were not met by an augmented home help scheme, highlighting the necessity to match services with need. Similar warnings were provided in the study cited above by Davies et al. (1990). Their research found the 'marginal productivities' of home support services, above a reasonable limit, were quite low. Consumers receiving larger amounts of assistance were found to be little better off than others with similar needs and circumstances receiving less assistance (Davies et al., 1990: 273-80).

Existing literature on the subject of effectiveness of low levels of community service use is, in short, inconclusive. Expressed consumer satisfaction with assistance received from public agencies tends to be high, but there is little evidence that might demonstrate a direct correlation between the receipt of assistance and the achievement of positive outcomes. Where such an association has been found, the evidence tends to be indirect: inferred, for example, from correlations between service provision statistics and statistics on older people living at home, rather than directly observed.

While the available evidence suggests a need for services which are now closely 'matched to the needs' of the client, it is not clear just how significant small amounts of basic help are over the longer term. Although research to date suggests that there is not a single, uniform effect of service provision, it is not known under what conditions specific types of intervention, such as the provision

of home help, are most effective, and under what conditions they are not. Given the preference of consumers, demonstrations of the impact of basic support, in terms of either its benefits or ineffectiveness in achieving outcomes for particular sub-groups, are required before it is possible to advise its discontinuation as a routine form of assistance.

The lack of information on the long-term outcomes for people with low service needs whose needs are not met, suggests that information should be gathered over time on this group. This could then be compared with the long-term outcomes for people with low-level needs which are being met to varying degrees. The research study conducted by the SPRC sought to address this issue by investigating whether the outcome for frail aged people with low-level service needs is affected by the receipt of small amounts basic home-keeping services. Before outlining the methodology of the study, a number of key issues which had to be addressed in setting up the study are discussed.

2.3 Activities of Daily Living and The Need for Help

An important insight into the significance of basic support services is provided by an understanding of models of functional disability and the requirements of tasks associated with living in the community. In the field of community care, as in certain other fields of long-term care, the concept of functional disability is used to indicate the primary support needs of individuals (DCSH, 1988; HACC, 1992). This follows from the widely accepted hypothesis that disability and the need for support arises from the interaction of individuals and their physical and social environment, and can not be simply inferred from an individual's medical condition (Wood, 1980; AIHW, 1994).

The measurement of functional disability is generally equated with the self-reported needs of an individual for help with a number of specified Activities of Daily Living (ADLs) required to maintain his or her biological and social functions (Wood, 1980). When individuals are not able to provide reliable reports of their capacity to undertake particular activities, the information may be provided by caregivers, or other reliable observers such as nursing staff or personal care staff. There are numerous different ADL scales, but perhaps the best known is the World Health Organisation's *International Classification of Impairments, Disabilities and Handicaps* (ICIDH) (Wood, 1980). Activities judged as essential each day range from the ability to communicate (speaking, hearing and seeing) through to self-care activities such as using the toilet, bathing and dressing. Domestic support activities needing to be undertaken in each household included cooking, cleaning and laundry. Other activities necessary for social participation outside the home included shopping, transport (travelling)

money management.[2] The ICIDH measures of need for help combines physical incapacities with social and environmental considerations to show how social or environmental elements cause disability and suggest how their modification may ameliorate the problem (Thuriaux, 1994; AIHW, 1994). In the process, however, there is a risk of confusing the help received as a result of social roles (such as husband, wife) with medically-related disability. A closely related problem arises from the common equation of receipt and the need for help. Need for help, for example, is often operationally defined as the answer to the question: 'Do you receive any help with this activity?' A positive response, for example from a male who always has his meals cooked for him, may imply a level of disability which is not necessarily equivalent to that which may be measured by direct observation of the individual's full capabilities.

An important finding from the use of functional disability measurements is that the distribution of need across a population may be ordered to form a hierarchical relationship, illustrated in Figure 2.1. This hierarchical ordering of ADLs is evident in almost all surveys of disability and handicap in the community, including the national surveys conducted in Australia in 1988 and 1992 (ABS, 1990; ABS, 1993) as well as in smaller scale studies, such as that conducted by the SPRC in the suburban community of Broadleigh (Fine and Thomson, 1995a). Only a relatively small proportion of those at home are likely to require help with more intensive, ongoing activities of personal care. A greater number are likely to require help to do housework, cook or shop, or will require help with transport. Concerns about incapacity to maintain lawns and gardens and undertake home or building maintenance, in turn, affect even greater proportions of home owners. Interestingly, those who rent their home or live in flats, retirement accommodation or other specialised residential settings may be less affected by these latter worries, despite greater levels of physical incapacity.

Building on the hierarchical characteristic of ADL scales, daily support tasks may be classified according to a hierarchy of needs, the frequency of their performance and the degree of their predicability. One interesting scheme is that proposed in Australia by Kendig (1986) which incorporates estimates of the frequency with which tasks need to be carried out and the degree of expertise required for their performance. Kendig, who refers to the work of Litwak (1985) and others in the development of this schema, classified tasks according to the degree of disability inferred by the measurement of ADL deficits, using it to illustrate the extent of service needs in his discussion of planning community care

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2   As it is not necessary to personally undertake household support and social participation
        activities on a daily basis, these are sometimes referred to as Instrumental Activities of
        Daily Living (IADL).

Figure 2.1: Number of People Aged 65+ with a Severe Handicap who Require Help with Activities of Daily Living (ADL), Australia: 1993

95 600
Meal Preparation

124 800
Self-Care

214 200
Mobility

344 300
Housekeeping/
Home Help

405 500
Transport

Source: ABS, 1993, Catalogue No. 4430.0, Tables 12 and 17.
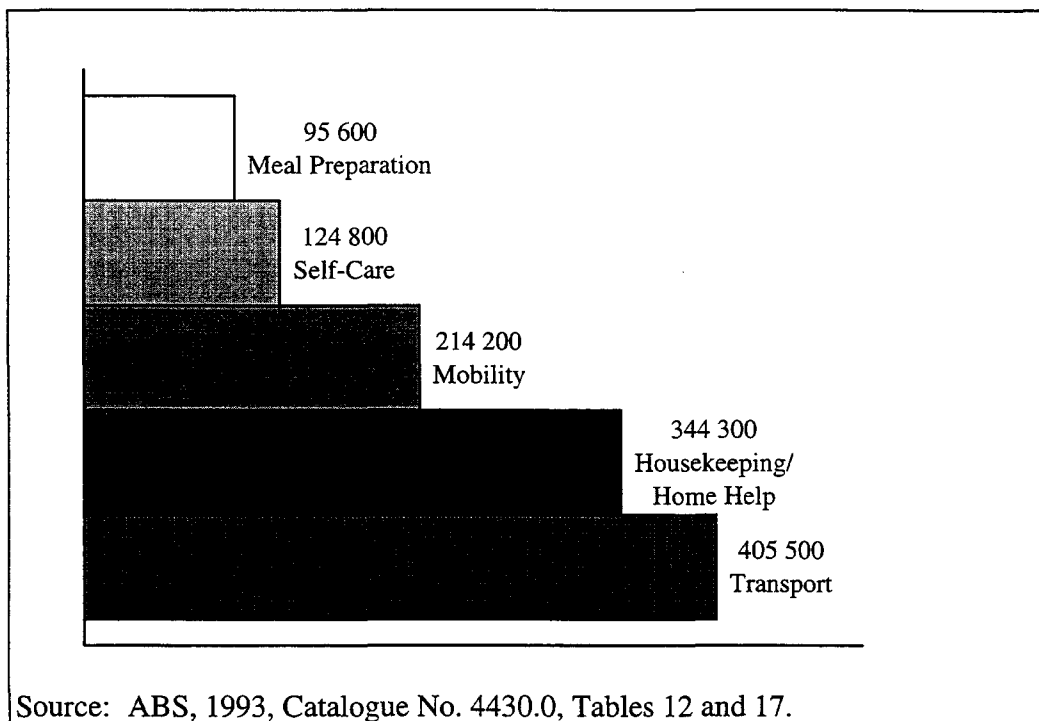
for the aged (see Table 2.2).[3]   Another example of the use of this sort of approach, from the United Kingdom, is that of Davies, et al. (1990) discussed above. Davies and colleagues, who refer to the work of the Scottish geriatrician Bernard Isaacs (Isaacs and Neville, 1976) when discussing the origin of their approach, use data on the time interval of need and the availability of informal support to analyse the different levels and types of need amongst the recipients of home care services in England and Wales.

The need for help with basic housework emerges from these schemes as representing the disabling condition most commonly reported in the domestic setting, a basic but necessary task for anyone who wishes to remain at home over a long period. Whilst it does not need to be performed on a daily or continual basis as a matter of life-threatening urgency, it is required for reasons of hygiene,

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3   Kendig used the terms 'low', 'middle' and 'high level' to classify the tasks. In this report, the term 'low level service' is used to refer to the frequency and intensity of service provision, and not to the severity of the disability.

Table 2.2: A Classification of Tasks Associated with Living in the Community

Tasks	Frequency	Regularity/ predictability	Amounts	Expertise	Importance of support[a]
Low Level					
Minor home upkeep	Low	High	Low	Middle	Low
Gardening	Low	High	Low	Middle	Low
Transport	Variable	High	Variable	Middle	Low
Middle level					
Shopping	Middle	High	Middle	Low	Low
Housework	Middle	High	Middle	Low	Low
Meals	High	High	High	Low	Middle
High level					
Personal care	High	Low	High	Low	High
Continual supervision	High	Low	High	Low	High
Nursing	Middle	Variable	Low	High	High

Notes: a)   As indicated by risk of institutionalisation if support is not forthcoming.

Source: Adapted from Kendig, 1986: 77, 82

safety and practicality to be performed on a regular basis. Housework also has considerable cultural and emotional significance, its performance being one of the attributes that defines a home and indicates the competence of its residents. In terms of service provision, most researchers and practitioners would probably agree with Kendig's classification of housework as requiring assistance at a middle level of frequency (once a week, once each fortnight), and intensity.

For research purposes, measuring the effectiveness of the provision of assistance with housework was considered to provide a useful proxy for a range of other forms of 'low level' assistance such as the provision of home delivered meals, not the least because it has been a major activity of home care providers and has proven to be a particularly relevant and controversial topic in the process of the continuing development of community support provisions in Australia.

2.4 Home Care and the Changing Patterns of Service Allocation in Australia

Evidence of the changing mix of assistance allocated to HACC clients in Australia in recent years is given in statistics on the provision of HACC services in the years 1988/89 and 1993/94 (see Table 2.3). These show that despite an increase in the total number of hours of home respite and centre day care, and a

corresponding increase in the number of home meals provided, there has been a relative decline in the total number of hours of home help provided. When this decrease in home help is considered as a ration of hours of help provided per thousand profoundly or severely handicapped aged persons, the national decrease in coverage is just over 20 per cent. This decrease was most marked in NSW, where the total hours reported were reduced by 46 per cent, falling from 2496.1 to 1416.2 hours per thousand profoundly or severely handicapped aged persons. In Tasmania, in contrast, the total number of hours of home help reported increased from 1618.9 to 2439.2, an increase of approximately 50 per cent. These figures support the different concerns expressed to the Parliamentary Inquiry into the Home and Community Care Program (Morris, 1994), discussed earlier in this section.

Table 2.3: Average Hours of Service Provided by HACC Services for Selected Service Types per Thousand Profoundly/Severely Handicapped Persons for each State and Territory: 1989 and 1993/94

	States and Territories								
Service Type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia[a]
1989									
Home help	2496.1	3236.2	1142.9	-	-	1564.2	2094.0	-	1995.0
Home respite	302.0	347.1	201.7	-	-	323.7	1101.9	-	251.2
Centre day care	323.3	227.8	2255.1	-	-	141.7	60.0		545.7
Home meals[b]	2033.4	3235.4	2523.0	3193.9	2700.0	3807.5	2005.0	4070.9	2701.7
1993/94									
Home help	1416.2	2468.2	994.9	2271.1	575.7	2467.9	1090.2	5438.6	1643.4
Personal care	654.4	220.2	85.7	781.8	275.4	546.3	674.7	1300.4	419.8
Home respite	944.5	374.7	402.8	494.2	228.6	540.9	1256.6	1752.4	595.0
Centre day care	1675.2	1306.8	2269.4	1779.6	1317.4	535.2	1198.6	176.9	1615.1
Home meals[a]	2582.4	2970.0	2932.6	3213.8	2869.2	3818.2	2389.3	7604.8	2865.1

Notes: a)   National figures in 1989 in some instances exclude data from WA, SA and NT.
　　　　 b)   Number of meals. Home meals in 1989 is the only service type where the national average is based on data from all States and Territories. For other service types, the 1989 national average excludes data from WA, SA and NT. Service provision data for 1989 was collected in February 1989. Data for 1993/94 was collected in November 1993 for NSW, Vic and WA, and in May 1994 for Qld, SA, Tas, NT and ACT.

Source: From Mathur, 1996, *Aged Care Services in Australia's States and Territories:* 19; figures derived from HACC Service Provision Data Collections and ABS, 1993, *Disability, Ageing and Carers,*Catalogue No. 4430.0.

More detailed figures from the Home Care Service of New South Wales (HCS), the largest provider of HACC services in Australia, indicate the extent of change within one agency. In the six years from 1988/89 to 1994/95, figures reported in the Annual Report show a marked reduction in the amount of hours of help provided with general housework (see Figure 2.2 and Table 2.4). This reduction, according to the information presented in the report has been brought about largely as a result of the priority accorded to the provision of personal care and respite services over the same period.

Figure 2.2: Changes in the Proportion of Total Hours of Assistance Provided for General Housework by the Home Care Service of New South Wales: 1988-1995

Sources: Home Care Service of New South Wales, *Annual Report 1992-93; 1994-95;*
           Alt Statis and Associates, 1995, *Services Summary Paper.*
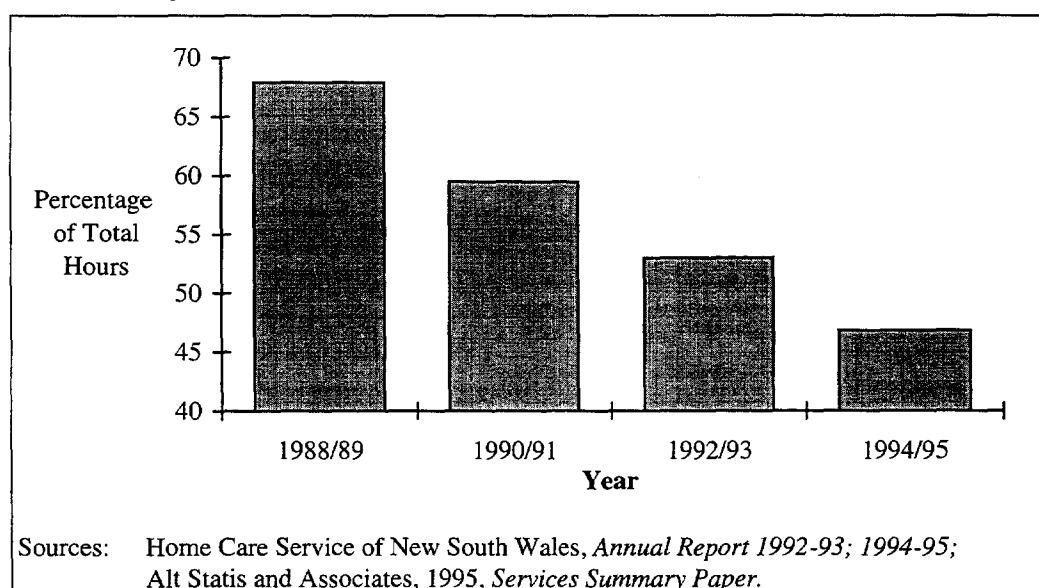
The priority accorded to personal care, an activity which is ongoing and quite labour intensive, has been largely responsible for a decrease in the total number of households assisted. There is, therefore, a clear trend towards a more intensive pattern of service allocation by the HCS, with fewer people/households receiving assistance, and an increasing concentration of resources on those clients with needs for greater amounts of support. This changing pattern of service allocation and the conscientious concern of HCS staff at the consequences of these changes made the organisation an ideal research partner for the purposes of this study.

2.5 Research Questions

A number of questions arise from the discussion presented above which this study is intended to address.

Table 2.4: Types of Assistance Provided by Home Care Service of New South Wales: 1988/89 to 1994/95

Type of Assistance	1988/89	1990/91	1992/93	1994/95	1988/89 to 1994/95
	Percentage of total hours				Percentage change
General housework	67.9	59.5	53.0	46.8	-20.9
Overnight care	0.3	0.2	0.2	0.2	-0.1
Live-in care	1.6	0.9	0.6	0.4	-1.2
Personal care	17.5	22.1	27.0	34.5	+17.0
Handyperson	2.9	2.9	2.8	1.6	-1.3
Respite care	5.7	9.9	11.9	12.2	+6.5
Other	4.1	4.5	4.5	4.3	+0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	
Total Households	na.	48 729	44 228	38 406	-21.2[a]

Note: a) Percentage change 1990/91 to 1994/95

Source: Home Care Service of New South Wales (1994 and 1995), *Annual Report 1992-93; 1994-95;* Alt Statis and Associates (1995), *Services Summary Paper.*

Target Groups and Outcomes

One of the main objectives of the Home and Community Care Program is 'to avoid the inappropriate or premature admission of frail aged and younger people with disabilities to residential care'. Other important aims of the Program are:

- 'to provide a comprehensive and integrated range of basic support services for frail aged people ... and their carers';

- 'to help those people to be more independent at home and in the community ... enhancing their quality of life'; and

- 'to provide a greater range of services and more flexible service provision to ensure that services respond to the needs of users' (HACC National Guidelines, second ed., 1989: 2).

In examining the effectiveness of providing help with housekeeping (as with other basic services), it is important that each of these outcomes be considered, and that the assumptions underlying the identification of certain groups as the most appropriate recipients of resources be tested. An assumption underpinning the trend towards the provision of personal care and away from housework is that people at greatest risk of institutionalisation are those who need the greatest amount for assistance from the formal sector. These people are consistently

defined as those with complex care needs and little informal support. People with lower levels of service need are often assumed not to be at risk of institutionalisation. Whether and for how long this is the case is uncertain. Important questions for this study, therefore, are:

- to what extent do basic housekeeping services prevent or postpone admission to long-term residential care?

- is it possible to measure different outcomes over time amongst those who have received assistance and those who have not received it?

If so, following on from this, an important policy question arises.

- How might the need for assistance for such services be best determined? Is it possible to identify uniform criteria or is a priority ranking system best?

Alternative Sources of Care and the Need for Basic Home Support Services

In exploring the issue of low level service use it is also important that the complete care network is considered. The complete care network includes informal care as well as public and private provision. The presence of informal care, in particular, creates a dilemma for many service providers, who are also charged under the HACC guidelines with responsibility for providing services to meet the needs of carers. The situation of carers who may require some small amount of assistance from formal services must be considered, in tandem with the needs of frail aged people, in research into the impact of low level services. A research question suggested by this is:

- what are the main forms of support used by those unable to undertake housekeeping on their own?

For policy development, a further question arises:

- how should alternative forms of support be taken into account in determining the need for assistance with basic home support services?

The development of a research design and methodology intended to address these research questions within the constraints of time and resources available to the study is outlined in the following section of this report.

3 Research Design and Methodology

3.1 Introduction

To better understand the implications of reducing the provision of low levels of basic support services as part of policies to improve the targeting of initiatives such as the Home and Community Care Program, an empirical study was proposed which would compare the outcomes of the receipt of low level formal support at home over a period of time for a group of frail aged applicants for assistance with a matched group who do not receive service. Using a quasi-experimental approach, the study was designed to test the hypothesis that the provision of small amounts of basic community support services, such as housekeeping, affects the outcomes of support of frail older people who have modest needs for assistance. It was intended to compare the outcomes of the receipt of such support at home over a period of six to nine months amongst two groups of frail aged people by collecting current and retrospective data by means of telephone interviews with the recipients and a matched group of non-recipients. One group was to be a sample of approximately one hundred customers of the Home Care Service of New South Wales who received assistance once a fortnight or more with house cleaning or other comparable household help. The second group, of equal size, was to consist of a comparable group of people who had been referred to the HCS but had been refused assistance.

In the early stages of the study, discussions with Branch Managers of the HCS and a review of a large number of files revealed that in the previous six months only a small (and still shrinking) proportion of new clients had been allocated help with housekeeping. It thus became apparent that it would have been very difficult to obtain a sufficiently large sample of service recipients from the seven metropolitan HCS branches which participated in the study if the sampling was confined to the period of six to nine months before the proposed follow-up. It was therefore necessary to extend the period of the follow-up slightly and conduct a retrospective study which examined what had happened to those who had been referred to the HCS 12 to 15 months before the interviews. The basic research design finally adopted for the study is set out in Figure 3.1.

The development and implementation of the methodology finally adopted for the study is described in more detail in the remainder of this section.

Figure 3.1: Research Design of the Study

	Referral to the HCS	
	↗ ↘	
	Intervention Group	Control Group
	Provided with	Not provided with
	housekeeping help by	assistance by HCS
	HCS	
Commencement T₁	— ⇑	T₁....Sept 1994 - Jan 1995
Selection of Sample T₂	Period covered by survey ⇓	T₂....Feb-March 1996
Conduct of Survey T₃	Measurement of Outcomes	T₃....April-May 1996
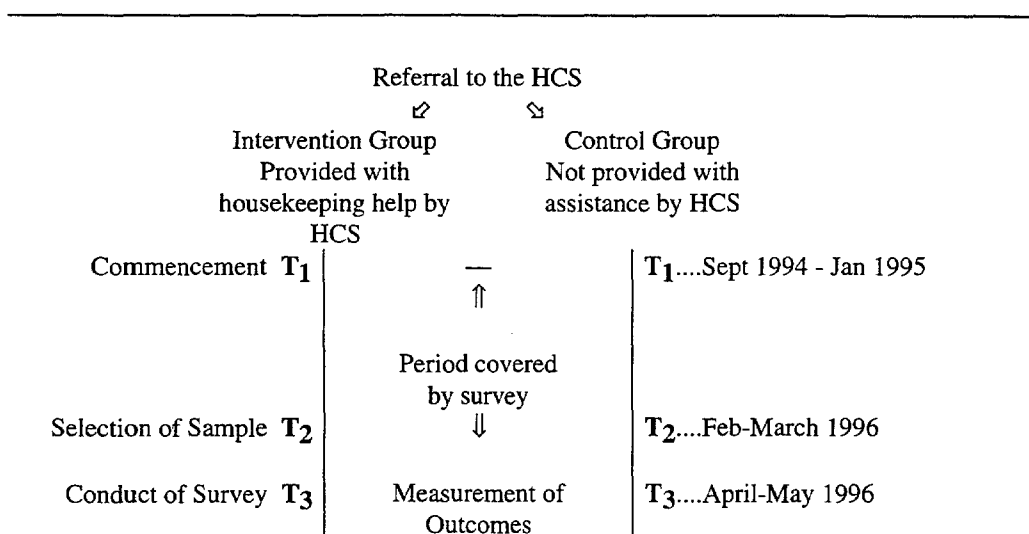
3.2 Background

As indicated earlier in the report, the HCS is the largest single provider of community support services funded by the Home and Community Care Program in New South Wales. In addition to providing personal care, in-home respite and other relatively intensive forms of assistance to people of all ages with a disability and with a need for high levels of ongoing support, HCS had provided a variety of levels of basic home support services such as cleaning, gardening and shopping to many aged people for many years.

Given the uncertainty surrounding decisions to accord those assessed as needing such help a lower priority for assistance than most other customers, HCS was anxious to obtain strong evidence of the outcomes of their decisions, to inform the ongoing development of their referral, assessment and targeting policy. The HCS actively supported the study, providing a near ideal sampling pool for the research.

Following discussions with the Managing Director of the HCS and other senior staff, formal approval for the commencement of the study was granted by the Board of Management in October 1995. Preliminary visits were made to a sample of seven HCS branches in the Sydney metropolitan area in December 1995. The visits, which involved discussions with the HCS Branch Managers and branch staff, shed light on the impact of resource allocation mechanisms within the Home Care Service. Discussions suggested that patterns of service provision varied considerably between branches. Despite a resource allocation

formula within the HCS which allocated each branch's annual finance based on projected relative need, there were marked differences in the number and proportion of elderly people and younger people with disabilities referred for assistance to each branch. This in turn influenced the internal branch mechanisms for resource allocation and the interpretation of the 'priority ranking score' within HCS branches. An understanding of the mechanisms of resource allocation which operate across and within the branches, is necessary for an interpretation of the results of the study and is discussed further in Section 4 of this report.

3.3 Selection of the Study Sample

The process of defining and selecting the sample for the study was undertaken in four stages:

- selecting Home Care branches to participate in the study;

- defining the selection criteria for potential participants in the study sample;

- selecting potential subjects for the study from Home Care branches (two stages); and

- contacting and gaining consent from those selected to participate in the study.

Determining the Sample Period and Home Care Branches to Participate in the Study

Discussions were held with staff at the Head Office of the HCS to select Home Care branches to participate in the study. Seven branches were chosen by HCS. The branches operated in regions that represented populations from a range of socio-economic statuses (SES), covering a variety of inner urban and suburban areas in the Sydney Metropolitan area.[4]

In December 1995 a preliminary discussion of the project was conducted with the Managers of each of the selected branches concerning changes in the patterns of service allocation in their branch over recent years and exploring the viability of different approaches to obtaining a sample of participants for the study. Despite evidence of marked differences in the coverage and mix of assistance provided by

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4   Some information on the characteristics of these areas is presented in Section 4 of this report.

each of the branches, the discussions confirmed that there had been a general reduction in the allocation of small amounts of basic household help to households with frail older people over the previous 18 months as allocation patterns had been modified to enable the intensification of provision to support high need customers, generally younger people with a disability. This meant that it was not possible to obtain a sample of intervention clients of sufficient size if the referral period was to be restricted to the period of six to nine months prior to planned follow up.

Subsequent discussions with Branch Managers and analysis of HCS records suggested that the period from September 1994 to March 1995 represented an important transition in the coverage strategy. During this time there had been a shift in the pattern of service allocation, from a pattern in which a relatively high proportion of elderly people with lower dependency needs were provided with basic home support services, to one in which the proportion of applicants who received assistance became much less.

In most instances records had been kept about applicants, whether or not they had received assistance. Comprehensive information was available in the customer file for all those who became HCS customers. The amount of information available for those refused assistance varied considerably, with some records providing details of a full in-home assessment, and others simply recording contact details and the reason for seeking assistance as the referral had proceeded to a full assessment. Based on the availability of this information, the period from which names of potential survey participants would be drawn was therefore extended to cover the period between September 1994 to March 1995.

Defining the Sample Criteria

Further selection of potential subjects from each of the seven HCS branches was made on the basis of a set of criteria designed to reflect the level and type of service provision required by older people who needed some assistance but remained largely independent in matters of self-care. The selection criteria were developed over a period of time based on a the review of customer files and of the information retained on those refused service in each of the seven branches. Potential participants were subsequently selected from the branch records on the basis of the following selection criteria:

- aged 65 years and over at the time of the initial referral;

- referral to the HCS during the period September 1994 to March 1995; and

- exhibited a relatively low level of dependency (available information should indicate an ability to carry out personal care tasks, such as washing,

dressing and toileting independently; where a full assessment had not been conducted, best available information was accepted).

Two further criteria applied to HCS customers only:

- assessed by HCS as needing three hours of basic home help, or less, per fortnight (coded as '01', or low priority, in HCS referral and assessment forms) ; and

- had received assistance for at least three months. This criterion served to screen out a small number of individuals who had received help for a couple of weeks only and were not, in other senses, comparable to others in the intervention group with histories of prolonged service use.

Potential subjects selected on the basis of the above criteria were divided into two groups. The first group, the intervention group, were HCS customers who had received no more than three hours of assistance, in the form of help with house cleaning, a fortnight. The second group, the control group, were likely to need a similar level of assistance but had been turned away as being lower priority than other applicants or existing customers needing a greater degree of assistance.

Selecting the Sample

The selection of the final sample was undertaken in two stages. Stage one involved identifying possible subjects from each branch. The second stage involved the HCS contacting all potential participants in order to obtain their consent to participate in the study before they were contacted directly by research staff. The issue of obtaining consent also extended to the point at which researchers made direct contact with potential participants or their representatives, who either confirmed their willingness to participate in the study or withdrew their consent.

Stage one of the sample selection proved to be an important and informative exercise. Each HCS branch was asked to provide referral forms or current files of approximately 50 people (25 intervention and 25 control, randomly selected from those on file) who fulfilled the criteria described above. There were, however, few branches which were able to provide equal quotas of both groups, an issue explored in Section 4 of this report. However, despite some difficulties, by collecting data manually from HCS client records over a series of visits made to the participating HCS branches between December 1995 and February 1996, sufficient background information was available to identify 141 intervention and 242 control subjects, as shown in Table 3.1.

Table 3.1: Results of Sample Selection, T1

	Characteristics of Potential Sample Subjects			
	Received Home Care		Did not Receive Home Care	
	Number	Percentage	Number	Percentage
Total	141	36.8	242	63.2

Some basic demographic and other data were collected from the client files and referral forms for each member of the sample. The information included: age, sex, living circumstances and information from the HCS activities of daily living, financial and priority ranking score from the assessment forms. To maintain client confidentiality at this stage of the data collection, each file was given a number which would allow the SPRC researchers to cross reference their information with HCS data. Names and addresses were held only at the HCS branch.

Contacting Potential Subjects

Following the first stage of the sample selection, the next part of the study involved making postal contact with the sample and gaining their consent to participate in the study. In order to further maintain confidentiality and minimise confusion, it was decided that each person should be contacted directly by the Manager of the HCS branch to which they had been originally referred. This exercise proved difficult to administer and coordinate and very time consuming.

Postal contact with the sample was staggered to enable an initial contact with 301 (141 intervention and 160 control) subjects out of the original 383 numbers in the sample. A further 82 control subjects who could be contacted if the initial response rate was low were maintained as a back up. As it turned out, the response rate to the mail-out provided sufficient numbers and the back up numbers were not required.

Subjects in the intervention group were sent a letter signed by the respective Branch Manager explaining the HCS's involvement in the study and the fact that participating in the study would not affect their receipt of services. Accompanying this letter was a SPRC brochure explaining the aims of the study and detailing the researchers who could be contacted if any further information was required. A form which people could sign and send back to the SPRC in a reply paid envelope if they did not wish to participate, was also included in the package. In addition, recipients were able to contact the HCS branch directly if

they did not wish to participate in the study. A similar package was sent to the control sample. The letter signed by the HCS branch Manager was slightly modified to take their circumstances into account.[5]

Table 3.2 provides details on the numbers of letters sent out and the initial refusals by post.

Table 3.2: Participation in the Sample, T2

	Intervention		Control	
	Number	Percentage	Number	Percentage
Contacted by Branch	141	100	160	100
Refused to participate	32	33	26	16
Remainder (initial particpiation rate)	109	77	134	84

3.4 The Research Instrument

The study employed a quantitative methodology through the conduct of a telephone interview with subjects. The interviews covered a variety of relevant topics such as demographic information, level of functioning, complete network of care and a description of their lifestyle since their referral to home care, including changes in functioning, any periods of care, accidents, or other critical incidents.

The study provided an ideal opportunity to test the appropriateness and effectiveness of a retrospective interview conducted over the telephone. The use of a retrospective telephone survey in the study was preferable to a longitudinal, face to face interview for a variety of reasons. A telephone survey method allowed a large number of interviews to be conducted relatively cost effectively over a shorter time period (Leinbach, 1982).

The use of a retrospective survey allowed longitudinal type data to be collected for two points in time in a single interview. The survey instrument was designed to collect information about Time 1 (T_1), the time of application for a home care service, and the current time, Time 3 (T_3). Questions in the interview were designed in such a way as to allow the subject to discuss their current situation and then compare this to the time that they were either assessed by, or referred to

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5   Copies of the letters, SPRC brochure and consent form are available from the SPRC.

Home Care. The landmark of 'around Christmas 1994' served as a useful method of helping subjects distinguish between their situation 'now' and 'then'.

Data on the receipt or non-receipt of services were collected to measure outcomes including residential outcomes, death, changes in level of functioning, the occurrence of a critical incident or a change in circumstances which requires assistance from the formal sector. The design of the questionnaire allowed a variety of outcomes to be measured as shown in Table 3.3.

Table 3.3: Measuring Outcomes in the Study

Outcome	Measure
Residential outcome	Living circumstances; admission to residential care
Continuing health	Mortality; hospital use, health problems
Change in level of functioning (increase, decrease or stable level of dependency from T_1 to T_3)	Activities of Daily Living Scale and Barthel Index
Critical life events resulting in need for more or less help from T_1 to T_3	· New health problems · Move house · Fall or accident · Change in family circumstance · Financial problems · Number of hospital/ nursing home/ hostel admissions and length of stay

Information on the subject's level of functioning was also collected retrospectively for Time 1 and Time 3, using an Activities of Daily Living (ADL) scale based on that employed by the HCS as part of its assessment. This emphasises questions relating to home care tasks, such as the capacity to undertake light and heavy housework, basic household maintenance, shopping and preparing meals.

The Barthel Index ,which has been used since 1965 to measure functional status at high levels of disability (Mahoney and Barthel, 1965), was also incorporated into the questionnaire. The activities covered by the index are: feeding; moving from chair to bed and return; personal toilet (wash face, comb hair, shave, clean teeth); getting on and off toilet; bathing or showering self; walking on a level surface; ascend and descend stairs; dressing; controlling bowels; and controlling

bladder. Although there are a number of different measures of functional status, the Barthel Index was deemed appropriate for this study for a number of reasons.

- It is in widespread usage in Australia and is used by Aged Care Assessment Teams (ACATs), therefore providing information comparable to many other studies (Butler, Fricke and Humphries, 1993).

- It complemented the existing HCS data, extending the range of the ADL scale used by the HCS to examine details of requirements for personal care.

- The Barthel Index has been successfully used among clients of home care programs and has been found to be suitable for use as a screening device for potential recipients of domiciliary care services, serving to accurately identify clients requiring household help alone from those requiring more intensive levels of assistance (Fortinsky, Granger and Seltzer, 1981 in Butler, Fricke and Humphries, 1993).

- The reliability and validity of the Barthel index has been well established (Butler, Fricke and Humphries, 1993) and when administered in an interview the Barthel only takes a few minutes to complete. The Barthel Index is now often used in an interview format and has been used in telephone interviews (Shinar et al., 1987).

Some qualitative data about the subjects' perceived ability to manage at home now and in the future, their ability to afford services, and their need for a small amount of basic home help for people such as themselves, were also collected by means of a number of open ended questions.[6]

Short and Conversational Interviews

A 'Short' and 'Very Short' interview schedule was developed to deal with cases where only a limited amount of data could be obtained for a particular subject. These abridged interview schedules served a number of purposes, such as being able to capture some selected information or guide the interviewers responses in sensitive situations, for example, if they found that the subject was recently deceased. A 'Conversational' interview schedule was developed to be used in cases where a subject was unwilling or seemed unable to follow a formal interview format, but seemed willing to discuss their experiences. The conversational interview schedule captured some basic demographic information as well as details of service use, ability to manage at home, events that had

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[6] A copy of the full interview schedule and other research instruments are available from the SPRC.

occurred over the past year, satisfaction with current arrangements, and need for help at home.

Pilot Survey

The interview schedule was tested using a pilot questionnaire. Pilot interviews were conducted over the telephone with a small sample of elderly people, some of whom were current Home Care clients, to simulate an actual interview situation.

Interview Protocol

A basic interview protocol was developed to standardise the responses of different interviewers and to set out the procedure to be used to trace participants who did not respond after repeated attempts to contact them by phone. The protocol and training of the six interview staff (four full-time and two part-time over a period of two to three weeks) was necessary as it was considered that many of the subjects in the study, elderly, often frail and in some instances possibly confused, made them more likely to have difficulty completing an interview. The chance that a subject might not be contactable was also high considering the possibility that they could have been admitted to hospital, moved to live with family or friends or have entered residential care over the last 18 months.

If subjects could not be contacted by the interviewer, the Manager of the relevant HCS branch was asked to contact the subject's caregiver or next of kin recorded on the assessment or referral form. This contact person was often a close relative or friend, but occasionally it was necessary to turn to a General Practitioner or an Aged Care Assessment Team (ACAT) assessor. Managers then asked this person if they knew the whereabouts of the subject. Where possible, subjects were traced and interviews conducted with them. If this was not possible, contact persons were asked if they wished to participate in the study and carry out a proxy interview. Proxy interviews were conducted where possible, if the subject was deceased, confused or unable to be contacted. If a proxy interview was not possible then the subjects residential outcome was recorded, if available.

3.5 Limitations of the Research Design and Methodology

One of the main reasons why there continues to be such controversy and uncertainty surrounding the issue of the value of providing low levels of basic household support services for large numbers of older people is that it is an inherently difficult topic to research. Prospective experimentation is not only expensive, but as it involves withholding basic services considered to be important for the recipient's survival it has also been considered by many to be

unethical. As Howe (1994) has pointed out, a number of earlier descriptive studies had concluded that without basic support many older people would be condemned to live at home in neglect and misery. Clearly there are moral reasons for not deliberately withholding assistance that is considered to be vital. In recent years, however, the trend towards increased targeting and the intensification of service coverage has not only raised the question of the value of such services once again, it has also opened the possibilities of research on the topic.

This study was developed to take advantage of changes in the pattern of service allocation that were occurring regardless of the conduct of the research. By comparing the outcomes of the receipt of services amongst one group with the outcomes for a comparable group which did not receive assistance, it was argued that it should be possible to determine whether their receipt has, in fact, made a difference. As it was necessary to design and conduct the research with the significant constraints of a tight timeframe and budget, however, there were a number of problems with the final research design of which we were aware and to which it is important to draw attention.

Foremost amongst these limitations is the retrospective methodology employed. Working backwards in time, rather than forwards, is a common, and legitimate approach to social science research. However, reliance on personal recall is not regarded as being as reliable as ongoing personal monitoring or self-report. Also associated with the semi-longitudinal approach adopted is the problem of the attrition of sample through time. By relying on information provided by telephone at a single point in time, there was a potential selection bias in the research towards those who remained at home. As it would be difficult to obtain information on members of the sample who have died, or were admitted to residential care or for any other reason could not be traced, the study focuses largely on the residual group remaining at home.

Another limitation is the comparability of the intervention and control groups. For experimental validity, both groups should be as near identical as possible. In this regard, in the field of 'human experimentation', the optimal research design would involve random assignment of subjects from a common pool (for example a referral source) into one or other of the streams. Groups which are 'matched' by purposeful selection are generally considered to be less reliable for research purposes, as selector bias is considered likely to enter the selection process and perhaps discredit the results. Accusations concerning the reliability of results from studies using matched control groups, or indeed from the absence of a control group, have long plagued the field of community care research (Fine and Thomson, 1995b).

The Organisation of Home Care Records and its Potential Influence on the Sample

Given the sensitivity of the research methodology to selection biases, it is important to acknowledge the potential influence that the system in which the HCS organises their current and closed client files and referral forms may have had on the selection process. Two issues arise in this respect. First, the selection of successful and unsuccessful applicants for assistance from HCS is unlikely to provide two perfectly matched near-identical groups of research subjects. For a variety of reasons it could be expected that some important, although perhaps subtle differences could be expected between the two groups. For this reason an important research task is to compare the two groups, a process that should shed some light on the processes by which services are allocated to community care clients.

A second issue associated with the comparability of the two groups is the potential for a second order selection process, which was not immediately apparent to the researchers at the time of the sample selection, to affect the results. The potential for such an effect is particularly acute where a retrospective study is being conducted, as it may result in the selection by personnel of 'successful' clients, with the result that an unrepresentative sample is constructed. Many HCS branches appear to archive files which were closed or where services were no longer required or remove them from their database. Hence it is possible that files on a small pool of people who received a service in Time 1 (T_1 on Figure 3.2) and left the service before the sample was selected in Time 2 (T_2), may have been archived and not have been available for selection in Time 2. However, as the intervention group was composed only of customers who received service for three months or longer, the time period in which there may be a gap in the potential sample pool is relatively small.

Figure 3.2: Time Line of the Study

Sept 94	**March 95**	**Dec 95 - Feb 96**	**April/May 96**
	T_1	T_2	T_3

T_1 Sample referred to Home Care
T_2 Study sample collection period. SPRC visits made to HCS branches to collect sample
T_3 Interviews conducted, 13 - 18 months after initial referral.
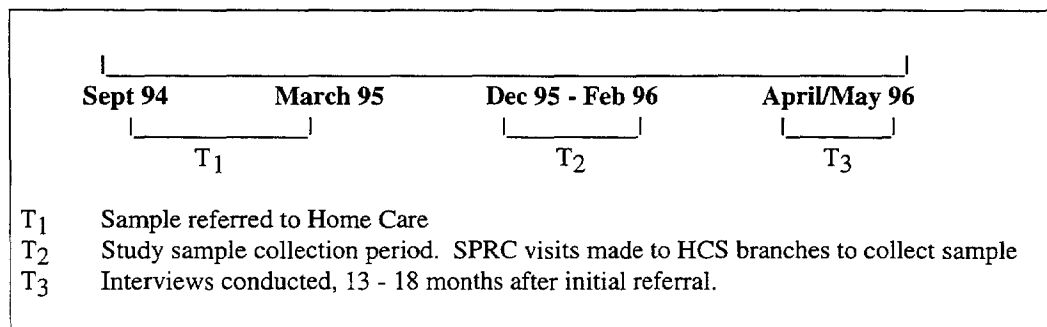
3.6 Conclusion

This study was established using a quasi-experimental design to test the research hypothesis in a reasonably rigorous and systematic manner. Importantly, the approach adopted can serve as a useful indicator of the value of further research on this topic. There are, however, a number of shortcomings in the methodology, as outlined above, which caution against uncritical or unqualified adoption of the results. The methodology, nonetheless, provided a cost-effective and timely approach to the subject of the value of low levels of service in the field of community care.

4 Agency Issues: Mechanisms of Resource Allocation in the Home Care Service

4.1 Introduction

The rationing of scarce resources in the field of community care is a central theme of this study. In an effort to utilise limited resources to greatest effect, resources have been increasingly targeted by Home Care to people with higher levels of dependency, away from people with lower levels of dependency who are the focus of this study. An understanding of the processes involved in distributing resources among home care branches and within the branches to clients is therefore of central importance.

The distribution of public resources through the HCS involves at least three rationing mechanisms before it reaches the final consumer. The first mechanism is the funding of the HCS itself, derived mainly from the Home and Community Care Program (HCS, 1994). The allocation of budgets to Home Care branches may be described as the second mechanism. While important elements of branch budgets are historically determined, other processes based on the principles of regional needs-based planning have also operated in recent years. As demand for assistance has increased and resources have been placed under pressure, despite the growth of the HACC program, a more finely tuned method of needs assessment has been developed by HCS to enable branches to prioritise applicants for assistance. This procedure, under which Branches are responsible for 'organising their resources to provide an efficient, effective, high quality and individualised service to customers' (HCS, 1995: 10), constitutes a third mechanism for the rationing of assistance.

HCS policy documents indicate that this third element, which reconciles fixed resources with variable demands, is central to the operation of the service, as the following statement indicates:

> The Home Care Service structure reflects the need to be able
> to make decisions about resource allocation wherever
> possible at local branch level. (HCS, 1995: 10)

The principle of branch stewardship of resources, under which each branch manages fixed budgets to meet locally varying levels of demand, results in the differing priorities accorded to clients with comparable levels of need. It is as a

result of this that applicants for household help in some branches have a greater likelihood of being accorded a low priority score and refused assistance, than in others. Before presenting the results of this allocation process, it is useful to understand how priorities for the allocation of assistance are determined within HCS branches. In this Section, information obtained by the researchers during the course of their visits to the seven participating Home Care branches is briefly discussed.

4.2 Variations in the Pattern of Resource Allocation Between HCS Branches

Early in the process of selecting a sample for this study it was found that the differing points of balance between the demand for assistance and resource constraints encountered in HCS branches meant that in some areas few if any applicants were allocated housekeeping help, while in others considerable numbers of such clients were accepted. Table 4.1 presents information from the files of applicants referred to the HCS that were made available to the researchers in the course of finding a sample for the study. This shows considerable variation between branches in the numbers and proportion of applicants who subsequently received assistance. In most cases, the subjects identified in the table represented the maximum number which could be located for each group in each branch, although, as discussed in Section 3, it is possible that some HCS files pertaining to assessments conducted in during the period September 1994-March 1995 were not located. In most instances branches had no difficulty providing some referral details for applicants who had not been able to obtain assistance. Many of these files contained details of complete HCS assessments in which the applicant had initially been found to have an assessed 'need for assistance', but had not received it as there were others accorded greater priority.

Due to the intensification of service provision that had been taking place in most branches, it was difficult to identify sufficient numbers of customers who had been assessed as requiring assistance and who had subsequently gone on to receive service. The differing proportion of applicants who went on to receive help in the form of a low level of assistance from each branch can be seen in Figure 4.1. Whilst not a precise measure across branches of all referrals, the statistics do suggest considerable variation between regions in the likelihood of receiving help.

The contrasting pattern of allocation in Branches 4 and 6 is an interesting example. In Branch Four, only 11 per cent of subjects referred to the HCS who fulfilled our sample criteria actually received service. This compares with Branch Six where 80 per cent of all eligible referrals went on to receive service.

Table 4.1: Number and Proportion of Applicants Who Received Assistance by the Socio-economic Characteristics of the HCS Branch District

Branch SES Index[a]	Applicants Allocated Help		Applicants Refused Help	
	Number	Percentage of Total Branch Sample	Number	Percentage of Total Branch Sample
1 Middle	13	22.8	44	77.2
2 Low	36	49.3	37	50.7
3 Low	11	35.5	20	64.5
4 Middle	10	11.2	79	88.8
5 Low	13	37.1	22	62.3
6 High	37	80.4	9	19.6
7 Middle	21	40.4	31	59.6
All branches	**141**	**36.8**	**242**	**63.2**

Note: a) High, Middle or Low status residential area. The SES (Socio-Economic Status) rating of the branch is indicative only, and does not necessarily reflect the characteristics of HCS customers of the branch. It is based on current house prices (*Sydney Morning Herald*, 25.5.1996) in the LGA in which the branch office is situated.

Figure 4.1: Proportion of Applicants Refused Low Levels of Service by HCS Branch and Socio-economic Characteristics of Branch District

Note: As for Table 4.1.
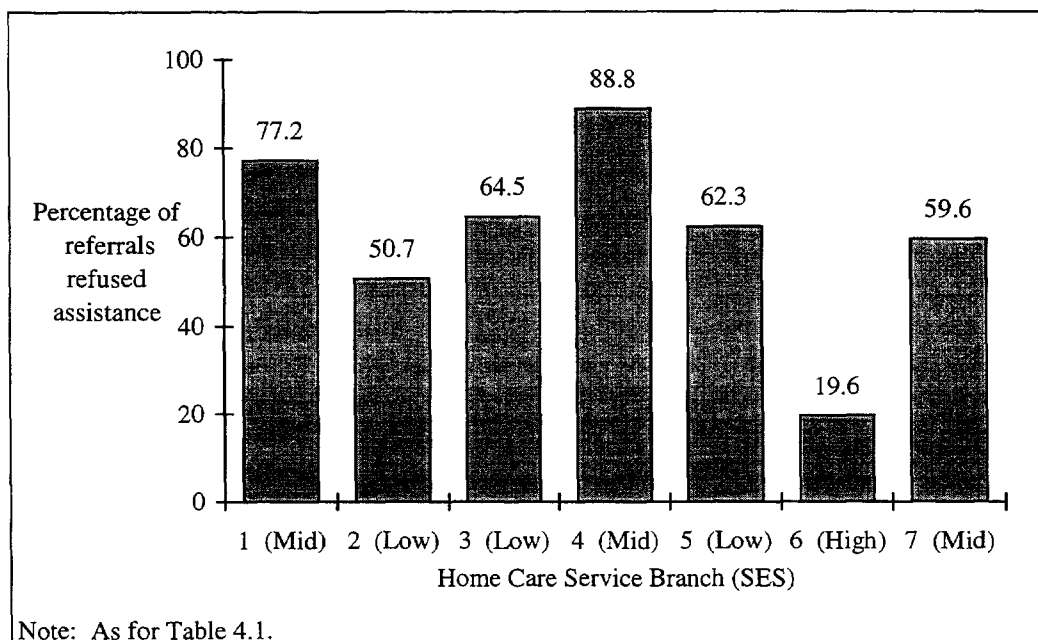
4.3 The Client Assessment and Prioritisation Process

Referral to community care agencies such as the HCS is for most applicants merely the first step in a more complex process of accessing assistance (Fine and Thomson, 1995a). The next step is that of assessment, the significance of which has long been recognised as the central point in the allocation of assistance by community care agencies. One authority, for example, recognising the importance of assessment for community care agencies, pointed out:

> In relation to service provision, assessment is the entry point, through which the person's need for and priority in using that service is determined. (Municipal Association of Victoria, 1987: 4)

Need is a relative concept and assessing need can often be a subjective process. To develop a level of objectivity and standardise the process of assessment and determining priorities for resource allocation, the HCS developed a client assessment form to be used across all of their local Home Care Branches. This was introduced as part of the new assessment procedure in April 1992. As the HCS *Annual Report* (HCS, 1994: 21) describes it, the procedure considers in detail the specific support needs of the frail aged, people with disabilities and their carers and also incorporates consideration of the applicants ability to purchase the service required from sources other than Home Care.

Referral and Assessment

Before an applicant is accepted for assessment, a preliminary screening process takes place, often at the point at which information is provided by phone. At the point of referral, or as one of the first steps in the formal assessment, HCS staff seek to determine whether there is evidence of an unstable health condition or acute illness affecting the applicant's condition. To ensure that HCS staff are not assuming responsibility for clients requiring skilled nursing assistance, the HCS will only take responsibility for applicants with stable health conditions. This policy decision is intended to prevent the duplication of service provision with home nursing services and to set out clearly defined roles and responsibilities for the two service types. Where there is evidence of unstable health, applicants for support at home are likely to be referred to a home nursing service.[7]

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7   The criterion of stable health emerged as being of central importance to the results later in the study. Its significance is discussed at greater length in Sections 6 and 7 of this report.

The HCS standard assessment form also records a large amount of information on key socio-demographic characteristics of a person applying for help. Examples of the information recorded include: whether the person lives alone, age, sex, language, income, expenditure, emergency contacts, current services and support (both informal and formal). The applicants ability to undertake the tasks of daily living including home care and personal care is assessed using an Activities of Daily Living scale. A further assessment of the need for help with six activities: housekeeping, shopping, food preparation, handyperson, respite care and personal care, forms the basis of a score for 'the need for Home Care Services'. A person scores points on how often they need help with the six tasks according to whether they need help: never, occasionally, usually or always. The assessor is then directed to ask for each of these six tasks, whether extra help is needed. A person scores an extra point for each task where extra help, apart from that already provided, is required.

A 'priority ranking score' is then calculated by combining the applicant's financial score (based on income and expenditure) and the points accumulated in the assessed need for home care service. A higher score reflects a higher priority for services to be provided by the HCS. The resultant priority score provides a method of ranking individuals and their need for home care service within each branch. In theory a person should receive the same score regardless of the branch to which they have been referred. Applicants with a score of, say, 25 points, may subsequently be considered a high priority and assigned assistance in one branch, but regarded as a low priority in another in which priority is assigned to those with higher scores.

This assessment and scoring system provides Home Care branches with a 'standardised' method of 'objectively' measuring and comparing individuals need and determining their priority for service. Perusal of approximately 400 client records across the seven Home Care branches that participated in the study, suggests some variation across the branches in the interpretation of the assessment and scoring system. In most cases, the priority ranking score was the major determinant in allocating services. However, in some cases, particularly where two clients obtained the same priority score, an additional approach to the judgement of the relative priority of different types of cases had been developed within each branch. The branch judgements were relatively uniformly applied within a branch and appeared to be sensitive to local needs, circumstances and level of demand expressed for services.

In some branches, clients were perceived to be at a lower level of risk and less in need of assistance from Home Care if they did not require a service often (for example, monthly compared to fortnightly), or if he or she could manage more housekeeping tasks unaided or had some family support. In other branches the definition of 'available informal support' was stretched to include the availability of local volunteer projects, a Returned Services Leagues club or a supportive

corner shop. In others, these sorts of support sources were not given as much weight in determining the need for assistance.

Despite these differences, concern was raised in all branches about the increased vulnerability of people who needed help but could not be provided with even basic support because of their low priority in comparison to others. Numerous examples were given of applicants who had been initially refused and who had reappeared a short time later with increased needs for service.

4.4 Other Agency Issues

Withdrawing Clients from Service Provision

Staff in all branches expressed concern about the risk of withdrawing clients from service who were currently receiving low levels of basic home help. In some branches this concern was directed particularly towards elderly couples who were often scored in the assessment process as one person. Many elderly couples receiving low levels of service were considered 'co-dependent', that is, as a means of compensating for each other's disabilities, one was able undertake tasks which the other could not. Withdrawing a few hours of basic home help in these cases was felt to be placing both clients at risk of premature institutionalisation.

Self-Assessment

Increased public awareness of the policy of targeting resources to those with higher levels of dependency, together with a growing awareness of the financial constraints experienced by the HCS, appears to have also had some influence on the number of people referred for help. One HCS branch had reported that referrals had 'slowed down' because referring agents had come to realise that Home Care was unable to provide services to people at the lower end of the dependency scale. The older population in general may also be carrying out their own 'self-assessments' as they come to realise that their local Home Care branch would probably not be able to provide them with a service.

4.5 Conclusion

It is clear that many factors influence the process of resource distribution to applicants for Home Care to provide them with basic home help. Some of these factors have been highlighted in the this section, particularly those which influence the process of resource distribution at the branch level, to people at the lower end of the dependency continuum. Factors such as living circumstance, perceived level of risk, and availability of informal support were just a few of the

need indicators drawn upon by the branches to prioritise needs and allocate resources.

The extent of reliance on branch-based judgements of priority appears to be closely related to the amount of resources available for service provision in relation to the total demand for assistance from each branch. Branches with relatively more resources (i.e. with less demand for assistance, particularly from high dependency customers) had more resources available and therefore had to make less detailed decisions about which individuals to assist. Branches with less funding made use of more need characteristics to determine which applicant required more need for help. Branch budgets, the second of the resource rationing mechanisms outlined earlier, were therefore of crucial importance in understanding the pattern of the allocation of low levels of assistance across the HCS.

The services summary study by Alt Statis and Associates found that the Home Care branches varied in their service type allocation strategies, their targeting of clients by dependency and the amount of support they offered to each client. Applicants assessed as 'largely independent' on the North Coast, for example, were found to be far less likely to get support than in any other area (Alt Statis and Associates, 1995). In our study, a clear example of the subtle variation that occurred across two branches was found. One branch was found to give clients a slightly higher score in the assessment of 'need for Home Care Services', reflecting a higher need for assistance from HCS, even if the person's need was currently being met by an informal carer. In contrast, another branch was found to give a lower score to a person with a similar level of informal support. Discussions with the manager of the first branch suggested that their branch had access to a relatively greater amount of resources, and could therefore afford to provide assistance to a greater number of people at lower levels of dependency.

It is not immediately apparent why the regional funding approach adopted by the HCS should have such a varied impact. It may be that the HCS branch funding formula, which relies on demographic figures drawn from census data provided by the Australian Bureau of Statistics (ABS) as well as on historic patterns of resource allocation, is somehow not immediately reflective of the level of demand evident in each area. Migration within and between regions of the State could be one cause of this, as certain areas, such as the North Coast of NSW, are affected by the resettlement of retirees and subsequent demands for assistance from older people living in isolation from their families to a greater extent than other areas. The variation in demand may also be indicative of lower demands for HCS services in higher-income residential areas, where potential applicants may be more prepared to avail themselves of other options (such as private live-in housekeepers or the purchase other assistance directly from the private market).

Another possible cause could be the reliance on figures on the distribution of disability in different regions of the State in planning the resourcing of branches. In the absence of a detailed regionally-based registration system for people with disabilities, the assumption is made in the 'synthetic estimates' of the HACC target population prepared by ABS that younger people with severe or profound disabilities are distributed equally between different regions. As a recent review of service provision targets in the planning of the Home and Community Care program has argued, such an equal distribution is, however, unlikely (Alt Statis and Associates, 1994: 89-104). Indeed, it would be surprising if there was not an unequal geographic distribution of younger people with disabilities. Those who are unable to work as result of disability and are constrained to exist on very limited incomes would be likely to seek accommodation in lower cost residential areas or in areas in which there is, historically, a pattern of supportive provisions (such as residential homes for the disabled).

Unfortunately, any attempt to understand why such differences emerged between branches in the proportion of applicants who received low levels of assistance must remain, for the purposes of this report, speculation. In the light of the national decision to promote approaches to the planning, provision and allocation of the community care services which in many respects closely resemble those already adopted by the HCS (DHSH, 1995: 49-51, 59-60), it is clear that the interaction of assessment procedures and regional resource allocation processes across the HACC program warrants further research.

The process of needs assessment at the branch level should be more fully documented to improve understanding of the impact of current resource allocation and needs assessment processes in the community care field. The fact that many Home Care branches have developed their own method of fine-tuning of the needs assessment process to accommodate to branch conditions suggests that standardised assessment approaches are unlikely to result in uniform assessments. This is reinforced by the real concerns raised by staff at the branches about the reappearance of people at higher levels of dependency, who were once refused low levels of services. Related to this is the fundamental importance of branch and regional budgets in the determination of patterns of service allocation between branches. Given the broad reform plans outlined in the recent *Efficiency and Effectiveness Review of the Home and Community Care Program* (DHSH, 1995), developing a better understanding of how both regional budgets and a standardised assessment process result in such differential allocation outcomes appears to be an important task for further research.

5 Outcomes of Receipt of Basic Home Help: Results of the Survey

5.1 Introduction

Two questions central to the research were raised in Section Two. To what extent do basic housekeeping services have a 'preventative function' in terms of delaying admission to an institution? Is it possible to measure different outcomes over time amongst those who have received assistance and those denied assistance? These questions have been addressed by comparing the information obtained on the two groups in the study for a number of outcome measures for the two groups.

The first outcome measure used in this study is the residential outcome, as measured by the place of current residence (Fine and Thomson, 1995a). This is referred to as the 'destinational outcome' by some researchers (Davies et al., 1990). An objective of community care has been to enable people to live independently in their own homes for as long as possible. In policy documents, as in research, the ability to maintain people at home by preventing their premature or inappropriate admission to a residential care setting is regarded as a fundamental objective of community care and as an important indicator of its effectiveness (Fine and Thomson, 1995b).

Other measures of outcome used in studies of community care include improvements in aspects of life in which community services specifically intervene. For example, Davies et al., (1990) developed an index of the clients' felt need for additional help with three activities, one of which was housework. In this study we have used change in the need for help with heavy housework as a simple proxy measure of the effectiveness of home help in promoting independence, helping someone manage at home and relieving or softening their experience of disability. Changes in the need for help with a number of other ADLs and IADLs were also examined.

Another common outcome measure in the field of community care concerns the extent of use of additional hospital and medical services (Fine and Thomson, 1995b). This provides a standard that reflects the capacity of community care to operate in a preventative manner, reducing the need for expensive, and intrusive additional services. In this study, subjects were asked to report on whether they had been admitted to hospital for a stay of one night or longer. The number of

hospital episodes and duration of hospital stay was noted and used as another outcome measure.

The analysis of the data suggests that some differences in outcome were apparent between the two groups. The intervention group were more likely to have remained at home compared to the control. Furthermore, the intervention group reported lower rates of hospital use, with fewer admissions overall and episodes of shorter duration. Interestingly, a greater proportion of the control group reported an improvement in physical function over time, as measured by the capacity to undertake heavy housework without help.

5.2 Full and Interview Samples

As shown in Table 5.1, a total of 237 direct contacts were made with either the subject or their carer, next of kin or another contact person such as a Home Care staff member or Aged Care Assessment Team assessor. Of this number, 111 were from the intervention group and 126 from the control. The residential outcomes are known for 224 people. A further 11 people were unable to be traced.

Table 5.1: Numer of Interviews Completed and Availability of Residential Outcome Data, Full Sample

	Interview Completed		No or Incomplete Interview. Residentidal Outcome Known		Unable to be Traced Residential Outcome Unknown		Total Number of Contacts	
	No.	%	No.	%	No.	%	No.	%
Intervention	82	73.8	27	24.3	2	1.8	111	100
Control	67	53.2	50	39.7	9	7.1	126	100
Total	149	62.9	77	32.5	11	4.6	237	100

The majority of the subjects who were unable to be traced were from the control group. Repeated attempts were made to contact this group. Interviewers attempted to make telephone contact at least five times, at five different times of the day and over five different days. If this was unsuccessful, HCS branch staff or the researchers contacted the subjects next of kin or contact person as recorded on the referral form (often a General Practitioner or Aged Care Assessment Team assessor). In the majority of cases, the subject's telephone had been disconnected because they no longer lived in that home. Whether this was because they had

died, had been admitted to residential care, had moved to another area or state or had moved to be with family it was not possible to determine. Following these attempts, a further strategy was implemented to track down the residential outcomes of 18 people by contacting the Register of Births Deaths and Marriages and the Department of Health and Family Services' Register of Nursing Home and Hostel admissions. This served to trace seven people, leaving a final total of 11 people who could not be traced. All that is known of these people is that they had not been able to remain living at the home in which they resided at the time of their initial referral to the HCS.

Complete interviews were undertaken with 149 people, 82 from the intervention group and 67 from the control group. In almost all cases the interview was conducted by telephone, directly with the subject, but in a few instances (for example, for those who had died or been admitted to a nursing home or hostel) the interview was conducted with a caregiver or close family member. Partial interview data was obtained from a further 18 people. Most of the 77 people for whom there is missing data simply declined to participate. In the 18 cases for which there is missing data, a modified form of the interview was undertaken (the short or conversational interviews described in Section 3), as it became apparent that it was not appropriate to require the respondent to provide full details for all questions.

Residential Outcomes

A comparison of the data available on residential outcomes for the full sample suggests a statistically significant difference (with a 95 per cent probability level) between the intervention and control group. Although the difference between the two groups in admissions to residential care was small, Table 5.2 shows that a higher proportion of those who received assistance from Home Care remained at home. The control group were also found to suffer higher rates of mortality compared to the intervention group. Furthermore, a far higher proportion of the control group were 'unable to be traced' during the interview period, one of the more disturbing findings to emerge from the research. Although it is known that these subjects moved from their home after their referral to the Home Care Service, no further outcome information is available, suggesting that the receipt of low levels of assistance from the HCS somehow had a stabilising effect on the lives of at least some recipients that was missing for those who were refused it. The results presented in Table 5.2 demonstrate that, over a period of more than a year, the receipt of assistance with low levels of basic household help from the HCS was associated with a reduced rate of admission to residential care and a reduced mortality rate. In comparison with the members of the control group who did not receive such assistance, the recipients of these low levels of assistance had an enhanced chance of remaining in their own home. These results

should not, however, be taken as demonstrating that the assistance provided by the HCS was the sole determining factor.

Table 5.2: Residential Outcome at T₃, Full Sample

	Home[a]		Residential Care[b]		Deceased		Unable to be Traced[c]		Other[d]		Total	
	No.	%	No	%	No	%	No	%	No	%	No	%
Intervention	95	85.6	7	6.3	4	3.6	2	1.8	3	2.7	111	100.0
Control	91	72.2	12	9.5	14	11.1	9	7.1	-	-	126	100.0
Total	186	78.5	19	8.0	18	7.6	11	4.6	3	1.3	237	100.0

Notes: a) Includes subjects who are living at the same home as at time of referral, in another private home, with family or in a self-care retirement unit.
   b) Includes both nursing homes and hostels. Sixteen of the 19 people involved were admitted to nursing homes.
   c) No longer at the address. Further outcome information is not known (see text).
   d) Other outcome. Subjects unable to be interviewed due to hospital (2) or respite (1) admission at time of survey.

Chi sq=10.09*, p=0.0178, df=3 (excludes those listed as having 'other' outcome).
* Significant at the 0.05 level.

Data on the residential outcomes and age of the full sample of 237 were obtained in the process of tracing potential participants using the records of the HCS. More detailed information was only available concerning those 160 participants for whom interview data is available. Comparative data on the residential outcomes of the interview and full samples, presented in Table 5.3, shows that the interview sample was broadly comparable to those in the full sample for whom residential outcome data was obtained. It is, however, important to note that there is a marked under-representation of those who had entered nursing homes or hostels and those who had died, in the interview sample. This affects the confidence with which conclusions can be drawn from the interview data, particularly with regard to the control group. The absence of information on those who had entered residential care and those who had died in the interview sample needs to be borne in mind in considering the remainder of the results presented in this report, which is confined to the data obtained from the residual group of the full sample from whom it was still possible to obtain data by telephone interview.

Table 5.3: Residential Outcome at T3: A Comparison of Interview and Full Samples

Residential Outcome	Interview Sample (n=167)		Full Sample[a] (n=223)	
	Intervention (Home Care) %	Control (No Home Care) %	Intervention (Home Care) %	Control (No Home Care) %
Home	98.8	92.8	89.6	77.8
Residential Care	1.2	2.4	6.6	10.2
Deceased	0	4.8	3.8	12.0
Total percentage	100.0	100.0	100.0	100.0
Total number	84	83	106	117

Note: a)   Figures for the full sample refer only to those subjects who were traceable at T3.

5.3   Substitution of Formal Services

Assistance provided by the HCS may be regarded as formal assistance provided by a public agency. Many individuals from the control group reported that they had sought help from alternative sources when refused assistance by the HCS, making private arrangements to hire a cleaner, relying on informal caregivers, or both. This raises the question of whether it is appropriate to simply confine the comparison of outcome data to the intervention and control groups, defined only as those who received help from public sources, and those who were refused it. Might it be possible that residential outcomes were determined by the availability of help from any source, rather than just help from the HCS?

To test whether the use of substitute formal assistance had an impact on residential outcomes, respondents were reclassified into two groups: those who received formal assistance from any source (HCS, other public community services, private agencies or private household helper) and those who received no such assistance. The results are reported in Table 5.4. Similar patterns to those described earlier were observed (compare Tables 5.3 and 5.4), suggesting that there was little difference in the impact of receipt of home care or privately paid help on residential outcome.

5.4   Change in Level of Dependency

Another outcome which the study attempted to measure was concerned with changes in the recipients' level of physical dependency as a result of receiving

**Table 5.4:   Residential Outcome   at T3 by   Receipt of   Formal   Basic   Home   Help[a],
Interview Sample**

	Interview Sample (n=167)		Full Sample (n=223)	
	No.	%	No.	%
Home	98	98.0	58	95.1
Residential Care	2	2.0	1	1.6
Deceased	0	0	2	3.3
Total	100	100.0	61	100.0

Note: a)   Covers receipt of Home Care and private home help in the period following
referral to HCS.

help from HCS over time.   To determine whether receipt of help with basic household help helped stabilise the recipient's level of dependency, or led to an improvement or decline in the recipient's need for help, information collected during the interviews on the need for help with a number of ADLs and IADLs at T_1 and T_3 (as discussed in Section 3), was analysed.   A new variable for each activity which measured change over time, was created to enable comparisons between individuals and groups to be made.

As difficulties with housekeeping/home help was the reason for the initial referral of respondents to the HCS, and is also the most commonly reported form of disability amongst community care recipients (see Section 2), the need for help with heavy housework serves as a useful illustration of the application of this series of measures.   Heavy housework, for the purposes of the interviews, was defined simply as the need for assistance with activities such as sweeping, vacuuming and laundry.

As can be seen in the results presented in Table 5.5, the outcomes for recipients in both the intervention and control groups of changes in the need for help with heavy housework at first glance appeared quite startling.   A significant proportion of the control group reported a marked reduction in their need for help with heavy housework, with 31.6 per cent reporting an improvement over time.   Only one person from the intervention group, 1.2 per cent of the interview sample, reported an improvement.   Although a slighter higher proportion of members of the control group reported a decline in their ability to undertake heavy housework unaided than was the case amongst the intervention group, the results at first sight suggest that receiving help from the HCS was not beneficial for the recipients.

Table 5.5: Change in Need for Help with Heavy Housework at T3[a], Interview Sample

Change in Level of Dependency	Intervention (Home Care) %	Control (No Home Care) %
Improvement	1.2	31.6
Stable	93.8	60.5
Decline	4.9	7.9
Total percentage	100.0	100.0
Total number	81	76

Note: a)   Figures do not include those subjects for whom only a residential outcome was known or who were untraceable.

These results are not, however, as robust as they first appear, as much of this apparent improvement can explained by a number of factors. First, it is likely that a certain proportion of the control group may have suffered from only a short-term need for help at T_1, for example, after discharge from hospital. Their need for assistance is likely to have declined fairly quickly after they recovered from their illness, reflecting an 'improvement' in Table 5.5. As discussed further in Section 6, this result may thus reflect the successful targeting of HCS assistance more than any 'improvement' attributable to being refused assistance by HCS.

A second factor to consider is, how well the control group was managing with undertaking heavy housework. When individuals in this group approached HCS, most subjects considered themselves unable to undertake heavy housework. Once refused assistance, many simply had to cope.   For example, many participants reported only being able to do the heavy housework when they felt capable, taking their time or not doing any work which was not considered urgent or necessary. At what cost to the health and well-being of the subject is the requirement to do heavy housework when he or she feels tired or unwell? What effect does the inability to maintain their homes as they would wish have on their quality of life and morale?

Third, a large proportion of the observed improvement in Table 5.5 may be explained by the methodological inadequacy of the question posed to subjects during the interview. The question was worded as follows:

I'd like to read you a list of some of the basic things that most people need to do every day. Firstly, I would like you to tell me how you are currently able to manage these activities and thinking back over the

*last year and a half to about Christmas 1994, tell me if you were able to
do these same tasks then.*

*Are you able to do heavy housework like sweeping, vacuuming and
laundry? Does anyone help you with this?*

Because the receipt of help is, *ipso facto,* an admission of a need for help, people
who were receiving assistance from HCS (or, for that matter, private help) would
be likely to report themselves as unable to carry out the task regardless of any
improvement in their condition over time. The responses to the question, in
which all but one recipient of assistance from the HCS reported no improvement,
suggests a methodological inadequacy, a tautology, in the question. This
criticism is a well known critique of the use of self-report ADL scales such as the
one used in this study (AIHW, 1994; Fine and Thomson, 1995a; Bentur, 1996).
In the absence of better measurement tools, however, it is best to be aware of their
limitations rather than to abandon their use.

Table 5.5 also shows that a slightly higher (although not statistically significant)
proportion of the control group reported a decline in their levels of dependency.
The decline in dependency experienced by a smaller proportion of the
intervention group and their relative stability compared to the control group may
reflect the achievement of the objective of the HCS to reduce the decline in
ability of their clients and help them to remain stable over time.

A further analysis to that described above was undertaken comparing those who
received some form of formal basic home help and those who did not, as shown
in Table 5.6. Again, a similar pattern of decline, improvement and stability as
described in Table 5.5 emerges, suggesting that there is little difference in the
impact of receipt of home care or privately paid help on this outcome.

**Table 5.6: Change in Need for Help with Heavy Housework by Receipt of Formal Basic
Home Help, T_1 -T_3, Interview Sample**

Change in Dependency	HCS or Private Help %	No HCS or Private Help %
Improvement	7.1	31.6
Stable	88.8	57.9
Decline	4.1	10.5
Total percentage	100.0	100.0
Total number	98	57

A similar pattern also emerges when a paired analysis (receipt of HCS and receipt of any formal help) is undertaken for other ADLs such as showering, dressing and shopping, as shown Table 5.7. The level of improvement in each of these activities is highest amongst those who reported that they received no formal help with basic housekeeping tasks. Similarly, the greatest decline is also evident amongst this group. The consistency of this pattern suggests that the use of formal assistance, both from the HCS and from all sources, was not arbitrary. The most capable and independent respondents were able to go without formal assistance because they did not really need it. The pattern of decline, however, also suggests that there are some, at least, who are going without assistance who would be likely to benefit from it, directly, for help with housework, and indirectly, for its impact on the need for help with other activities.

Table 5.7: Change in Need for Help with Certain Activities, T_1-T_3, Interview Sample

Activity/Change in Level of Dependency	Intervention (HCS) %	Control (No HCS) %	HCS or Private Help %	No HCS or Private Help %
Bathing/Showering				
Improvement	5.3	-	-	6.9
Stable	94.7	98.8	99.0	93.1
Decline	-	1.3	1.0	-
Dressing				
Improvement	1.3	11.8	3.1	12.1
Stable	96.3	86.8	94.1	86.2
Decline	2.5	1.3	2.1	1.7
Shopping				
Improvement	14.1	23.7	14.9	24.1
Stable	76.9	69.7	77.7	67.2
Decline	9.0	6.6	7.4	8.6
Heavy Housework				
Improvement	1.2	31.6	7.1	31.6
Stable	93.8	60.5	88.8	57.9
Decline	4.9	7.9	4.1	10.5
Total percentage	100.0	100.0	100.0	100.0
Total number	78	76	96	58

5.5 Hospital Admissions and Length of Hospital Stay

A more dramatic difference in outcome between the two groups may be observed when receipt of home care or private home help is cross-tabulated with the number of hospital admissions and length of hospital stay in the 12-15 month period following their referral to HCS, as shown in Tables 5.8 and 5.9. The data suggests that people who received either home care or private help were less likely to be admitted to hospital than those who did not receive either form of assistance.

Table 5.8: Number of Days In Hospital by Receipt of Home Care[a], Interview Sample

| | Intervention | | Control | |
	No.	%	No.	%
No days	51	64.6	41	53.2
1 day	2	2.5	3	3.9
2-5 days	3	3.8	5	6.5
6 - 20 days	13	16.4	20	26.0
21 or more days	10	12.8	8	10.4
Total	79	100.0	77	100.0

Note: a)   Figures do not include those subjects for whom only a residential outcome was known or who were untraceable.

Table 5.9: Number of Days In Hospital by Receipt of Formal Basic Home Help[a], Interview Sample

| Number of Days in Hopsital | HCS or Private Help | | No HCS or Private Help | |
	No.	%	No.	%
No days	60	64.5	31	54.4
1 day	3	3.2	2	3.5
2-5 days	4	4.3	4	7.0
6 - 20 days	16	17.2	14	24.5
21 or more days	10	10.8	6	10.5
Total	93	100.0	57	100.0

Note: a) Includes Home Care and private home help. Figures do not include those subjects for whom only a residential outcome was known or who were untraceable.

A similar pattern emerges when the number of days spent in hospital is cross-tabulated by the receipt of either home care or private home help, as shown in Tables 5.10 and 5.11. The data suggest that people who received either home care or private help were likely to have fewer days in hospital. It is important to note, however, that it is not possible from this data to demonstrate a direct causal relationship between hospital admissions and the receipt (or non-receipt) of assistance with basic household help from the HCS. Analysis of other data collected during the interviews, discussed in Section 6.3 of this report, suggests that other factors, most importantly the medical conditions reported by participants, were more directly related to both hospital admissions and to the allocation of assistance by the HCS.

Table 5.10: Number of Hospital Admissions[a] by Receipt of Home Care, Interview Sample

Number of Hospital Episodes	Intervention		Control	
	No.	%	No.	%
No times	51	61.4	41	52.6
1 time	19	22.9	23	29.5
2-3 times	12	14.4	12	15.3
4 or more times	1	1.2	2	2.6
Total	83	100.0	78	100.0

Note: a)   Defined as an overnight stay in hospital. Figures do not include those subjects for whom only a residential outcome was known or who were untraceable.

Table 5.11: Number of Hospital Admissions by Receipt of Formal Basic Home Help[a], Interview Sample

Number of Hospital Episodes	Home Care or Private Help		No Home Care or Private Help	
	No.	%	No.	%
No admissions	60	61.9	31	53.4
1 time	21	21.6	16	27.6
2-3 times	14	14.5	10	17.3
4 or more times	2	2.0	1	1.7
Total	97	100.0	58	100.0

Note: a)   Includes Home Care and private home help. Figures do not include those subjects for whom only a residential outcome was known or who were untraceable.

5.6   Availability of Informal Help

Regardless of the availability of formal assistance, the overwhelming majority of participants, 87.4 per cent of those from whom we had obtained information by interview, were also supported informally by family members, friends or neighbours. The help provided by such informal carers varied from changing a light bulb when required to helping with heavy housework, mowing the lawn and undertaking other regular activities including shopping, cooking, and, on occasions, assistance with personal care. The availability of informal help was often related to a subject's living circumstances. When subjects did not live alone, informal help was generally provided by co-residents, usually a spouse, but sometimes a partner or other family member with whom they lived in the same home. Subjects who lived alone often received assistance from a greater variety of sources which not only included friends, neighbours and family, but also other people such as security guards and apartment block caretakers.

The results shown in Tables 5.12 and 5.13 suggest that access to informal help was so widespread that when it is taken into account it appeared to make little difference in subjects' residential outcome or change in need for help with heavy housework. The majority of subjects on whom this information is held were still at home at the time of the interviews, regardless of whether they received informal assistance. Similarly, the majority of subjects reported no change in their need for help with heavy housework (72.2 per cent of those who reported either formal or informal help, and 78 per cent of those who did not).

There does, however, appear to be a difference when the availability of informal help is cross-tabulated with the number of days in hospital between T_1 and T_3, as shown in Table 5.14. In fact, 62.5 per cent of subjects who had access to informal support had no days in hospital, compared to only 47.1 per cent of subjects who did not.

Table 5.12:   Residential Outcome by Informal Help Received, Interview Sample

Residential Outcome	Formal or Informal Help		No Help	
	No.	%	No.	%
Home	128	97.0	18	94.7
Residential Care	2	1.5	1	5.3
Deceased	2	1.5	0	0.0
Total	132	100.0	19	100.0

Table 5.13: Changes in Need for Help with Heavy Housework by Informal Help Received, Interview Sample

Change in Level of Dependency	Formal or Informal Help		No Help	
	No.	%	No.	%
Improvement	22	17.1	2	11.1
Stable	101	78.3	13	72.2
Decline	6	4.7	3	16.7
Total	129	100.0	18	100.0

Table 5.14: Number of Days in Hospital by Informal Help Received, Interview Sample

Number of Days In Hospital	Formal and Informal Help		No Help	
	No.	%	No.	%
No Days	80	62.5	8	47.1
1-5 Days	8	6.2	3	17.7
More than 5 days	40	31.25	6	35.2
Total	128	100.0	17	100.0

5.7 Conclusion

The results reported in this section suggest that the receipt of formal home help from the Home Care Service was associated with a statistically significant difference in the residential outcomes of the full sample, with those who received asistance from HCS having a better chance of remaining at home. Similar, although not statistically significant differences were also found in the residential outcomes of those subjects in the study for whom detailed information was obtained by telephone interview, both with regard to assistance provided by HCS and all forms of formal household help, including the use of private cleaning services. Although a higher proportion of the control had died or were unable to be traced, the majority of members of both the intervention and control group remained at home. A large proportion of the control group also reported an improvement in their ability to carry out tasks, particularly heavy housework, while only a small proportion of the intervention group reported they had improved. The 'improvement' reported was not entirely unexpected given the methodological inadequacies of the question and characteristics of the control group. Differences in outcome were also found in the frequency and duration of hospital episodes, with members of the intervention group again having better outcomes than those in the control group.

It is not, unfortunately, possible to determine the cause of these statistical correlations on the basis of the data presented in this section alone. In the following section, therefore, we examine data on the similarities and differences between the two groups to identify other possible explanations for the differences in outcomes discussed here.

6 Home Care Service Recipients and Non-recipients: Further Results from the Survey

6.1 Introduction

The previous section reported on the outcomes of the provision of low levels of basic home keeping services for a sample of Home Care Service customers and a control group consisting of a number of comparable individuals who had also sought assistance but had been unable to obtain it. In this section we examine data on the comparability of the two groups and discuss the reliability of the conclusions which emerge from the retrospective survey.

The control group was composed of individuals referred to the HCS who were assessed as having a similar level of need as those who became customers on the basis of an assessment or the best available information, usually a brief telephone screening conducted at the time the referral was taken. The selection of the control group was possible because of the operation of the HCS priority ranking system policy of targeting assistance to those with the greatest levels of need in each branch. By comparing the outcomes for the control group over a period of more than a year with the outcomes for service recipients, it has proven possible to learn much about the impact of low levels of housekeeping services to frail older people who seek help to remain in their home as a result of age related disability or illness. The lessons that can be drawn from the comparison, however, depend on the comparability of the two groups.

It would, of course, be unreasonable to expect the two groups to be identical in every, or perhaps even in most respects. Membership of each group was not determined by a process of random assignment from a common pool, nor was there any attempt by the HCS or the researchers at achieving a systematic match between individuals in each group. Rather, as described earlier (see Section 3), the two groups were selected using HCS records, first at the time of referral, later at the time details were being sought by the researchers for suitable participants in this study. The information available suggests an amount of overlap between those who received assistance in one branch and those turned away in another, although the decision within each branch to provide assistance to some applicants and to refuse it to others was not an arbitrary or irrational process, but an informed and relatively consistent one. It nonetheless appears from the analysis that individuals refused assistance by one branch may well have been assisted if they had initially been referred to another.

A troublesome element of comparison to emerge from the study concerns the absence of details on those members of the full the sample who no longer remained at home. As there were 35 such individuals in the control group (27.7 per cent of the control group in the full sample) who had either been admitted to residential care, died or were unable to be traced, and only 13 in the intervention group (11.7 per cent), their omission from the data collection may have resulted in an account which is, in certain respects, less representative of the problems experienced amongst the control group.[8] For this reason, it is important to bear in mind the residual nature of the interview samples on which the comparisons presented in this section are based.

What emerges from the comparison of the data collected by telephone interview is a picture of overall similarities, but also some important differences. While there is much overlap between the two groups on most measures, fewer control group member reported living alone than did the intervention group. There were also other interesting differences between the two groups, in terms of income, the medical conditions they reported and the sources of support they relied on. Despite these differences, the need for help amongst both groups, as measured on an ADL scale, was remarkably similar, with one important exception which we shall discuss later in this section.

Drawing on the data available on the interview sample, the next part of this section examines information on the basic demographic and socio-economic characteristics of each group. Data on the need for help and the use of different sources of support used by each group are then presented in Section 6.3. Finally, Section 6.4 reports on the perceptions of the adequacy of support amongst each group and discusses the finding that most members of both the intervention and control groups reported that access to help with basic housekeeping is important for frail older people like themselves who wish to remain at home.

6.2 Demographic and Social Characteristics of the Two Groups

The basic demographic information available on the sample shows some interesting differences between the members of the intervention and control groups. Details of the age of members of the full sample were obtained from the information available in HCS records. As can be seen from Table 6.1, women

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8   The decreasing aggregate level of disability amongst community support populations who continue to remain at home has been commented on elsewhere (Fine and Thomson, 1995a). As those with the greatest level of need either die or are admitted to residential care, the aggregate level of disability amongst the residual population who remain at home decreases.

formed the clear majority of the full sample of both groups, as might be expected by anyone familiar with the demography of old age and disability in Australia. In both the intervention and control groups approximately three of every four of those referred for assistance were female. Differences are also apparent in the age range of those in each group. Amongst the control group there were also more 'young older' people, especially those aged between 55 and 74, and less 'old old', aged above 85 years. The mean age of the control group was almost three years below that of the intervention group.

Table 6.1: Age and Sex of Participants, Full Sample

	Group		All
	Intervention %	Control %	%
Male	24.3	23.0	23.6
Female	75.7	77.0	76.4
Age of Participants (in years)			
Mean Age	80.0	77.7	78.8
Standard Deviation	6.8	6.7	6.8
Age Groups of Participants (in years)			
55-74	19.8	30.2	24.8
75-84	55.8	51.6	54.3
85 or above	24.4	18.3	20.9
Number	111	126	237

Additional details were not generally available from HCS records, so further comparison of the characteristics of the two groups must rely on data obtained during the telephone interviews from the 162 people for whom such information is available. As pointed out earlier, reliance on this data has the effect of underestimating the difficulties faced by the aggregated control group.

Important differences were nevertheless recorded in the living circumstances and income of the members of each group. As Table 6.2 shows, members of the intervention group were more likely to be living alone than those not assisted by the HCS. In turn, a greater proportion of control group members lived with a spouse or partner than was the case amongst the intervention group. Intervention group members were also more likely to live with children and other family members. The proportion of both groups living in 'other' circumstances was similar. Most accommodation classified as 'other' was purpose built retirement accommodation of various kinds. For one member of the intervention group, however, it was a boarding house.

Table 6.2: Residential Circumstances of Participants, Interview Sample

	Group		
	Intervention	Control	All
	%	%	%
Lives Alone	69.0	62.0	65.6
Lives with Spouse or Partner	20.2	29.1	24.5
Lives with Other Family or Friends	6.0	3.8	4.9
Other[a]	4.8	5.1	4.9
Total percentage	100.0	100.0	100.0
Total number	84	79	163

Note: a)   Other accommodation. Most lived in specialised accommodation in retirement units, but also includes one person living in a boarding home and one in a mobile home.

There is also evidence, shown in Tables 6.3 and 6.4, that many members of the control group enjoyed a better income than those in the intervention group. Overall, a large majority of both groups were dependent on the Age Pension or, in a few instances, on other government benefits such as a Disability or Veterans Pension (see Table 6.3). However, a greater proportion of members of the control group reported that their main source of income was superannuation or other private sources, which placed them in a higher income group and disqualified them from receiving a pension. The figures available on weekly income (Table 6.4), while clearly indicative of a greater average income amongst the control than the intervention group, are aggregated at household level. In interpreting these figures, therefore, it is important to take into account the greater proportion of the control group members reporting joint household incomes.

Table 6.3: Source of Income of Participants, Interview Sample

	Group		
	Intervention	Control	All
	%	%	%
Govt. Pension or other Govt. Support	90.4	78.4	84.8
Superannuation	4.8	9.5	7.0
Other	4.8	12.2	8.2
Number	83	74	157

Table 6.4: Weekly Income of Participants, Interview Sample

| | Group | | All |
| | Intervention | Control | |
	%	%	%
$199 p.w. or less	80.6	56.0	69.5
$200-399 p.w.	15.3	28.9	21.4
$400 or more	4.2	15.3	9.2
Number	72	59	131
Income Unit Recorded			
Individual	97.6	87.9	93.3
Household	2.4	12.1	6.7
Number	83	66	149

6.3 Need and Sources of Support

A systematic attempt was made during the telephone interviews to record information on a wide range of factors associated with the need for help amongst sample members. The data available reveal a varying and contrasting picture. Data on the medical conditions experienced by participants point to some differences in the pattern of health problems reported by members of the intervention and control groups. Differences between the two groups, however, were less evident in the self-reported need for help with a range of Activities of Daily Living. As might be expected, given the sampling methodology, marked differences existed in the sources of support received by members of the intervention and control groups.

Health Problems and Hospital Use

Information on the chronic health problems experienced prior to referral to the HCS was reported by 161 subjects. Up to three main conditions were recorded for each individual. Sixteen people, or 10 per cent of all respondents who answered these questions, reported no chronic medical conditions. One hundred and forty-five reported at least one condition, with a considerable number of these reporting two, three or more problems. The problems reported were coded into ten categories for analysis. The results, which must be treated with some caution due to the relatively crude measures used, nonetheless suggest that there were some important differences between the intervention and control groups. The intervention group, in general, reported more stable, ongoing chronic and disabling conditions than did the control group, amongst whom there was

evidence of a greater prevalence of acute conditions and conditions from which some degree of recovery in physical capacity might be expected over time. Muscular-skeletal conditions, primarily arthritis, were the most common set of conditions amongst both groups. They were, however, markedly more prevalent amongst the intervention than the control group. Conditions of the nervous system, such as Parkinson's disease and multiple sclerosis were also more common amongst the intervention group. These types of chronic health conditions, characterised by either relatively stable medical condition or slow, progressive physical deterioration, make heavy physical work difficult and could be reasonably expected to be a major cause of a functional disability requiring assistance with housework. Circulatory and respiratory diseases, in contrast, were more common amongst the control group than the intervention group. The reported prevalence of other conditions, such as neoplasms amongst the control group, and mental conditions and nervous diseases among the intervention group, also are suggestive of differences between the two groups. The control group reported more unstable medical conditions that were likely to be manifest in unpredictable medical crises, and were also often associated with post-acute recovery of functioning. Consistent with this pattern of more unstable medical conditions, members of the control group also reported a higher incidence of major new health problems since T_1 than did members of the intervention group.

It is important that this pattern of illness be borne in mind when interpreting the data on the use of hospital services among the two groups presented in the previous section. The higher rates of admission to hospital and the longer length of hospital stay recorded amongst the control group are consistent with the pattern of health problems recorded in Table 6.5. Although there was a statistical correlation between the receipt of basic assistance from the Home Care Service and reduced hospital use reported earlier, it was not demonstrated that there was a direct causal relationship (in either direction) between the two phenomena. The more immediate explanation of the use of hospital services being associated with this pattern of illness is, in our minds, far more plausible. It is also consistent with knowledge of the processes and criteria associated with screening and assessment of applicants for assistance from the HCS branches described elsewhere in this report.[9]

Need for Help with Activities of Daily Living

The need for help with a range of activities was also recorded during the telephone interviews. Data on the proportion of subjects from both groups

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9   Unfortunately data were not collected on the use of hospital services prior to referral to HCS.

Table 6.5:   Medical Conditions Reported by Participants as Main, Second or Third Chronic Health Problem, Interview Sample

Problems Reported[a]	Group Intervention %	Control %	All %
No Chronic Problems	8.4	11.5	9.9
Mental Condition	7.2	2.6	5.0
Nervous Diseases	22.9	9.0	16.1
Circulatory Diseases	38.6	46.2	42.2
Respiratory Diseases	14.5	29.5	21.7
Digestive System Diseases	4.8	10.3	7.5
Genito-urinary Conditions	4.8	7.7	6.2
Muscular-skeletal Conditions	73.5	55.1	64.6
Neoplasms	1.2	10.3	5.6
Other Problems	16.9	11.5	14.3
Major New Health Problems since T_1	32.1	45.0	38.5
Number	83	78	161

Note: a)   Most subjects reported more than one condition. Percentages indicate percentage of the total respondents (for this question) reporting the condition, and therefore sum to more than 100 per cent.

reporting a need for help at the time of referral (T_1) is presented in Table 6.6, and data referring to the time 13-18 months later at the time of the interviews (T_3), is shown in Table 6.7.   A comparison of both tables reveals that, in general, both groups showed a similar pattern of need.   The need for help with heavy housework (such as sweeping, vacuuming and laundry) was the second most commonly reported need at both points in time.   In both instances, a greater proportion of intervention group members reported that they needed help with this activity than was the case with members of the control group.   The relatively dramatic decline in the proportion of control group members needing help with heavy housework has already been discussed in the previous section.   It is interesting to note that in terms of a number of other activities, including light housework (such as dusting, tidying and washing up), the use of stairs, and especially with personal care tasks such as the need for help with bathing/showering and dressing, a greater proportion of control group members reported a need for help than was the case among the intervention group.   As discussed in Section 2.3, the need for help with activities of this kind is usually considered indicative of a greater degree of functional incapacity than is an inability to undertake heavy housework.

Table 6.6: Proportion of Participants Dependent on Help with Activities of Daily Living At T_1, Interview Sample

Activity	Group		All
	Intervention	Control	
	%	%	%
Home Maintenance	89.6	94.7	92.2
Heavy Housework	95.1	75.0	85.4
Shopping	65.4	72.4	68.8
Cooking	41.3	53.3	47.1
Light Housework	26.3	42.7	34.2
Use Stairs	20.3	29.7	24.8
Bath/Shower	6.3	18.7	12.3
Dressing	5.0	14.5	9.6
Incontinence Urine	5.1	8.1	6.5
Incontinence Bowel	3.8	8.2	6.0
Walk	5.0	6.8	5.9
Move from Chair or Bed	3.8	6.8	5.2
Face Wash	0.0	7.9	3.8
Use Toilet	1.3	4.0	2.6
Feeding	1.2	1.4	1.3
Number[a]	82	78	160

Note: a)   The availability of data varied for some questions, with total responses ranging from 153 to 160.

Table 6.7: Proportion of Participants Dependent on Help with Activities of Daily Living, at T_3, Interview Sample

Activity	Group		All
	Intervention	Control	
	%	%	%
Basic Home Maintenance	91.0	90.7	90.8
Heavy Housework	98.8	51.9	76.3
Shopping	61.0	55.1	58.1
Cooking	24.1	18.2	21.3
Light Housework	16.9	14.3	15.6
Use Stairs	16.0	15.6	15.8
Incontinence Urine	5.0	14.5	9.6
Bath/Shower	7.3	6.4	6.9
Walk	3.7	3.9	3.8
Incontinence Bowel	2.5	9.3	5.8
Dressing	7.3	3.9	5.7
Move from chair or bed	2.5	2.6	2.5
Face Wash	1.2	2.6	1.9
Use toilet	2.5	1.3	1.9
Feeding	1.2	0.0	0.6
Number[a]	82	78	160

Note: a)   The availability of data varied for some questions, with total responses ranging from 153 to 160.

The data pertaining to the time of the interviews, some 13-18 months later, presented in Table 6.7, suggests that in terms of a range of household support activities, such as shopping, cooking and light housework, more members of the intervention group required help than was the case with members of the control group. But the picture is not consistent, with a higher proportion of control group members reporting difficulty with stairs and incontinence. In summary, the data presented in Tables 6.6 and 6.7 point to some differences between the intervention and control groups, but the overall impression is of membership of a common population. Both groups display patterns of a need for help that is typical of a frail aged population able to remain at home, but requiring at least some regular assistance to do so.

The types and amounts of support used by each of the two groups is shown in Table 6.8. This shows, as expected, that assistance provided by the Home Care Service was the most common form of support amongst the intervention group. There was a very strong pattern of continuity in the use of this service, with 95 per cent of all those who reported receiving assistance following the initial referral still receiving it more than a year later. This suggests that reassessment had confirmed their continued need for assistance or that there had either been little reassessment of the service recipients during this time. The pattern of use of other public services amongst the intervention group was also consistently higher at both times than for the control group. This appears to indicate that receipt of help from the HCS was associated with a greater degree of integration into the local service system.

Interestingly, the proportion of members of both groups assisted by home nursing services was almost identical at both times on which data is held. A far greater degree of variance in the receipt of home nursing services was evident than was the case for the HCS. Clearly, the distinctions made between the assessment of the two groups by the HCS were not replicated in those conducted by home nurses.

The use of private cleaning services by members of the control group, also evident in results presented in Table 6.8, contrasts with the relative absence of use of private cleaners amongst the intervention group, who clearly relied on the HCS for this function. It could be concluded that in this instance, for the control group members, private cleaners were acting as a substitute for the public service. Importantly, however, a majority of those in the control group did not report using either source. Clearly other solutions, such as reliance on spouses, family and friends, and self-provision were also serving as substitutes for Home Care. Other individuals were able to provide for themselves, some by simply doing without.

Table 6.8: Use of Support Over Previous 12-18 months, Interview Sample (Percentage of Each Group)

Source of Assistance	Currently Recieved (T3)		Received at Referral (T1)	
	Intervention %	Control %	Intervention %	Control %
Public Community Services				
Home Care Service	95.2	4.9	100.0	0.0
Home Nursing	7.2	5.1	14.8	15.6
Meals on Wheels	16.9	10.1	32.1	19.2
Day Care	7.2	6.5	3.8	5.2
Home Shopping	2.4	3.8	1.2	2.6
Community Transport	11.0	6.5	6.3	5.2
Paramedical Services	18.1	7.8	27.2	13.0
Other Public Community Support	13.4	5.2	13.6	6.5
Private Services				
Private Cleaning	3.6	25.6	1.3	20.8
Private Nurse	0.0	0.0	3.7	1.3
Private Personal Care	0.0	0.0	0.0	0.0
Personal Alarm Systems	3.7	5.1	1.3	3.9
Other Private Services	40.2	29.5	34.2	23.1
Informal Support				
Spouse/Partner	16.2	26.5	17.9	26.9
Other Family	53.7	51.3	67.1	61.3
Friends/Neighbours	36.1	29.5	40.0	34.2
Number[a]	83	79	83	79

Note: a) The numbers of subjects varied slightly for different questions, total subjects varying from 153 to 161. Spouse/partner refers only to those to whom this question applies, a total of 136 subjects for current circumstances.

The use of most of the private care services nominated in the interview (private nurse, private personal care, and personal alarm systems was not great amongst either group. In other instances, such as gardening and podiatry, private services were used extensively by members of both groups. Interestingly, more members of the intervention group reported using these services than was the case amongst the control group. Whether this is indicative of greater disposable income (after other necessary payments), greater need, less help from family, greater integration of intervention group members into their local community, or other causes is not known. Whatever its cause, it is clear that at least for a great many of the control group, a withdrawal of public services has not led to their replacement by private sources. Nor has the provision of assistance with basic housekeeping by the public sector prevented members of the intervention group using private sources of assistance in other instances.

It is also interesting to note the consistency of support received by both groups from informal sources. The greater number of spouse/partners amongst the control group is directly attributable to the residential situation of each group, discussed earlier. Perhaps in compensation, there was a slightly higher incidence of support from other family and friends amongst the intervention group. The slight fall away in help from other family in both groups is consistent with the proposition, raised earlier, that there is a slightly reduced aggregate level of disability amongst the residual members of both groups who have remained at home over the last year. This pattern of reduced need for assistance is also evident in the data on the need for help presented in Tables 6.6 and 6.7.

6.4 Subjective Perspectives of the Value of Low Levels of Support

In addition to collecting factual information from the participants in the study, efforts were also made to learn about the value placed by participants on the provision of assistance with housekeeping and to understand how participants felt about a range of closely related issues. Information on a range of broad indicators of subjective well-being and quality of life at home, readily presentable in tabular form, is reproduced in Tables 6.9 - 6.13.

Perhaps the most outstanding and unequivocal finding concerns the importance that the participants placed on the availability of at least some level of help with housekeeping. When asked, an overwhelming majority of the sample, 93.7 per cent of all those who provided information, replied that they found basic help with housekeeping either important or very important for people such as themselves. As can be seen in Table 6.9, the majority of these responses indicated that such assistance was 'very important'. There was some, although little, variation in the responses from members of the intervention and control groups. This suggests that even amongst those who had gone without help, such assistance was regarded as valuable.

There was also a high degree of unanimity concerning the subjects' self assessment of their prospects of being able to continue to remain at home, and their degree of satisfaction with their arrangements for support at the time of the interviews[10] (see Table 6.10). As shown in Table 6.11, a large majority of both

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10   As might be expected, this almost unanimous satisfaction did not extend to the time of referral. A considerable number of control group members were still angry at having been turned away by the HCS. Indeed this anger often made interviewing quite difficult, at least in the early stage of gaining consent to continue.

Table 6.9: Subjective Importance of Basic Help with Housekeeping[a], Interview Sample

	Group		
	Intervention	Control	All
	%	%	%
Not at all important	0.0	2.6	1.3
Not that important	1.2	5.2	3.2
Don't know	2.4	1.3	1.9
Quite important	13.4	16.9	15.2
Very important	82.9	74.0	78.5
Number	82	77	159

Note: a)   Results of responses to the question: *Do you think that receiving help with basic household chores for no more than a few hours a fortnight is important in helping people like yourself manage at home?*

Table 6.10: Self-Assessment of Ability to Continue to Manage at Home, Interview Sample

	Group		
	Intervention	Control	All
	%	%	%
Yes	91.4	93.0	92.1
Don't know	6.2	4.2	5.3
No	2.5	2.8	2.6
Number	81	71	152

Table 6.11: Degree of Satisfaction with Current Arrangements, Interview Sample

	Group		
	Intervention	Control	All Subjects
	%	%	%
Satisfaction with current arrangements			
Very Unhappy	0.0	1.3	0.6
Unhappy	3.7	6.5	5.1
Uncertain	19.8	20.8	20.3
Happy	37.0	32.5	34.8
Very Happy	39.5	39.0	39.2
Number	81	77	158

control and intervention group members also reported that, on balance, they were happy or very happy with the current support arrangements. There was, however, a disturbingly large group who were unable to answer in a positive manner. On the basis of research in the United Kingdom, Gail Wilson has recently suggested that such neutral and non-committal answers from frail older people should be regarded as cautious and highly deferential, and therefore counted as being negative (Wilson, 1993). If such an approach were adopted, it could be argued that almost one-third of control group members and a quarter of the intervention group members did not feel they were adequately and securely supported at home with the current arrangements.

An indication of the extent to which additional help was thought to be required is evident from Table 6.12. Again, the majority of both groups reported that they felt they were receiving enough help. More than a quarter of both groups, however, found their current levels of support inadequate. A large proportion of these people wanted more help with housekeeping. Many also reported that they wanted a range of different forms of support: nursing, help with gardening, and paramedical help were the most common forms. Included in the figures presented in Table 6.12 are seven people from the intervention group who stated they felt they needed two or more different kinds of help, and two people from the control group who wanted three or more different services.

Table 6.12: Adequacy of Current Level of Help, Interview Sample

| | Group | | All Subjects |
| | Intervention | Control | |
	%	%	%
Receiving Enough Help			
Yes	71.1	71.4	71.2
No	28.9	28.6	28.8
Extra Help Needed			
Home Care/Cleaning	12.0	18.8	15.1
All Other Services	28.9	27.5	28.3
Number	83	70	153

Finally, participants were also asked whether they had difficulty paying fees for services they received. It is often believed that fees represent a barrier to the use of services, so it might have been expected, especially amongst a sample of low-income individuals, that the majority of participants would have experienced difficulties with the payment of fees. Somewhat surprisingly, the overwhelming majority of participants who answered this question said they did not have difficulty paying for assistance. As can be seen in Table 6.13, 83.7 per cent of all

Table 6.13: Difficulty Paying for Services, Interview Sample

	Group		All
	Intervention	Control	
	%	%	%
Yes	6.3	30.0	15.4
No	93.8	66.0	83.1
Uncertain	-	4.0	1.5
Number	80	50	130

respondents answered that they did not, at present, experience difficulty paying fees. The proportion was higher amongst the recipients of Home Care assistance, whose standard of reference was perhaps the subsidised level of fees to which they were accustomed. Among the control group, where the reference standard was perhaps the higher level of unsubsidised fees charged by market-based private services, the proportion reporting difficulty paying fees was far higher. It is also perhaps significant that a relatively large number of members of the control group did not provide responses to this question. Other data collected showed that, in general, members of the control group who received services payed more than their counterparts who relied on publicly supported services.

In answering the question about difficulties paying fees, many respondents who indicated that they were happy and able to pay fees, usually qualified their remarks to point out that this only applied while fees remained low and could be paid from limited disposable income. The response of one relatively active women was typical of those of many others in the survey.

> No. I don't really have any problem paying for services now,
> as long as they don't get too expensive. (But) I can't really
> afford to pay any more than I'm paying already.[11]

Respondents feared that if they became more dependent they would be unable to pay for all the help they might require. Whilst it was still possible to pay a little, those who responded reported that were, by and large, happy to do so. The relatively large group of subjects amongst the control group who indicated they had already experienced difficulty in paying for assistance is, however, indicative

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11   This was a subsidised fee of around $5.00 an hour for 1.5 hours help with cleaning each week from HCS, compared to $12-$20 an hour required by those who used private cleaners and other related private services.

of the difficulties likely to be faced by those who are more reliant on the private market for support.

Although it would be unwise to attempt to draw conclusions about the capacity of consumers to pay for more help on the basis of this data, it is interesting that it appears to indicate that the respondents did not regard low levels of fees as a major barrier to using assistance. The low cost of low levels of services appears, indeed, to be one of their most attractive features to consumers and governments alike.

6.5 Conclusion

As the evidence examined in this section has shown, there is considerable overlap between the two study groups on most variables examined. There were, however, also a number of important differences identified, suggesting that in some respects the comparison between the two groups is not entirely a comparison of like with like. The comparison shows that despite the considerable overlap between the two groups, the individuals in the control group appear to have been slightly better off overall than their corresponding equivalents in the intervention group. From this perspective, therefore, the initial research question should perhaps be rephrased: why did the control group, on the whole, not achieve better outcomes than the intervention group? The answer suggests that in some way the allocation of HCS may have made up for some of this intervention group's disadvantage. If the unknown fate of the sixteen individuals from the control group the researchers have been unable to trace is also borne in mind, the lessons that can be drawn from the comparison are even less supportive of the decision to reduce the availability of low levels of support for such clients.

It is also important to learn from the almost universal support expressed by respondents from both groups for the availability of housekeeping assistance for people such as themselves. Given the indecisive nature of the 'hard' data and other evidence available on the outcomes of the provision of low levels of support, the decisiveness of the more subjective evidence should, in our view, be taken into account. Trying to balance this evidence to draw lessons for policy concerning ways in which this support might be most effectively and efficiently made available, is the subject of the next, and final section.

7 Discussion and Conclusion

7.1 Fundamental and Policy Questions

This study was commissioned by the Department of Health and Family Services, following widespread concerns in the field of community care about 'the impact of the unavailability or withdrawal of services on individuals with lower needs and on their carers and families' (Morris, 1994: 38). To investigate the importance of providing low levels of support to frail older people who make application to Home and Community Care agencies for assistance with basic housekeeping, research was conducted which attempted to answer three fundamental questions.

- To what extent do basic housekeeping services prevent or postpone admission to long-term residential care?

- Is it possible to measure different outcomes over time among those who have received assistance through the HACC Program with basic housekeeping, and those denied it?

- What are the main forms of support used by those unable to undertake housekeeping on their own?

Following on from these, there were a number of important questions for policy which the study also sought to address.

- How might the need for the receipt of such services be best determined?

- How should alternative forms of support be taken into account in determining the need for public assistance with basic home support services?

We conclude this report by addressing each of these two broad areas of interest in turn. Section 7.2 summarises the evidence from the study which pertains to the fundamental questions about the significance of different sources of support used by a sample of older people who requested assistance with basic household tasks from the Home Care Service of New South Wales to help them remain at home. In Section 7.3, some of the policy implications of the study's findings are considered.

7.2 The Outcomes of Low Levels of Support: Results of the Study

The study used a quasi-experimental approach, based on the comparison of data collected from a group of service recipients and an equivalent group of non-recipients, to test the hypothesis that the provision of small amounts of basic community support services, such as housekeeping, affects the outcomes of support for frail older people who have modest needs for assistance.

The results from the study, discussed in Sections 5 and 6 of this report, found small but statistically significant differences in the residential outcomes of support at home for those who received public assistance for three hours a fortnight or less with basic housekeeping, and those who had sought such help but had been unable to obtain it (see Table 5.2). While the evidence points favourably towards the value of low levels of support for some home and community care clients, interpretation is difficult because the majority of both groups of research participants on whom data are held remained at home over the 13-18 month period following their initial referral to the Home Care Service. Although the information obtained on the residential outcomes of support for the full sample suggest that a greater proportion of the members of the control group faced difficulties, detailed information was obtained by telephone interview for only a few of those unable to remain at home, limiting the conclusions that can be drawn from much of the data collected.

The available evidence suggests that low levels of basic assistance provided by public community support agencies were associated with marginally superior residential outcomes, and marked improvements in the longer-term perceptions of residential security amongst the recipients. Publicly organised assistance was at least as effective as the alternatives and was, arguably, preferred to other forms of help to which most respondents had access. Although it was not possible to demonstrate improved health outcomes for recipients, the positive effects of basic home help on the subjects' perceived quality of life and subjective well-being were undeniable. An overwhelming majority of participants reported that they found small amounts of housekeeping to be 'important' or 'very important' for people such as themselves (see Table 6.9). Perhaps the most surprising aspect of this finding was that it applied equally to those who had received such help from the HCS, and to those in the control group who had not.

The need for help with housework was a very real issue for all participants. For those with direct, personal experience of the issue, there was little doubt as to the value of small amounts of housekeeping services. The strength of this finding is supported by the evidence that a large proportion of those refused help by the

HCS either received such help from family or friends or purchased it from private cleaners for at least some of the period covered by the study.

It is tempting to conclude from these results that the research hypothesis - that low levels of assistance with basic household help has a preventative effect - should be supported. Such a conclusion, would, however, be premature for several reasons.

First, despite the efforts of the researchers and HCS staff to ensure that the comparison between intervention and control groups was a valid and equal one, it is clear that although there was considerable overlap between the two groups, there were also a number of important differences. From the evidence presented in Section 6 it is clear that those in the control group were, for example, less likely to be living alone, more likely to report a higher household income and rely on income from private sources, and more likely to suffer from unstable medical conditions than their counterparts from the intervention group. There was also some evidence of differences in the levels of functional dependency, as measured by the ADL scale, between the two groups, as well as differences on a number of other measures.

Second, the results presented in Sections 5 and 6 show that the majority of those in the control group did receive support at home. Approximately a quarter of the sample substituted private cleaning services for the public support they had been unable to receive. There was also evidence of the receipt of a considerable amount of help from other services, both public and private, and from spouses, other family members and friends and neighbours among both groups. In short, rather than the study comparing the difference between two groups, one composed of individuals who received support and one of comparable individuals who went without it, the evidence is that assistance provided by the public agency was just one part of a far more complex and diverse range of supports drawn on by members of each group.

A third reason to counsel caution when interpreting the results of the study arises from the difficulty the researchers experienced attempting to trace all members of the sample. At the time of interviewing it proved impossible to contact 16 members of the control group and two from the intervention group. While this number was later reduced, the number still missing represents over seven per cent of the control group and almost two per cent of the intervention group on whom residential outcome data are available. The greater number of control group members unable to be traced is itself evidence which suggests that the receipt of assistance from HCS provided an important source of stability and security. Adding to the difficulty posed by those who could not be traced was the fact that there were a total of 35 individuals in the control group (27.7 per cent of the control group in the full sample) who had either been admitted to residential care,

died or could not be traced, and a further 13 in the intervention group (11.7 per cent) who could not be included in the more detailed collection of data by telephone interview. Their omission may have resulted in an account which is less representative of the problems experienced amongst the control group.

An Alternative Perspective

Drawing the available evidence from the study together, the comparison of the two groups suggests a rather different research question than that which the study originally set out to answer. Relatively low levels of mortality and admission to residential care were recorded among both groups, but the comparison suggests that the number of deaths and the rates of hospital use were higher amongst control group members (see Tables 5.2 to 5.9). Given that the members of the control group appear to be somewhat better off than the members of the intervention group on a number of measures (for example, being on average somewhat younger, less likely to be living alone and having a higher income), the research question which needs to be addressed is:

> Why were the outcomes for the members of the control group not better
> than those of the intervention group?

In addressing this question, it could be argued that the allocation of low levels of assistance with basic household support to the members of the intervention group appears to have acted in some way to remove the disadvantage that the recipients of HCS help would otherwise have experienced. Several possible factors that could lead to such an outcome were suggested by the results. The positive results, for example, may be a result of the integration of intervention group members into a service and support network that they may otherwise have missed out on. It may be the result of the stability and security provided by regular assistance, or the result of other factors, such as the short-term impact of support during a time of crisis.

In turn, the results may reflect the targeting of services within the HCS.

The current standardised approach to assessment within the HCS provides a reliable and objective method for prioritising need between applicants. As discussed earlier (see Section 4), the approach appears to produce relatively consistent results within branches, although there was some evidence that the likelihood of an applicant with a similar profile to that of most of the participants in this study receiving help, varied considerably between branches. By prioritising service recipients with a particular set of risk factors (such as financial disadvantage, living alone, stable disability) the procedure may be selecting out others who face greater mortality risks and a higher risk of

hospitalisation. Such a conclusion would be consistent with the findings from a study of the discharge from hospital of older people in Dubbo (McCallum et al., 1994). The Dubbo evidence suggests that only very few patients discharged from hospital, who had not previously been customers of the HCS, would be likely to be accepted by the service.

One plausible explanation for this selection bias, suggested by one of the HCS Branch Managers, is that home nursing services, in the past, have disputed the competency of HCS staff to intervene in instances where an unstable health condition or acute illness may affect the client's condition. To reduce conflict between the two agency types, the HCS agreed to take responsibility for applicants with stable health conditions only. This decision, which prevented the duplication of service provision and set out clearly defined roles and responsibilities for the two service types, has become a firm policy. Where there was evidence of unstable health, applicants for support at home would be more likely to be referred to a home nursing service than to receive assistance from the HCS.

It is, of course, also possible that the HCS provides a more secure, higher quality and effective service than that which may be purchased on the open market. Although the assessment and selection procedure gives priority to people facing financial disadvantage over those from higher-income groups, it is clear that the mix of substitute supports utilised by those refused assistance did not provide the continuity, nor perhaps the security of service enjoyed by those who received it from the HCS.

A Tentative Result

Having conducted this study and undertaken a preliminary analysis of the results, it must be accepted that the results, with regard to the outcomes of service provision, remain somewhat less than inconclusive. While the results suggest that the availability of small amounts of basic assistance would, in general, have beneficial effects for most applicants, the hypothesis that small amounts of household help will act to prevent premature institutionalisation was not conclusively proven. Nor has it been disproved. Further research on the topic, including the establishment of medium to large size prospective evaluative studies using randomised controls, remains an important task.

Given the continuing budgetary pressures likely to be faced in the field of community care, future research on the general topic should also be extended to examine the impact of other forms of basic support, such as Meals on Wheels, shopping and transport services for the housebound, and social day care services. Similarly, the outcomes of the use of practical in-home technology, including

personal alarm systems, telephone-based monitoring services, and equipment to assist with personal care, also warrants further attention (McInnes, Hailey and Crowley, 1994).

On the basis of the research literature reviewed in this report and elsewhere (Fine and Thomson, 1995b) there is also a strong case for research on the value and marginal effectiveness of much higher levels of servicing. The reasoning behind the reduction in the availability of small amounts of assistance with housework has been that small amounts of help are unlikely to be decisive for most people seeking to remain in their own home. But the question should also be asked about the marginal value of additional amounts of assistance for those who already receive significant amounts of help. At what point does additional assistance cease to be cost-effective? How significant, for example, is an additional ten hours personal care for a person who already receives 30 or 40 hours a week? If it is significant, is it a cost-effective expenditure given the availability of cheaper, alternative forms of care? How cost-effective is ten hours of in-home respite each week, and how does it compare with ten hours of respite provided at a day care centre?

7.3 Implications for Policy

Although the principle of evaluation is now widely accepted, and indeed has been an in-built feature of Commonwealth programs since 1987 (Department of Finance, 1987; Saunders and Fine, 1995) it is important to remind ourselves that this kind of detailed outcome evaluation is a relatively new phenomenon. Most of the services, interventions and expenditures that are accepted by government and citizens alike as vitally important have not been, and are unlikely to ever be, subject to such scrutiny.[12] In the absence of a more balanced picture of the utility of other forms of help, attempts to make policy decisions about future targeting strategies for community care which draws on systematic information of the effectiveness of only one type and level of service would appear to be most unwise.

Given the inconclusive nature of the results of this study, it is important to be suitably modest in drawing lessons and making suggestions for future policy development. There are, nonetheless, some implications which are likely to be of

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[12]   A pertinent recent example is the effects of the introduction of tax rebates for holders of private medical insurance. This expenditure, in its first year of operation (1997-98), has been estimated to be of approximately equal in value to the entire Home and Community Care program, costing many times the amount involved in the the subsidy of the provision of access to basic household help (Department of Finance, 1996).

interest to policy makers, service providers and others and therefore deserve at least some comment.

7.3.1 Mechanisms for Providing Basic Help: Some Directions for Future Development

The emphasis placed by participants on basic help should be a signal for service providers and others to improve the current service provision structures and targeting strategies to ensure that existing resources are used in ways which will ensure those in need will have the knowledge that basic assistance will be available to get them through periods of need. Evidence collected in the course of this study, particularly regarding the use of assessment and prioritisation strategies by the HCS and the length of service provision for those who successfully applied for it, suggests that consideration of alternative approaches to the targeting of assistance may offer considerably better prospects for both consumers and for the stewardship of HCS resources.

Assessment and the Length of Service Provision: A New Strategy for Service Rationing

The reduction in access to small amounts of basic household assistance arose as an attempt to ration the scarce resources of the HCS, ensuring that priority was given to those with the highest need for assistance. As is common practice amongst community care agencies, the rationing of resources occurs mainly at the point of entry, as part of the initial referral and assessment screening procedures that take place before an applicant is deemed eligible for assistance. But, as the figures on service provision demonstrate (see Table 6.8) there was little evidence of subsequent readjustment by the HCS. Around 95 per cent of successful applicants for assistance from the HCS continued to receive help 15-18 months after their initial assessment, while an even great proportion of those who were unsuccessful at the time of their referral were forced to continue to manage without HCS help. Those assessed as requiring assistance at the time of their initial application were thus unlikely to see their assistance withdrawn at a later date as a result of further reassessment. It was as if those who were successful in getting through the first hurdle of the initial assessment were given a life long entitlement to support from the HCS. Those who were unsuccessful, were, in turn, also effectively excluded for the longer term.

This pattern of provision suggests that there may be a capacity to reorder the emphasis of the assessment and allocation strategy in a manner which would achieve an equally economic rationing of assistance, but enable community care providers such as the HCS to continue to provide low levels of basic household

support to a far higher proportion of applicants. Indeed, if such a commitment to ongoing service also applies to other existing clients, a different assessment and rationing strategy may enable the service to provide assistance over time to a considerably enlarged number of clients.

The application of such an approach may be illustrated as follows. Providing assistance to 100 clients for a period of two years requires the same quantum of assistance as the provision of equal levels of assistance to 400 clients who each receive help for a period of six months. If it were possible to reduce the length of service for a proportion of clients by enhancing their capacity to continue to live at home independently and providing them with the security of ready access to further assistance should their condition become unstable or their need for help increase, an equivalent proportion of resources would be freed up to provide assistance to applicants currently excluded. For example, if half of the original 100 clients were reassessed after six months as no longer requiring assistance, a further 50 clients could be helped in the first year, increasing the total number of clients assisted in the year to 150. This represents an annual increase of 50 per cent in the capacity of the service (measured as the total number of clients who can be helped), without the need for additional resources. Attempting to obtain a similar result by rationing resources by focusing exclusively on reducing admissions to the service would require a reduction in the number of people who could be assisted of approximately 50 per cent. If the rationing is targeted exclusively at applicants who require only low levels of assistance, the actual number of applicants who would be excluded would be considerably greater.

The potential for utilising an ongoing (re)assessment strategy has been clearly demonstrated by research and recent changes introduced to home care services in a number of European countries (Hutton and Kerkstra, 1996). In Britain, for example, computer modelling of service provision data was used to predict the impact of three different targeting strategies on the use and outcome of home care in the United Kingdom (Davies and Baines, 1992). The results showed that regular reassessments of all clients, and the discontinuation of services to a relatively small proportion of those who were found to no longer require assistance (assumed to be approximately 10 per cent of all service users each six months), proved to be a more effective means of extending service coverage than other approaches to the targeting of services which served to exclude important client groups from receipt of any service. After five years, the costs of serving the population without reassessments was found to be approximately one and a half times that of assisting the population remaining after regular reassessment.

At present, very little is known about the extent to which changes in the turnover rate of HCS clientele, as indicated by length of service provision for particular clients, would effect the overall cost and use of resources. It is, however, clear

that increased emphasis on ongoing (re)assessment, with the introduction of shorter periods of service where appropriate would lead to greater turnover of clients than presently exists. Such an approach would be facilitated by a reconsideration of the aims of providing assistance, entailing a shift from a philosophy based exclusively on the 'maintenance' of clients in their homes and the adoption, where appropriate, of a more explicitly preventative and restorative approach to service provision where help was provided for the period of need, with the aim of enabling recipients to regain an optimum degree of independence. The adoption of such an approach would provide an equally cost-effective, but considerably more effective and attractive targeting strategy than that which has been currently adopted.

Changes in Branch Resource Allocation Mechanisms

Another aspect of the operation of HACC services highlighted by this study concerns the resource allocation formula for different branches of the Home Care Service. As shown in Section 4 of this report, there were marked differences between HCS branches in their capacity to respond to the demands made by applicants for assistance. The existing resource allocation formula, based on a combination of historical accounting procedures and population figures, appears to operate in a way which (unintentionally) discriminates against residents of some regions while favouring others. For the principle of equity of access to apply, it is important that equal access be ensured regardless of the address of those referred for assistance.

Payment of Fees and the Availability of Substitute Support

Closely relate to the issue of access to basic services is the issue of the capacity of applicants to pay either for the assistance provided by public agencies or to organise and finance substitute support. While many participants indicated that they were able to pay for some assistance, the qualification was usually added that they could only manage this while costs remained within their budget (see Table 6.13). It is, therefore, important to emphasise that their capacity and preparedness to pay for assistance was limited by the very constrained incomes most experienced. Most individuals who mentioned fees spoke of levels ($5-$15 for two hours help a week) that were below current market prices. A further qualification to bear in mind is the fact that a sizeable proportion of the control group, those who were most often forced to pay full market rates, indicated that they did experience difficulty in paying and would be unable to meet realistic market fees for service.

One of the attributes of low levels of basic home support services is that the cost, per household or consumer, remains relatively low. With appropriate payment mechanisms, the cost of providing potential frail aged consumers with access to household help may be brought within reach of most if not all households, without the need for invidious competition between applicants that flows on from current rationing procedures. It is understood that such schemes already operate in a number of European countries, where the provision of publicly provided community support has become increasingly targeted in recent years to provide for a more intensified form of provision for consumers with needs for more greater amounts of support (Davies et al., 1990: 291-402; Hutton and Kerkstra, 1996). In the Netherlands, for example, trained 'Alpha Helps', as they are termed, may be directly employed by older householders without requirements of meeting assessment criteria (Kastelein, Dykstra and Schouten, 1989). A capped maximum fee structure is employed, so that if need increases and the costs would exceed a given threshold, access to fully subsidised care is available.

While it would not be appropriate to recommend such a scheme on the basis of the findings of this study, it was clear that the participants in the study placed a high value on access to housekeeping. It would be particularly disappointing if the inconclusive results of the outcome measurements were used to justify the withdrawal of this provision without detailed consideration of alternative mechanisms for ensuring that such provisions are made accessible for those older people, and their caregivers, who feel (correctly or incorrectly) that they require them. As personal finances clearly play a significant role in the capacity of those in need to access substitute services, it is important that further attention to the issues of fees for Home and Community Care services take into account the need to encourage, rather than prohibit, cost-effective access to low levels of basic home support.

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